TEAMhealth SUBMISSION: NDIS SERVICES FOR PEOPLE WITH PSYCHOSOCIAL DISABILITIES

JOINT STANDING COMMITTEE ON THE NDIS

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Top End Association for Mental Health Inc. (TEAMhealth) has been providing community mental health services to people with mental illness in the Northern Territory (NT) since 1987. TEAMhealth is an incorporated association providing benevolent and charitable activities wholly in the NT.

TEAMhealth's vision is that *all people lead a full and valued life.* This is articulated through our purpose and operational philosophy of *creating community capacity for good mental health, enabling people to live a full and valued life.* We believe that mental health, being socially and emotionally strong, is an integral and essential component of health and well-being.

TEAMhealth has worked over the last 30 years to support the mental health of people across the Top End of the NT and provides a range of recovery focused services. These include residential services for people with severe and persistent mental illness, a community housing service, individual recovery and group based support, together with early intervention support, mental health promotion, suicide prevention and education. We support people from infants and their families to the aged, with 40% of our 500 participants being Aboriginal and Torres Strait Islander people.

We operate in the urban areas of Darwin and Palmerston, down and around the Stuart Highway to Katherine and Mataranka, across the Arnhem Highway region to Jabiru and around Darwin Harbour to the Belyuen community. We have remote services that are valued by community members in the Maningrida, Gunbalanya and Daly River communities and the broader Darwin, Litchfield and Katherine regions and Top End Shires.

Our ability to support people with their recovery and enhance their experience of TEAMhealth services is enhanced by our 70 skilled staff, our use of the Outcome Star and the nationally recognised YES survey (Your Experience of Service).

TEAMhealth is accredited to the National Standards for Mental Health Services (since 2014), has recently received accreditation to the NT NDIS Safety and Quality Framework and will shortly be registered under the National Regulatory Standards for Community Housing, demonstrating our focus on ensuring quality service provision and the pursuit of goals with participants.

TEAMhealth support services <u>known</u> to be within scope of the NDIS are:
- Personal Helpers & Mentors (PHaMs) in Maningrida, Daly River, and Darwin Rural & Remote
- Day to Day Living in the Community (D2DL) in Darwin
- Mental Health Carer Support (Top End)

Our support Services that <u>may</u> be within scope of the NDIS have NT Government funding/ support:
- Recovery Assistance Program (RAP) – outreach in Darwin, Palmerston, Katherine
- Long term Mental Health residential rehabilitation
- Potentially the short term Residential Rehabilitation sub-acute service
- TEAMhealth Community Housing program (self-funded model)

Our non-NDIS services include Child and Family Wellbeing, Youth Suicide Prevention and Education, and our Home Care (Aged Care) service.

This submission

TEAMhealth prepared this Submission to the Joint Standing Committee on the NDIS inquiry into the provision of services under the NDIS for people with psychosocial disabilities related to a mental health condition in January 2017 and submitted it in February 2017.

TEAMhealth CEO Helen Egan (the author) is a Board member of both the Northern Territory Mental Health Coalition (NTMHC) and of Community Mental Health Australia (CMHA). TEAMhealth endorses the views and recommendations put forward in the submissions from CMHA and NTMHC to this inquiry.

This submission includes recommendations against the terms of reference. It includes an Appendix which places mental illness in context both nationally and in the Northern Territory. This information is included to show the mental health need and the limited mental health service capacity across the vast areas of the NT and the daily challenges faced by people with mental illness, and those who walk and work alongside each individual.

The NDIS alone is complex; together with mental illness, remoteness, culture, poverty and housing stress, the NDIS is even more complex to understand, and engage with. TEAMhealth asks that the Senate Committee take these matters and our recommendations into consideration.

