

**SUBMISSION**  
**SENATE SELECT COMMITTEE ON MENTAL HEALTH**

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## **Introduction**

1. This submission is jointly written by the offices of the Northern Territory Community Visitor Program (CVP) and the Northern Territory Legal Aid Commission (NTLAC).
2. Each of these offices plays an important role in safeguarding the rights of consumers as outlined in the *Mental Health and Related Services Act* (NT) 1998 (hereafter referred to as 'the Act'). The CVP is charged with inquiry functions, complaint functions and visiting duties in relation to approved treatment facilities and agencies and persons receiving treatment at the facility or from the agency. NTLAC operates a Duty Lawyer service which provides representation to clients the subject of proceedings before the Mental Health Review Tribunal.
3. The aim of this submission is to address the broader, systemic issues which appear to be beyond the current capacity of mental health services to address due to factors such as limitations in resources. Issues identified in this submission are drawn from observations by practitioners within the two agencies and from comments by consumers and mental health service providers.
4. For ease of presentation, the submission addresses each term of reference individually.

## **Summary of Issues Identified in This Submission**

5. The major issues addressed in this submission are as follows:
  - integrated care between mental health services and other health services;
  - rehabilitation services;
  - suitable supported accommodation;
  - early intervention services for young people with psychosis;
  - choice of transport to hospital for consumers;
  - diversion programs to prevent the inappropriate imprisonment of people with mental illness;
  - mandatory sentencing;
  - access to interpreter services for indigenous Territorians; and
  - training and support for Aboriginal Mental Health Workers to provide culturally appropriate mental health care in their own communities.

- a. *the extent to which the National Mental Health Strategy, the resources committed to it and the division of responsibility for policy and funding between all levels of government have achieved its aims and objectives, and the barriers to progress;*

## **Strengths of mental health service provision in the Northern Territory in response to the National Mental Health Strategy**

### ***Legislation***

6. The legislation governing mental health service provision in the Northern Territory is the *Mental Health and Related Services Act* (NT) 1998. The Act, while currently under review and in need of some amendment, establishes provisions for the care, treatment and protection of people with mental illness that are for the most part consistent with the United Nations' Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care<sup>1</sup>, the Australian Health Ministers' Mental Health Statement of Rights and Responsibilities and the National Mental Health Policy and Plan 1992 and the National Mental Health Plans 1998 and 2003.
7. Provision is made for the review of the voluntary and involuntary admission of people into approved treatment facilities and the treatment they receive there. The Mental Health Review Tribunal is established under the Act, as is the right of a person to appearance and representation. The right to complain is enshrined in the legislation, and the Act creates both internal and independent complaint mechanisms.

### **Barriers to progress**

#### ***The legislative definition of mental illness***

8. While the way mental illness is defined<sup>1</sup> by the legislation largely protects consumers by excluding social, health and cultural factors which are unrelated to psychiatric illness, the narrowness of the definition effectively works against people with personality disorders for whom there is no other intervention available in the Northern Territory.
9. The community visitor has received complaints indicating that although such persons are able to receive treatment under 'mental disturbance' provisions in the Act when in crisis, they are not receiving the specific and specialist intervention which can address the issues underlying behaviour.

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<sup>1</sup> Section 6, *Mental Health and Related Services Act* (NT) 1998

## Transport to Hospital:

10. Client reports to NTLAC, community visitor panel reports and complaints to the CVP indicate that when a person with mental health issues requires admission in crisis in the Northern Territory, they are most likely to be transported to a facility by police, often in handcuffs and/or in the lock up section of a police vehicle. Ambulances are not used. The authors are aware that this relates to three issues. Firstly, the ambulance service is perceived to be in financial crisis and not able to deliver a service to mental health consumers. Secondly, mental health services are not funded to provide transport to hospital by ambulance; and finally, the practice of transport by police is entrenched as standard mental health practice in the Northern Territory.
11. Clients often report that transportation by police is a traumatic experience – they are traumatised by the stigma of police intervention in their neighbourhood or workplace, and some clients have reported feeling violated by police procedures. The authors believe that people with mental illness should be treated equally with other people who experience a health issue with transport to hospital by ambulance being the first option.
  - b. *the adequacy of various modes of care for people with a mental illness, in particular, prevention, early intervention, acute care, community care, after hours crisis services and respite care;*

## Community Care

### **Early Psychosis**

12. While there are specialist, small teams in both Darwin and the Alice Springs Region who work with young people, there is no specialist early intervention programme for young people with psychosis. According to the Australian Clinical Guidelines for Early Psychosis, specialist programmes for young people with psychosis should include groups for young people and their carers<sup>2</sup>.

### **Case Management**

13. One of the areas most in need of increased resources is case management. For example, the adult team in Darwin provides a service to approximately 380 to 400 consumers. Twelve case managers work in this team, each with a case load of between **30** and 40 consumers<sup>3</sup>. There is evidence that effective case management requires not only that medication be administered but also that the social, spiritual and economic dimensions to mental health are addressed. With the current load of case managers in the Darwin region, this is not possible at an adequate level for all consumers. The failure to address these quality of life issues can negatively impact on a person's ongoing mental health, and obstruct their ability to live successfully independent of the mental health system.

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<sup>2</sup> *The Australian Clinical Guidelines for Early Psychosis 1999 - 2000*

<sup>3</sup> Community Visitors Panel 2005

14. The situation is even more dire for mental health teams operating in rural and remote NT, in vast geographic regions with a relatively sparse population. In Katherine for example, a team of four case managers manage a geographic area the size of Victoria.
15. There is evidence that assertive case management is the most effective model for reducing hospital admissions and improving mental state over a period of time<sup>4</sup>. This incorporates a model where case loads are kept to a maximum of 15, with the most effective management occurring at a case load of ten. In its current structure and at its current resourcing level, the mental health service does not appear to be able to provide intensive case management.

