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NORTHERN TERRITORY
An Australian Government Initiative

Productivity Commission Draft Report

Mental Health

NT PHN SUBMISSION

January 2020

The following submission is a response from Northern Territory Primary Health Network (NT PHN) to the Productivity Commission's publication of the draft reports (Volume 1 & 2 and Overview and Recommendations) on Mental Health released on 31st October 2019.

The NT PHN submission is in support of the Collective Submission from the Primary Health Networks Cooperative and has been provided to complement this and further highlight specific priorities and challenges related to the Northern Territory context.

Context

Northern Territory Primary Health Network (NT PHN) is the Primary Health Network for the Northern Territory (NT). One of 31 Primary Health Networks Australia-wide, its charter is to improve health outcomes for the Northern Territory's population, through building local partnerships and directing resources towards an integrated, high quality primary health care system.

NT PHN, a not-for -profit company, is governed by a membership of three – the Aboriginal Medical Services Alliance Northern Territory (AMSANT), the NT Government Department of Health (NT Health) and the Health Providers Alliance Northern Territory (HPANT). By virtue of this membership coverage including Aboriginal community controlled health services, public, and private health sectors, NT PHN considers that it is well placed to foster system wide collaboration and integration.

The Northern Territory (NT) has a population of approximately 247,000 people, dispersed across 1.4 million square kilometres. The majority of the NT falls within Modified Monash Categories 6 and 7[1], the most remote classifications. Aboriginal and Torres Strait Islander peoples (hereafter Aboriginal) represent 30% of the population, with over half living in remote and very remote locations. People who live in remote and very remote areas have generally poor access to health care practitioners, and experience poorer health outcomes including an increased number of potentially preventable hospitalisations (2.5 times higher than in major cities), reduced life expectancy and increased total

[1] The Modified Monash Model (MMM)

MM1	Metropolitan
MM2	Regional centres
MM3	Large rural towns
MM4	Medium rural towns
MM5	Small rural towns
MM6	Remote communities
MM7	Very remote communities

https://www.health.gov.au/resources/publications/modified-monash-model-fact-sheet

disease burden. Against this backdrop NT PHN is a single jurisdiction PHN, committed to the equitable distribution of health services across this large and complex environment.

There is a range of complex and interrelated factors that impact on the accessibility and quality of mental health services in rural and remote communities in the NT. The scarcity of services, in particular across the spectrum of low to high intensity mental health services, in rural and remote areas due to the wide geographic spread of a small population is a key factor in rural and remote Australians accessing mental health services at a lower rate. A 'thin' market in a very large geographic area means that there are limited public and private services available to meet the diversity of need. Despite some of these challenges, the NT PHN continues to make positive progress towards improvements in integrated and coordinated high quality care across range of health and mental health domains.

Against this backdrop, and consistent with the view of the PHN Cooperative, NT PHN rejects the Rebuild and Renovate Models proposed by the Productivity Commission (draft recommendation 23.2: Structural Reform), recognising the risk posed through the embedding of an additional layer to a system that is already working toward localising commissioning and regional service integration. NT PHN is supportive of the Repurpose model proposed by the PHN Cooperative that supports a local collaborative decision making mechanism through a joint Regional Commissioning Function (RCF) that sustains and strengthens the existing collaborative partnerships between PHNs and LHNs and provides scope for Aboriginal Community Controlled Organisations to participate fully in the partnership environment. The design of the Repurpose model takes into account the regional progress that is ongoing in an environment that is already reorientating to a significant mental health reform agenda, inclusive of the NDIS.

NT PHN is in agreement with the PHN Cooperative submission in that we believe dedicated attention must be given to the combined social, emotional, cultural and physical wellbeing of a person through an authentic integrated approach underpinned by collaborative relationships, in particular with Aboriginal Community Controlled Organisations (ACCOs). Therefore, we strongly support the draft recommendations that recognise the significance of the social determinants of mental health and suicide prevention and the need to prioritise the expansion of collaboration across health and non-health sectors, including justice and housing, and the recognition of the need to address systemic discrimination.