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TEAMhealth recommendations:

(a) eligibility criteria for the NDIS for people with a psychosocial disability;

1. **Recognise that mental illness support is built around recovery and remove the eligibility focus on disability and permanence for psychosocial disability.**
   This focus creates an inherent conflict and a barrier for people who could benefit from NDIS support during the fluctuations of their mental illness, leaving them unlikely to engage or even test their eligibility for the NDIS.

2. **Ensure the language of the NDIS is appropriate for many cultures and viewpoints.**
   As a highly culturally diverse Territory we have many Aboriginal languages and cultural groups, plus many people from migrant groups, again from diverse backgrounds.

3. **Consider the community living and obligations of family and kin in both urban and remote communities.**
   Trying to implement a one-size fits all national approach to the NDIS is not compatible with effective community discussion and decision making.

4. **Consider remoteness when assessing functional impact.**
   Functional impacts that may be identified in metropolitan and urban settings may not be identified in remote settings simply because different (often much lower) resources exist in remote communities. To discount the remoteness factor is to remove consideration of equity.

(b) transition to the NDIS of PHaMs, D2DL, Carer Support and PIR programs;

1. **Do not allocate all of the funding for PHaMs, D2DL, Carer Support and PIR to the NDIS.**
   Many people who currently benefit from the PHaMs and D2DL support services are likely to be ineligible for the NDIS. Removing funding from these programs will create large gaps in the community support available, ultimately leading to an increase in disadvantage and mental illness with heightened impacts and costs upon the population as a whole.

2. **Reconsider withdrawal of block funding for PHaMs, PIR in remote communities and isolated towns.** Isolated towns and remote communities such as those in the NT will be harmed if the "national NDIS" model is the only model possible. Service providers who work in isolated regions and remote communities will be unable to sustain services under the NDIS model, and individuals and the community will lose supports currently available.

3. **Ensure that the skilled workforce of psychosocial rehabilitation workers who support people in PHaMs, D2DL, Carer Support and PIR can be effectively recruited, trained, and retained under the NDIS.** Failure to sustain this skilled workforce will result in the quality and effectiveness of mental health support to individuals declining. In addition future workforce will not be attracted to a sector that is unable to support them with ongoing training and development, and appropriate remuneration.

4. **Design changes that ensure carers supporting people with mental illness will have ongoing access to support.**
Carers supporting people with mental illness are at risk of being excluded from further support if all carer support funds are rolled into the NDIS. Given the vital role that carers have on an individual and community basis this would be short-sighted and reduce the sustainability of carers dramatically.

whether these services will continue to be provided for people deemed ineligible for the NDIS;

1. **Ensure greater clarity about practical meaning of continuity of support (COS) as a matter of urgency.**
   a. Does COS only apply to those people who are currently receiving support from PHaMs, D2DL, Carer Support or PIR, and who have tested their eligibility and been found ineligible?
   b. What support will a person who starts to receive PHaMs support a year after roll-out commences, but before full roll out has occurred in June 2019, be able to receive in the long term?
   c. What support is able to be provided people after June 2019 who have been deemed ineligible for the NDIS?
   d. What support will be available to individuals whose need for support is identified after June 2019 when PHaMs, D2DL, Carer Support and PIR have ceased?
   e. What does COS mean for a carer?
   How will the carer be supported if the person whose NDIS plan has been determined does not recognise the impact of the caring role on the carer and hence no provision for carer support is included in the plan?

2. **Consider how service providers will be able to recruit, train and retain skilled workers in the community mental health sector.**
Meaningful, practical approaches to costing of mental health support is required to ensure jobs are sustainable and that recruitment and retention of a skilled workforce is not impeded by lack of recognition of these skilled workers' important role in the community and lack of certainty about their ongoing employment and contribution

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(d) transition to NDIS of all current long and short term mental health territory government funded services, and in particular;

whether these services will continue to be provided for people deemed ineligible for the NDIS;

1. **Recognise that in the Northern Territory the lack of clarity regarding psychosocial disability within the NDIS has been influential.** Wisely I believe the NT Government has not committed to roll its mental health funding into the NDIS.

2. **Understand that service providers will operate in a spirit of 'no double dipping' assuming the long term funding for support services they provide is sustainable.**
It is clear (but unwritten), that once a participant in an NT Government funded service has an activated NDIS package that includes sustainable, adequately funded and resourced support, then the NTG funding question needs to be addressed.
It is not clear whether discussion with the service provider will enable funds to be reallocated for support provision to other people on the waiting list and/or to those determined to be ineligible.

3. **Avoid a situation in the future where the NT Government did allocate all of its community mental health funding to the NDIS.**
If this was to happen in the future then there would be a significant gap in service provision, which would increase over time. As a result, many people would deteriorate, become unwell and increase demand for acute hospital based services, whether in emergency department or the inpatient psychiatric unit at Royal Darwin Hospital.

4. **Assist clarity about funding for support services for those people who are not part of the NDIS in the NT to be developed and communicated well.**

(f) the scope and level of funding for mental health services under the Information, Linkages and Capacity building framework;

1. **Consider the range of issues identified below regarding Information, Linkages and Capacity (ILC)**
   a. ILC is inadequately funded for the range of roles and expectation placed upon it.
   b. ILC skills in dealing with people impacted by mental illness is untested and in the current underfunded model they are unlikely to have the range of skills and/or capacity to respond required to mental health related matters when compared to all other disabilities
   c. ILC intention is to refer people to 'mainstream services' outside the NDIS. There is great concern that 'mainstream services' in the community mental health sector will not be viable and hence will not exist.
   d. ILC model is not suited to isolated and remote communities.

(g) the planning process for people with a psychosocial disability, and the role of primary health networks in that process;

1. Recognise that Primary Health Networks (PHNs) are struggling to understand their role in mental health sector reforms and in alcohol and other drugs sector reform.
    a. If working appropriately the PHNs would have an important role in educating their members about their roles as registered health professionals in supporting individuals to learn about and gather the evidence needed to test NDIS eligibility.
    b. It is not clear that PHNs have the resources or time to undertake this role for people with mental illness.

(h) whether spending on services for people with a psychosocial disability is in line with projections;

1. **Adopt the recommendation that any mental health funding that is allocated to the NDIS to be quarantined and only available to spend on mental health related supports.**
There is a major risk that the mental health funding could be swallowed into the NDIS and that people with mental illness will lose access to supports within the NDIS and outside the NDIS as a result.

(i) the role and extent of outreach services to identify potential NDIS participants with a psychosocial disability; and

1. **Ensure that all participants in the Partners in Recovery (PIR) program are eligible for the NDIS.** In the NT we know this is not happening and the Tennant Creek trial site demonstrated this.

2. **Consider how assertive outreach could engage with people with mental illness, taking account of** language, remoteness, homelessness, lack of 'on the ground support services', difficulty in explaining the NDIS and the processes that a person who has to go through, then add in isolation owing to weather, roads, rivers, island location, funding, etc. to make assertive outreach function in the NT. All of this is almost impossible so maybe start with ensuring that all participants in PIR are eligible for the NDIS.

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(j) the provision, and continuation of services for NDIS participants in receipt of forensic disability services;

1. **Understand the prevalence of mental illness among those people in jails and detention centres; particularly a concern for young people.**
For an insight into this area please refer to the recent Northern Territory Mental Health Coalition Submission to the Royal Commission into the Protection and Detention of Children in the Northern Territory, October 2016.
https://www.ntmhc.org.auNTMHC-Submission-to-NT-Youth-Detention-Royal-Commission-Oct2016

2. **Recognise that there are numerous elements concerning NDIS and the justice system**
   a. For people who will exit jail or similar, who have mental illness but no NDIS engagement, they need to have a wide ranging assessment of where they will live and how they will function outside the institution in which they have been held.

   b. For people who may get involved in the justice system, and have no involvement to date with the NDIS, could an NDIS assessment (once the eligibility criteria for psychosocial disability are clarified) and access to sustainable support services under NDIS help to prevent time in custody and further deterioration in their mental health and life conditions?

   c. For people who do receive NDIS support and who subsequently become involved in the justice system, how are they going to continue to receive the support in a custodial environment, and
   What will happen towards the end of their time in custody and transition to new living arrangements.

   d. For staff in the justice system, specific and ongoing education and training regarding the NDIS is required.