The compounded impact of social determinants that include intergenerational trauma and dislocation, is high in the Northern Territory, with people living in rural and remote areas encountering a range of stressors that are unique to living outside major cities, including greater prevalence of some chronic conditions and disability, and generally poorer health. Social and emotional determinants of health exacerbated over the long term are a significant contributing factor for episodes of mental ill health in rural and remote areas.

Through its codesign and commissioning processes, NT PHN has worked to ensure access to targeted and culturally appropriate mental health and alcohol and other drug services, through a social emotional wellbeing (SEWB) model. The SEWB model is based on a holistic model of primary health care that provides responses to mental health and alcohol and other drug (AOD) issues in an integrated and coordinated way. The SEWB Model is delivered through three streams of care (Medical stream, Therapeutic stream and Social/Cultural stream) which are multidisciplinary, integrated and inclusive of strengthening the local Aboriginal workforce. Trauma informed training, supervision and critical reflection of the impact of trauma and ways to improve the mental health and wellbeing of individuals and communities effected by trauma is an integral component of the workforce support within the SEWB model. The model is located within comprehensive primary health care settings and is able to be locally adapted to community need. The model is delivered within Aboriginal Community Controlled organisations where available to support Aboriginal people's control of their own mental health and AOD services in order to provide services that are culturally appropriate and effective.

Case Study: Co-designing a Social and Emotional Wellbeing (SEWB) model of care for NT

NT PHN undertook a codesign process in partnership with the Northern Territory Aboriginal Health Forum members (AMSANT, NT Government Department of Health, Australian Government Department of Health, NT PHN) for the commissioning of Indigenous Mental Health and Indigenous Drug and Alcohol Treatment Funding for the NT. It was considered that a co-design process would enable a systematic and collaborative mechanism for the design of culturally appropriate and quality models of care based on equitable needs-based planning. The codesign process considered appropriate models of care, cost analysis and financial modelling, service mapping to determine areas of greatest need, procurement approach, workforce development and support requirements and monitoring and evaluation. Codesign with system partners ensured integration and coordination

across the service system with a model that had shared commitment and support, was appropriate and acceptable to providers, communities and individuals to ensure community empowerment, stakeholder buy-in and trust, and was built on evidence and agreed standards of quality and clinical safety.

Supporting and sustaining the local workforce has been integral to the delivery of the SEWB program (and other mental health programs) for delivery of culturally appropriate, safe and high-quality service responses. The NT (like many rural and remote areas) has traditionally experienced challenges in health workforce recruitment and retention including:

- Accessing potential workforce
- Attracting potential workforce
- Cultural safety and competence relevant to NT communities
- Pathways and training for Aboriginal Health Workforce
- Matching workforce skills and needs with the particular needs of the NT population
- Supporting the transition of employees to new workplaces, including relocation and professional development to attain minimum standards
- Ensuring orientation, professional development, networking and peer support
- Ensuring appropriate professional supervision
- Ongoing support to ensure the health professional adjusts to a rural remote environment (both professionally and personally) and feel comfortable that they are well equipped to meet these challenges.

A well-trained, well-supported and well-resourced Aboriginal mental health workforce is widely seen to be critical for the delivery of equitable, culturally engaged mental health care for Aboriginal people. It is also necessary to ensure that psychological assessment and related psychometric tools are validated for Aboriginal people.

Workforce issues are further outlined below in response to specific Draft Report Recommendations.

Draft Recommendation Responses

NT PHN has identified a number of Recommendations in the Draft Report where there are specific implications for mental health and wellbeing and associated services in the Northern Territory context including:

- Consumers Treatment Needs
- Online Treatment Options
- Mental Health Nurses
- Peer workforce
- Care Integration and coordination
- Psychosocial
- Housing
- Health Workforce
- Suicide Prevention
- Models of Funding
- Data and Information Sharing
- Reporting

Responses to Draft Recommendations and specific Information requests are addressed individually in the remainder of this submission, and the responses should be considered in parallel with the overarching priorities and comments outlined within the PHN Collaborative submission and above.