3. **Ensure there is a set of NDIS planners who are skilled in the area of mental illness** and the functional impairments that arise,
AND
who are familiar with both the custodial environment and transition out processes.
This is a specialised set of skills and is a requirement to ensure this group of people is engaged, adequately assessed, planned for and supported over the long term.

(k) any related matter.

1. **TEAMhealth is gravely concerned about the following matters in relation to the NDIS and psychosocial disability**.

   a. **NDIS costing structure for NDIS support in the NT.**
   Please refer to the costing information in the Appendix for some background information on the costs of NT mental health services in comparison to national costs. Please recognise that all services cost more to deliver in the NT, not just those in rural and remote locations.

   b. **NDIS related service provision in remote communities.**
   It will be impossible to deliver this for people with mental illness using skilled staff employed by viable, skilled providers if block funding for psychosocial disability is removed.

   c. **The principle of being "no worse off" is not going to be met.**
   Under NDIS it is very possible that complex participants with psychosocial disability and challenging behaviours will be worse off as service providers are unable to provide the range, scale and support practices required in a sustainable, viable and stable manner.

   d. **Major risk of inadequate NDIA skills in psychosocial disability/mental illness.**
   The skills of internal NDIA planners regarding both psychosocial disability and the NT context are a major risk. Without these crucial skills the NDIS will be unable to effectively gain trust and engagement with individuals with mental illness in the NT and with culturally competent community mental health service providers.

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Appendix:

Note re: the Appendix

TEAMhealth has tried to footnote and provide recognition to the sources of the material presented here. Where the information has been expressed clearly we have not rewritten the content. TEAMhealth thanks the authors of the material presented in the Appendix for their work and ongoing reporting and research regarding mental health in Australia and the NT.

Mental illness

Mental illness is a major health and social policy issue, and mental health is one of the nine National Health Priority Areas agreed to by governments.[1]

The prevalence of mental illness in Australia is extraordinary in its breadth and scope. One in five Australians (almost four million) aged 16 to 85 years will experience a mental disorder each year and almost half will experience a mental disorder in their lifetime[2].

After cancer and cardiovascular disease, mental health is the third largest disease burden in Australia and the largest non-fatal burden[3] [4].

In summary, each year in Australia:
- 16.8% of the population (3.7 million people) experience symptoms of a mental illness sufficient to warrant a diagnosis. Of these:
    - 3.1% (690,000) will have a severe illness;
    - 4.6% a moderate illness (1.03 million); and
    - 9.1% (2.02 million) a mild illness.
- A further 23.1% (5.2 million) will have symptoms that fall short of a formal diagnosis but have other indicators of need for mental health assistance. About half will have had a previous mental illness and may require help to prevent relapse. The remainder may require early intervention to prevent development of a full scale illness.[5]

- Less than half of people living with mental health issues seek and treatment each year, with untreated mental illness incurring major personal suffering and economic costs.[6]

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[1] *Fifth National Mental Health Plan   Draft for Consultation -October 2016*

[2] *Australian Bureau of Statistics (2008), National Survey of Mental Health and Wellbeing 2007: Summary of Results, ABS cat. no. 4326.0, Canberra, ABS.*

[3] *Australian Institute of Health and Welfare (2016), Australian Burden of Disease Study: Impact and causes of illness and death in Australia 2011. Australian Burden of Disease Study series no. 3. BOD 4. Canberra, AIHW.*