Draft Recommendation 5.2 – Assessment and Referral Practices in-line with Consumer Treatment Needs

Information Request 5.2: Mental Health Treatment Plans

How should the requirements of the Mental Health Treatment Plan (MHTP) and MHTP Review be changed to ensure that GPs assess, refer and manage consumers in line with best practice (as laid out in the Australian Department of Health's guidance)?

The MBS item requirements and associated notes for the relevant items (2715, 2717 and 2712) should be reviewed and updated to be in line with best practice guidance. Given the complexity and importance of providing quality mental health care, these consultations are generally time-consuming and a higher rebate than is currently offered would seem appropriate. Nonetheless the MHTP remains a useful tool to assist GPs in the assessment, management and review of consumers with mental illness. The MHTP is also a useful document for the consumer with documented individual goals and strategies for the individual to implement.

Consideration should be given to incorporating the Stepped Care model into the MHTP; this could provide GPs with the framework to determine if psychological services are required or if online treatment may be a valid initial intervention. The MHTP should continue to be a reference source for accessing and communicating with psychological services as it provides a comprehensive summary of the mental health issue and can be used for monitoring improvement or deterioration in mental health over time. Non-health supports as noted in the Stepped Care model can also be considered and addressed as appropriate.

Consumers should be offered a copy of their plan when it is written and again whenever their plan is reviewed. This provides consumers with a documented form of the conversation that has been undertaken with their GP, the mutual goals that have been created, and the plan for fulfilling these goals.

Draft Recommendation 5.8 —Increase consumer choice with referrals

The Medicare guidelines already state that referrers should let patients choose where to present the referral. As a referral letter is deemed to be a communication between medical practitioners, often using complex medical terminology, the inclusion of a consumer-directed statement is determined to be beyond the scope of a referral document. With the increased use of secure messaging, referrals are more often being directed straight to the specialist or allied health professional and information contained in the referral may not be seen by the consumer.

This recommendation is in keeping with the current Medicare referral guidelines however, there continues to be significant confusion and misconception among GP, specialist and allied health professionals regarding the requirements for referrals to be 'named'. PHNs could support information and education activities that increase both provider and consumer awareness around patient choice.

Draft Recommendation 6.1 — Supported online treatment options should be integrated and expanded

NT PHN supports the expansion of supported online treatment to cater for people from culturally and linguistically diverse backgrounds, as it offers an opportunity to significantly increase access to mental health services for people living in remote communities. We note that this expansion and the implementation of same will not be without its challenges due to the inconsistency of access issues

across rural and remote locations. Further to this, consideration regarding models of support to assist individuals to access online treatment services could broaden and expand mental health treatment reach and acceptability.

Education for GPs regarding the various online treatment options, how to access them, and how to support patients through their mental health treatment journey and integrating the online treatment with face to face healthcare services could be provided through PHN education programs.

Nonetheless NT PHN believes that the benefits of integration and expansion of online treatment will ultimately outweigh the design, implementation and access challenges.

Draft Recommendation 5.7 — Psychology consultations by videoconference

NT PHN endorses this recommendation. NT PHN currently commissions several providers to deliver psychological consultations to clients via video conferencing in locations such as Tennant Creek where there are no placed based psychological therapists available. A culturally informed workforce is important to ensure telehealth approaches are delivered in an appropriate and effective way.

Draft Recommendation 7.2 — Psychiatry consultations by videoconference

NT PHN supports the expansion of psychiatric videoconference services through all regional and remote regions. Some regional and remote communities have limited, or no, access to face to face psychiatric services, and some consumers are unable to attend face to face psychiatric appointments. Psychiatry services are limited in the NT. Expanding consultation access through videoconferencing will assist in bridging this service gap. Supporting and educating psychiatrists to fully understand the wide ranging health, social and cultural issues for remote communities should also be considered. There should also be provisions (and funding) for the care coordination role of GPs in this setting as they will be critical to contextualising the clinical situation for the psychiatrists.