[4] *Australian Government Response to Contributing Lives, Thriving Communities – Review of Mental Health Programmes and Services, page 2.*

[5] *Australian Government Response to Contributing lives, thriving communities – Review of Mental Health Programmes and Services (2015) http://www.health.gov.au/internet/main/publishing.nsf/content/mental-review-response*

[6] *Whiteford H, Buckingham W, Harris M, Burgess P, Pirkis J, Barendregt J, Hall W (2014), Estimating Treatment Rates for Mental Disorders in Australia, Australian Health Review, 38: 80-85.*

Impacts of mental illness

Mental illness includes a wide range of disorders that vary in severity and duration. Many mental illnesses have significant and harmful effects on individuals and the community as a whole. Each of the following factors are associated with mental illness[7].

poverty	unemployment	reduced productivity
homelessness	social isolation	discrimination & stigma

Although mental illness is ranked third in Australia's top 5 burden of disease groups, behind only cancer and cardio-vascular, mental illness often coexists with one or more physical disorders. For example people with mental illness are more than 3 times as likely to have diabetes and more than one and a half times likely to have heart disease than the general Australia population[7]

People living with mental health issues, particularly those with severe mental illness have a lower average life expectancy than the general population.[8,9] The overall gap in life expectancy for people living with mental health issues compared against the general population is almost 16 years for men and 12 years for women, with most causes of early deaths being due to physical health conditions.[10]

In addition, people living with mental health issues are:
- less likely to be employed compared to those without a mental illness[11],
- more likely to experience homelessness[12] and
- more likely to experience housing instability.[13]

These factors may not only further exacerbate their mental illness, but may also contribute to worsening health and social outcomes overall.

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[7] Morgan VA, Waterreus A, Jablenski A, Mackinnon A, McGrath JJ, Carr,V et al 2011. People living with psychotic illness 2010: report of the second Australian national survey. Canberra: Department of Health and Ageing

[8] Western Australian Mental Health Commission (2015), Better Choices. Better Lives. Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015–2025. Perth, Western Australian Mental Health Commission.

[9] The Royal Australian and New Zealand College of Psychiatrists (2016), The economic cost of serious mental illness and comorbidities in Australia and New Zealand.

[10] Lawrence D, Hancock KJ, Kisely S (2013), The gap in life expectancy from preventable physical illness in psychiatric patients in Western Australia: retrospective analysis of population based registers. BMJ 2013;346:f2539.

[11] Department of Health and Ageing (2013), National Mental Health Report 2013: tracking progress of mental health reform in Australia 1993 – 2011. Canberra, Commonwealth of Australia.

[12] Australian Bureau of Statistics (2016), Mental Health and Experiences of Homelessness, Australia, 2014, ABS cat. no. 4329.0.00.005, Canberra, ABS.

[13] Kamieniecki GW (2001), Prevalence of psychological distress and psychiatric disorders among homeless youth in Australia: a comparative review. Australian and New Zealand Journal of Psychiatry, Vol. 35, No. 3: 352- 358.

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Mental health of Aboriginal and Torres Strait Islander people

For Aboriginal and Torres Strait Islander people, there is a greater prevalence of mental health issues compared to the general population. Research indicates that 27% of Aboriginal and Torres Strait Islander people experience high or very high levels of psychological distress; twice the rate of the non-Indigenous population. Additionally, Aboriginal and Torres Strait Islander people are hospitalised at twice the rate of non-Indigenous people for instances of self-harm[14].

While accurate population prevalence rates for Aboriginal and Torres Strait Islander people in the Northern Territory are not currently available, NT Government mental health services data for 2012/13 indicates that:

- 43% of all consumers assisted by the community based (non-inpatient) mental health services are Indigenous (13% above the population proportion of 30%); and
- 52% of admissions to mental health inpatient facilities are Indigenous (22% above population proportion of 30%)[15].