The role of the local clinic and GP in supporting the teleconference process and implementing and monitoring management plans initiated by the specialist psychiatrist should also be considered. Funding for the GP/local clinic staff/mental health nurses to implement and support this process should be considered.

Draft Recommendation 5.1 — Psychiatric advice to General Practitioners through the introduction of MBS item numbers so that patient diagnosis and management issues can be managed with the support and input from a psychiatrist

NT PHN agrees that increasing psychiatrist availability to provide diagnosis and management advice directly to GPs within the community is essential.

We strongly recommend that initiatives such as the GP Psychiatry Support Line service, established by PHNs in eight regions across NSW, which facilitates immediate advice for GPs from psychiatrists, and provides them with the skills and knowledge needed to deliver care to their community, continue to be supported and expanded. This approach enables GPs to improve the quality of mental health services delivered in the primary health care setting, building capacity and capability of GPs and ensuring timely care. It is has been identified as a significant need and gap in the Northern Territory. While NT PHN supports the expansion of availability of psychiatrists to provide advice to GPs, the implications of the incentivisation of this through MBS rebates should be thoroughly worked through.

Once a defined specialist is involved within patient care, GPs and psychiatrists should consider utilising case conferencing/teleconferencing item numbers, with a review component, for the provision of advice and ongoing case management.

Draft Recommendation 11.3 – more specialist mental health nurses

NT PHN supports an increase in the numbers of specialist mental health nurses through the development of accreditation standards to obtain a degree in mental health nursing and review the merits of introducing a specialist registration system for nurses with advanced qualifications in mental health. (pg 63). Expanding the number of specialist mental health nurses could assist with mental health treatment and care in rural and remote settings where mental-health workforce numbers and staff retention is an issue.

Draft Recommendation 11.4 — strengthen the peer workforce

NT PHN supports the progression of work being undertaken by the National Mental Health Commission on peer workforce guidelines and the establishment of a professional organisation to represent peer workers. We agree that professionalisation of peer workers should include educating health professionals about the value of a peer workforce and the legitimacy of their roles. The peer

workforce will be advanced and sustained as the recommendations suggest through the development of a comprehensive system of qualifications and professional development.

NT PHN and other stakeholders such as the NT Mental Health Coalition are actively engaged in supporting the advancement of peer workers in the Northern Territory. The NT PHN funded the recent peer worker needs assessment that will inform peer worker planning into the future.

Case study: Peer Led Education Program Darwin

A Peer Led Education Pilot program is being run by the NT Mental Health Coalition (NTMHC) in the Darwin region, and is scheduled to be completed by mid-March 2020. The Pilot program has been commissioned by NT PHN.

The first stage of the Pilot involved the delivery of the My Recovery program in August 2019, which generated significant interest (including 50 'Expressions of Interest') and received very high praise from the 17 people who completed the program.

The My Recovery program is a person centred, recovery-oriented education program that was created by Wellways Australia Ltd people by those who experience mental health challenges and is delivered by trained Peer Facilitators (i.e. people who have also experienced mental health challenges). A significant element in the success of the Peer Led Education Program in Darwin is attributable to the peer centric model employed by the NTMHC and is reflective of the evidence based recovery-orientated practice outlined in the Fifth National Mental Health and Suicide Prevention Plan and the PHN Guidance for Peer Work in Mental Health and Suicide Prevention.

Participation in the My Recovery program provides a pathway for people who experience severe and complex mental illness to undertake vocational training in the My Recovery Train the Facilitator Program. As an avenue of psychosocial support and a vocational pathway, My Recovery has the following key objectives:

Provide a time limited, capacity building form of psychosocial support;
Provide support to people who experience comorbid mental illness and AOD issues;
Provide a broad reaching service, accessing populations of people experiencing severe and

complex mental illness who may never have access psychosocial support before;

Reduce the stigmatisation experienced by people with mental illness, and

Stimulate the capacity of the peer workforce through the provision of a vocational pathway.

The delivery of My Recovery in Darwin for the Peer Led Education Pilot is subject to an external evaluation that is currently being undertaken by the Menzies School of Health Research. This is anticipated to be completed in early 2020.

The testimonials and qualitative feedback provided by participants showed a genuine appreciation for the peer-led approach and the ability of the program to build their skills and capability to respond to mental health and alcohol and other drug challenges. For example:

My Recovery facilitated connectedness with a diversity of others with similar experiences and wisdom to share. I truly believe in the personal recovery and peer-led model because it honours our journey and reimagines us as a community of active, capable and knowledgeable individuals. Participant Number 1 (September 2019)

I would recommend the Wellways My Recovery Program to anyone who has experienced mental health challenges and is thinking about working on improving their health and wellbeing. Participant Number 2 (September 2019)

Draft Recommendation 11.5 — improved mental health training for doctors

NT PHN acknowledges that the management of medication side effects is an important factor for the mental health competencies of GPs. However, broader education regarding the diagnosis and management (medication and other) of mental health issues is essential and should be made available to all practitioners who see clients with mental health issues. NT PHN continues to expand the utility of mental health HealthPathways for GPs and has developed a GP Mental Health Skills Training package for NT GPs.

Expansion of the availability of post-graduate certificate or diploma level training (akin to that offered by many other colleges including Obstetrics and Gynaecology through the DRANZCOG qualification) would be attractive to some practitioners. The lack of availability of structured post-graduate training programs for non-Fellowship candidates in Mental Health / Psychiatry is a limitation to having a highly skilled generalist primary health workforce.

Consideration of additional mental health item numbers available to providers who have undertaken advanced training should be considered. GPs could be incentivised to participate in this training through the availability of additional item numbers for those who have completed level 1 and 2 mental health skills training as approved by the General Practice Mental Health Standards Collaboration (GPMHSC).

Draft Recommendation 11.1 — The national mental health workforce strategy

The NT PHN supports the development of a National Mental Health Workforce Strategy and notes that it should align and have input from the Rural Workforce agencies, including NT PHN's Rural Workforce Agency NT, and the Allied Health Professions Australia. In addition, the development of a national mental health workforce strategy should be informed by the, *Indigenous Allied Health Australian Workforce Development Strategy 2018-2020*, the *National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework* (2016-2023) and the Council of Australian Governments' Health Council's (CHC*) National Aboriginal and Torres Strait Islander Health and Medical Workforce Plan* (in development).

Draft Recommendation 11.7 — Attracting a rural health workforce

NT PHN is in support of the Commission's recommendation that the Australian Government contribute funding to the full range of mental health workers, that includes clinical and non-clinical health workers in regional and remote areas and increase the availability of supervision for trainees that includes remote models of supervision for trainees outside of major cities (pg 29 Overview draft report). As such, the NT PHN is supportive of expanding the breadth and depth of skills available within the health workforce. This ideally would include expanding the number of Aboriginal health workers,

peer workers and peer support networks, navigation services, low-intensity psychological and psycho-social supports.

To enable the greater use of *videoconferencing* in rural and remote locations, much work would need to be done to ensure that systems are robust enough to support this expansion and enable greater access across all potential users.

The expansion of the *Rural Locum Assistance Program* should consider the following issues that are consistent with rural health workforce strategies in general:

- Extending education leave, taking into account some of the complexities (for example: wet season) and time-consuming travel to and from remote regions.
- Future workforce development could be enhanced by profiling mental health workforce roles to local students and community members with supported pathways into the roles.
- Increasing the capacity of the Aboriginal Health Practitioners to incorporate mental health care into the scope of the work with confidence.
- The expansion of Australian college of Applied Psychology (ACAP) type programs which focus on providing mental health services to patients with different cultural expectations and norms of health and wellbeing.
- Improving the dual modality capacity of digital health so that it works in tandem with face to face support. This would enable outreach service health practitioners to continue to provide comprehensive and consistent mental health care.
- Introduce strategies to assist new health professionals and locums to build relationships in community when they relocate. Establishing respectful and consistent professional and personal boundaries in remote settings will improve the health professionals' experience of working in a remote location and provide role clarity for members of the community.