Death from suicide amongst Aboriginal and Torres Strait Islanders is almost three times higher than for non-Indigenous people in the Territory, with an age standardised rate of 30.8 deaths per 100,000 compared to 16.4 deaths per 100,000 for non-Indigenous persons over the period 2000 to 2010[16].

National figures show that the incidence of Aboriginal and Torres Strait Islander people presenting to emergency departments in public hospitals for mental illness treatment is significantly higher at 9.3% than the national Australian average of 6.3%.

Overall Aboriginal and Torres Strait Islander people have significantly higher mental health related hospital care rates than that of other Australians. Hospitalisation without specialised care was more than three times the rate of other Australians. Hospitalisation with specialised care was double the rate of other Australians[17].

Social and Emotional Wellbeing (SEWB) responses for Aboriginal and Torres Strait Islander people. In the NT, inter-generational trauma associated with the impacts of colonisation, cultural dislocation and child protection practices contribute to social dislocation and increased vulnerability to the risk factors associated with violence, substance abuse and mental ill-health. Young people are particularly vulnerable as noted in the national mental health reform process[18].

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[14] *Australian Red Cross Mental Health (2015). http://www.redcross.org. au/mental-health.aspx*

[15] *Department of Health (DoH), 2014. Mental Health data from the Community Care Information System (not previously published), Department of Health, Darwin quoted from Northern Territory Mental Health Services Strategic Plan 2015 - 2021*

[16] *Australian Bureau of Statistics (ABS), 2012 , Suicide in Australia, 2010, ABS cat.3309.0*

[17] *Australian Institute of Health and Welfare: Mental health services in Australia (Psychiatric disability support services (2016)*

[18] *Northern Territory PHN. (2016). Mental Health and Suicide Prevention- Stakeholder feedback 2016 quoted from Department of Health Primary Health Networks Mental Health and Suicide Prevention Needs Assessment Northern Territory PHN – 30 March 2016 https://www.ntmhc.org.au/wp-content/uploads/2016/09/2016-NT-PHN-Needs-Assessment-Mental-Health-and-Suicide-Prevention.*

Mental illness in the Northern Territory

Mental health is an integral and essential component of community health and well-being. The demand for treatment of mental illness in the Northern Territory is high.

There are significant socioeconomic factors that can contribute to health and wellbeing outcomes in the NT, including health infrastructure, housing (without overcrowding), sanitation, clean water and food, homelessness and participation in education[19].

There are particular challenges in relation to social determinants of health in remote communities. The levels of unemployment in the NT are low compared to the rest of Australia. The participation of individuals with severe and persistent mental illness in the workforce remains low[19]. Despite the low unemployment rate for the NT as a whole, under employment and few employment opportunities are present in remote communities.

Another known determinant of mental ill health in the NT is trauma. Exposure to traumatic events, particularly from a young age, is thought to have profound neurological, biological and social effects on individuals, families and communities. It is thought that such experiences also correlate with increased risk taking behaviours and problematic mechanisms for coping with stress and negative emotions such as self-harm and antisocial behaviours including violence towards others.[19]

The ABS 2007 National Survey of Mental Health and Wellbeing found that 20 per cent of Australians between 16 and 85 years of age had experienced a mental disorder in the 12 months prior to the survey, with only 35 per cent of these individuals using a health service during the same period[20].

- Mental illness and substance use disorders have been estimated as being responsible for 7.4 per cent of total disease burden in Australia and were the leading cause of non-fatal burden of disease in 2010 [21]
- By comparison, in the NT mental health conditions contribute to 16.3 per cent of the burden of disease[22].
- Mental disorders are under reported and under diagnosed nationally and in the NT[19].

The population of the Top End of the NT is currently approximately 200,000 people including about 140,000 people in the greater Darwin region. Northern Territory Government Finance and Treasury population estimates show a predicted population growth of 18%, with 20% growth in the greater Darwin region for the period 2016-2026[23].