Information request 11.1 — Aboriginal and Torres Strait Islander health workers

The Productivity Commission is seeking information from participants on any barriers impeding career progression for Aboriginal and Torres Strait Islander health workers, including barriers to the ability to move to broader health professions, such as mental health nursing

As stated above (Recommendation 11.1) NT PHN supports aligning the development of the National Mental Health Workforce Strategy with other health strategies that relate to and have relevance for health and mental health workforce, including Aboriginal workers, in rural and remote setting.

The vital role of Aboriginal Health Workers in the delivery of health services to Aboriginal people must be strongly supported and acknowledged. There are however a range of barriers that impede participation rates and career progression for Aboriginal health workers, a number of which are characterised as systemic. It will require strong and sustained system change to address some of these barriers that are not limited to, but include, social disadvantage, language, literacy and racism.

A review of the Aboriginal Health Worker (AHW) profession in the NT (NT Department of Health and Families, 2010), identified key areas for action in strengthening the Aboriginal health workforce. These include the following:

- achieving clarification of the role(s);
- increasing the AHW workforce;
- cultural awareness training for the non-Indigenous workforce;
- promotion of AHP careers in local schools by local AHPs;
- parity in wages and conditions including housing;
- putting in place major training and support structures;
- developing improved training models;
- implementing professional mentoring support structures;
- accepting job classifications and establishing more enticing career pathways;
- adopting management practices that better demonstrate human resource management best practice; and
- establishing working structures/relationships with other health staff.

There is a common view that more incremental pathways such as VET through to tertiary pathways would support an increase in the Aboriginal health workforce. A number of these initiatives are progressing in the NT:

- Menzies School of Health Research run a Certificate III course for Indigenous Research Assistants to support current research projects

- Batchelor Institute of Indigenous Tertiary Education offers a Certificate III Aboriginal and/or Torres Strait Islander Primary Health Care and a Certificate III in Community Services. These may serve as a pathway to the Certificate IV, although this does not often occur. Positions are NT Government funded and only open to NT applicants.
- The Northern Territory Aboriginal Health Academy (NTAHA) is a pilot program coordinated in a partnership between Indigenous Allied Health Australia (IAHA) and Aboriginal Medical Services Alliance Northern Territory (AMSANT).

Including compulsory cultural content in the curriculum and having culturally safe university and placement experiences are critical to increasing the participation and progression of Aboriginal students in allied health courses.

There should be a key focus on expanding opportunities for training, career advancement and career progression pathways which are not often readily available regionally for people living in rural and remote communities.

Draft Recommendation 10.2 – Online Navigation Platforms to Support Referral Pathways

NT PHN strongly supports these recommendations. Since 2018 NT PHN has developed pathways through the HealthPathways platform and have recently localised a suite of mental health pathways for the Northern Territory. Discussions are currently underway to expand access to similar content to that which is available through HealthPathways via a NT Health Literacy Library.

Draft Recommendation 10.3 – Single Care Plans for some Consumers

NT PHN supports the principle of single (shared) care plans for people with chronic or complex illnesses (including mental illness) and has been locally progressing plans for a unified shared care planning tool for all Northern Territory clinicians to use and collaborate on. It should be noted that any proposed plan will also need to encourage involvement and engagement from consumers and their carers, promoting self-management and patient-centred care.

The concept of MBS additions or amendments to recognise time spent in oversight and coordination of a single care plan is very sound recommendation, as this is currently unbillable under existing Medicare rules.

Draft Recommendation 23.2 – Responsibility for Psychosocial and Carer Support Services

NT PHN endorses the response of the PHN Cooperative and does not support the recommendation that State and Territory governments take on sole responsibility for commissioning psychosocial support programs outside of the NDIS. Psychosocial support program activities have been commissioned by PHNs since July 2019 when the previous PIR, D2DL and PHaMs programs ceased. As much work has subsequently been done by NT PHN to establish service delivery models and partnerships with stakeholders, the revision of the current model would create more instability in a sector that is restabilising as a result of significant system change.

Draft Recommendation 12.1 – Extend the Contract Length for Psychosocial Supports

As per the PHN Collective submission, NT PHN supports that the length of the funding cycle for psychosocial and clinical supports should be extended from one year to a minimum of five years to enhance planning, service delivery, evaluation and data collection. These five-year cycles should then be aligned to ensure that relevant work streams commence and end at the same time. Currently the delivery of a Stepped Care model of service procurement is impeded by the disjointed nature of funding cycles. Furthermore, there should be a mapping process undertaken that identifies other government policy reforms where the opportunity for a more cohesive and "joined up" approach can be achieved in the delivery of mental health services. This is particularly relevant in the current aged care reform agenda. Greater regional control of mental health funding is required in conjunction with clarification and transparency around the roles and responsibilities of Commonwealth, state and territory governments.

Draft Recommendation 12.2 – Guarantee Continuity of Psychosocial Supports

NT PHN supports that specific consideration be given to contact extension and continuity of psychosocial support issues in rural and remote settings. There are many regional areas and remote locations where FIFO models of service delivery are heavily relied upon and thin markets that make place based NDIS service providers unviable. Rural and remote workforce issues must also be considered with short funding cycles resulting in increased barriers to recruitment, retention and thus delivery of needed services.

Draft Recommendation 15.1 – Housing Security for People with Mental Illness

NT PHN is supportive of the recognised need to dedicate strategies and funding to better integrate social and health sectors, with more support for our State and Territory government partners to be provided by the Australian Government. We recognise the 'no exit from institutions recommendation', highlighting the pathway from inpatient hospitalisation and prisons into homelessness. This signifies an important recognition of the role that institutions implicitly play in homelessness and the impact of this on mental wellbeing. Expanding the availability of stable, affordable and secure housing should be a priority.

Draft Recommendation 21.2 – Empower Indigenous Communities to Prevent Suicide

NT PHN supports the recommendation that Suicide Prevention services for Aboriginal and Torres Strait Islander people should be commissioned through Aboriginal Community Controlled Organisations (ACCOs). Our experience in the Northern Territory supports the Commission's findings that program provision is sensitive to the experience, cultural and specific social issues facing particular communities.

Case Study: Strengthening Our Spirits

NT PHN received funding under the National Suicide Prevention Trial to consider how a systems-based approach to suicide prevention might best be undertaken to effectively respond to local needs, and to identify new learnings in relation to suicide prevention strategies for Aboriginal and Torres Strait Islander people. Through extensive Aboriginal community engagement and community led processes, a systems-based model of care referred to as the 'Strengthening our Spirits' model was developed. The Strengthening Our Spirits model draws on the concepts and symbols that are meaningful to the Aboriginal and Torres Strait Islander community in the Greater Darwin Region and links these to key elements believed to be important when taking a systems-based approach to the prevention of self harm and suicide. The model is based on the guiding principles that suicide prevention activities will:

- be flexible and responsive
- build capacity
- develop the local Aboriginal workforce
- engage culture, elders and lived experience

• involve local design or adaptation.

For more information please visit: https://www.ntphn.org.au/strengthening-our-spirits

Outcomes of the Strengthening Our Spirits project are in full support of Recommendation 21.2 in regard the importance to empower Indigenous Communities to prevent suicide.

Draft Recommendation 21.3 – Approach to suicide prevention

There are no one-size fits-all approach to reducing suicide rates in regional communities. A suicide prevention strategy that works in one community, may have very little impact in another. To ensure culturally appropriate services are developed in rural and remote areas, community consultation and engagement is essential. As one of the Australian Government's National Suicide Prevention Trial sites, NT PHN facilitated and supported the development of a community driven strategy called the 'Strengthening Our Spirits' model a local systems-based approach to suicide prevention for Aboriginal people in Darwin(Case Study above). The University of Melbourne is undertaking a National Evaluation of all Suicide Prevention Trial activities.