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[19] *Northern Territory Mental Health Services Strategic Plan 2015 - 2021*

[20] *ABS 4326.0 - National Survey of Mental Health and Wellbeing: Summary of Results, 2007*

[21] *Whiteford HA, Degenhardt L, Rehm J, Baxter AJ, Ferrari AJ, et al. (2013) The Global Burden of Mental and Substance Use Disorders, 2010. Lancet*

[22] *NTGOV. Dept. of Health and Families, Preventable Chronic Disease Program. (2009). Northern Territory chronic conditions prevention and management strategy 2010 – 2020.*

[23] *Northern Territory Government Department of Finance & Treasury NTPOP Summary (2014) – TOTAL REGIONAL POPULATIONS*

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In the Northern Territory 3-4% of people have severe and persistent mental illness[24]. This means that in the greater Darwin region, there are approximately 4,900 people dealing with severe mental illness and that this is expected to grow to 5,900 people by 2026. By way of context, in 2014 over 2,300 people were admitted to the Royal Darwin Hospital for treatment of mental illness and 1,100 of these went on to receive community based mental health support for serious mental illness[24].

Mental illness and homelessness

The Northern Territory has 15 times the national average rate of homelessness and mental illness is a feature of the shortened lives of many homeless people and those who struggle to maintain secure housing.

The Commonwealth Department of Health summarised the situation well in their National Mental Health Report 2013 as they recognised that quantifying the prevalence of mental illness among the homeless is difficult[25].

"For now, it is reasonable to conclude that mental illness is a significant problem for many homeless people, and the two issues often occur together; mental illness may jeopardise people's chances of securing or retaining stable accommodation, and homelessness takes a toll on people's emotional wellbeing."

Housing and people with mental illness

People living with mental health issues, particularly those with severe mental illness, are more at risk of experiencing a range of adverse health outcomes and have a lower average life expectancy than the general population. [1]

Frequently people dealing with homelessness or insecure housing are also dealing with mental illness. The mental health status can be greatly worsened during period of homelessness and the cycle of acute metal illness, hospitalisation, crisis/temporary or hostel accommodation, back to homelessness can be ongoing. Self-care, ability to resist humbug, alcohol, other drug and gambling behaviours can be severely compromised.

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[24] *Northern Territory, Department of Health Annual Report 2013-2014: Mental Health Directorate*

[25] *Australian Government Department of Health: National Mental Health Report 2013*

Mental health funding

Mental health funding in the Northern Territory is comparable to other states/territories and slightly less than national average, however cost of treatment is substantially more. Utilization of community mental health care services much higher than national average.

In terms of total State/Territory funding spending for mental health in 2013-2014, the NT spent nearly 6% more per capita than the national average: $222.81 vs $210.59 respectively[26]. The situation is reversed when considering the cost of service provision as treatment costs in the NT are exceedingly high.

The NT had highest average cost per patient (acute) bed day than any other jurisdiction in 2013 - 2014. The average cost nationally was $996; the Northern Territory was $1,571[26], nearly 60% higher for every inpatient bed day in the NT's inpatient mental health service.

In terms of community mental health care service patients per 1,000 population in 2013- 2014, NT has a much higher number than any other state/territory and national Australian average: NT is 30.2/1,000 vs 16.7/1,000 for the national average[26].

The average number of public sector mental health hospital beds is much lower in the NT than the national average. The Northern Territory has only 16.8 public sector specialised mental health hospital beds per 100,000 population and no private sector specialised mental health hospital beds. The NT has less mental health hospital beds than any other state/territory and is much lower than the national average at 16.8 vs 29.2 respectively[26].

There are extremely limited inpatient facilities across the NT with less than 50 mental health beds available in total, with no facilities available in remote areas[27].

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[26] *Australian Institute of Health and Welfare 2016 Mental Health Services Australia*

[27] *3 Northern Territory Medicare Local. (2014). The Northern Territory Medicare Local Health Atlas 2014*

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