NT PHN supports a role for the NMHC to assess the evaluations across all of the trial sites as a means of expanding the evaluation findings across a range of sites not included in the Trials, that could include other locations in the NT.

Draft Recommendation 24.1 – Flexible and Pooled Funding Arrangements

NT PHN is supportive of this recommendation and believes that pooled funding will offer greater flexibility to develop, commission and implement locally responsive and integrated service models that are sustainable.

The current model negatively impacts sustainability of service models across the NT. With MBS rebates as the only source of revenue and the high cost of undertaking primary health care in remote settings, it is very challenging to service many of these locations in the NT. Pooled funding arrangements offers the potential to explore innovative and creative solutions that could augment existing service provision activities. Having a secure alternative funding stream would assist with ensuring the viability and sustainability of services.

Draft Recommendation 24.2 — regional autonomy over service provider funding

While PHNs support headspace as the best practice model for low to moderate youth mental healthcare, PHNs require greater flexibility over the use of youth mental health funds to best meet the needs of local communities and populations. Positive mental health outcomes will be better served if PHNs have regional autonomy over service provider funding. In the Northern Territory context where many Aboriginal people live in rural and remote areas, access to mental health services (of choice) are often characterised by a range of challenges that include long distance travel where transportation is limited and costly and the common experience of a sense of stigma and shame about seeking help.

These identified challenges related to rural and remote settings support the need for PHNs to have flexibility around commissioning decisions. Autonomy over service provider funding will assist with an ability to make place-based decisions about mental health service activity that is designed to meet the unique needs of Aboriginal young people.

Draft Recommendation 25.2 – Routine National Surveys of Mental Health

NT PHN strongly support both the increased frequency and robust sampling of particularly Aboriginal and Torres Strait Islander peoples living in remote locations. Definitions of 'service' should also be considered carefully to capture the range of social and emotional wellbeing and other culturally informed and integrated service models which can operate in remote locations with limited access to clinicians.

Draft Recommendation 25.3 – Strategies to fill data gaps

NT PHN is aware of (and participating in) the mental health services mapping project being funded by the National Mental Health Commission and undertaken by the University of Queensland, and we would welcome the alignment of these strategies and the resultant data collections with the National Mental Health Service Planning Framework – Planning Support Tool.

NT PHN recognises the sovereignty of Aboriginal people over data generated by and about them. It is recognised that the collection and use of health and health-related data about Aboriginal people must be carried out in partnership with Aboriginal people and organisations to ensure that the collection

and use of this data is meaningful and useful and can be directly linked to improved health outcomes and/or better service delivery for Aboriginal people. It must protect confidentiality and privacy and incorporate informed consent and feedback mechanisms. The reasons for the collection and use of data must therefore be transparent and clearly understood by people so that informed consent is obtainable and unnecessary private data is not collected and distributed without permission.

When health and health-related data about Aboriginal people is collected, the data must be held with strict privacy and confidentiality controls (which are established in consultation with the data owners). Analysis and interpretation of data should also be undertaken in partnership with the owners.

The current siloed funding arrangements, which are particularly evident in ACCHS environments, impose a significant administrative reporting burden. NT PHN is committed to commissioning for outcomes, and sees the development of safe, meaningful and streamlined reporting requirements as a critical element in the measurement and evaluation of mental health services.

Draft Recommendation 25.6 – Standardised Regional Reporting Requirements

NT PHN agrees that regional reporting requirements should be standardised and suggest that the key performance indicators for monitoring and reporting on mental health make some reference to cultural determinants such as social and emotional wellbeing.

Conclusion

Thank you for the opportunity to provide this submission. NT PHN consents for this submission to be publicly released with our details. Should any further information be required, please contact NT PHN CEO Nicki Herriot on 08 8982 1012 or by email at nicki.herriot@ntphn.org.au.