### ***Liaison/Education of Carers***

16. Carers have made numerous complaints to the authors of this submission about their ability to effectively liaise with mental health services. Some carers report that they experience difficulty in obtaining the information and education they require in order to adequately care for the person with mental illness. Some carers report difficulty in accessing mental health services when their child is showing early signs of relapse, and state that their knowledge and expertise in relation to the person they are caring for is not given adequate recognition.

### ***Rehabilitation Services***

17. There are limited rehabilitation services in Darwin and Alice Springs. In Darwin, funding is provided for a non government agency to provide recreational activities. There is limited funding available to provide non-clinical psychosocial rehabilitation at home through outreach and community training programmes operated by TEAM Health, a community based mental health organisation. In Darwin, TEAM Health also operates two 5-bed facilities comprising a total of 10 beds. These are the only facilities in Darwin that provide supported accommodation specifically for consumers with a mental illness. One of these facilities, staffed 24 hours/day, provides a 3 month psychosocial rehabilitation program for clients, after which the client is placed in alternative accommodation. Available services are not able to provide sufficiently for the breadth of the rehabilitative or compensatory needs of consumers who experience disability associated with their mental illness, nor to provide sufficiently for those clients who require intensive rehabilitation and support to meet the goal of recovery.

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<sup>4</sup> eg Ziguras SJ & Stuart GW (2000) A Meta-Analysis of the Effectiveness of Mental Health Case Management over 20 Years. *Psychiatric Services* 51(11) 1410 - 1421

18. There are no long stay rehabilitation facilities in the Northern Territory for people who, due to the severity of their illness, require 24 hour support and/or training over an extended period of time. If a person requires a long-term admission to hospital, he or she is likely either to remain in an acute care setting or to be transferred interstate away from community ties. Plans to introduce “step up and step down facilities” in Darwin and Alice Springs, and currently in the process of being implemented, may alleviate this situation to some extent.

### *Vocational Rehabilitation*

19. Vocational rehabilitation is available through community training offered by TEAM Health, Rehabilitation Australia (formerly Commonwealth Rehabilitation Services) and other job network support centres through Personal Support Providers. Job network agencies are often not suitable for persons with mental illness due to a requirement that the person be “job ready” at the time of referral. Rehabilitation needs to be available for some consumers at a basic level, providing such skills as learning how to arrive on time each day and working for a continuous period without a break. Currently such support is available in a limited way through the community training program. There is no workshop specifically set up for clients of mental health services along the lines of STEP programmes operating in other jurisdictions which have demonstrated success in return to work programmes for people with severe rehabilitation needs<sup>5</sup>.

### ***Crisis Services***

20. A meeting in Alice Springs with carers from NT Carers and the Association of Relatives and Friends of People with Mental Illness (ARAFMI) on 21 April 2005 identified that at home crisis support can be difficult to access, and extremely difficult to access after hours. Service providers and carers in Alice Springs quoted waiting times of up to three days for a home visit, and instructions to contact the police or transport the person to the Emergency Department on other occasions.
21. Service providers in the Darwin region, particularly providers of services for carers of people with a mental illness, have made similar complaints about the responsiveness of mental health services when contacted by family and/or care providers concerned about relapse of illness.

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<sup>5</sup> For example STEP programme operated by Port Adelaide Central Mission, South Australia

## **Remote Services**

22. Many people with mental illness in the Northern Territory live in remote areas. Such people have complained that they experience great difficulty in accessing treatment and other support services. Service providers in urban centres such as Darwin report that community management orders for involuntary patients cannot be effectively carried out in remote regions, and therefore rather than discharging patients and allowing them to be managed in their homes, people living in remote areas spend more time in hospital as a result. Furthermore, because there are insufficient facilities for recognition of early signs of onset or relapse, the person with the illness is more likely to come to the attention of mental health services when they have already reached crisis point and require hospitalisation.
- c. opportunities for improving coordination and delivery of funding and services at all levels of government to ensure appropriate and comprehensive care is provided throughout the episode of care;*

## **Funding for Mental Health Services**

26. Mental health services in the Northern Territory are managed within the health system. However, they are funded and managed separately from mainstream health services such as the Royal Darwin Hospital, contrary to the practice and policy of other jurisdictions<sup>6</sup>. This approach has the advantage of ensuring that mental health funding is not lost in the health sector budget. The disadvantage of this approach however is that mental health services often fail to receive standard services provided elsewhere in the health system. For example, the prescription of psychiatric medication on the mental health wards of the hospital does not benefit from any pharmaceutical supervision, although such a service is routinely provided to the rest of the hospital. Similarly, although a social work service exists in the hospital, it does not extend to the inpatient mental health unit.

## **Isolation from other sectors**

27. In the Northern Territory, the Alcohol and Other Drugs Service operates independently of mental health services. Because there is no inpatient detoxification unit, detoxification is undertaken in a community setting, generally in partnership with a non government agency such as St Vincent's de Pauls or the Salvation Army. This is problematic for people with co-morbid mental health issues and alcohol and other drug use. For example, a client who presented with co-morbid substance abuse (amphetamine) and suicidal ideation was not provided a service by mental health services due to his drug use issues.

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<sup>6</sup> *National Mental Health Report 2004 p 19*

*d. the appropriate role of the private and non-government sectors;*

25. The private mental health sector in the Northern Territory is limited. Consumers often complain about the lack of choice of treatment providers available to them. Another consequence of the paucity of alternative providers external to the public system is the inability of consumers to access sufficiently frequent and comprehensive treatment privately.

*e. the extent to which unmet need in supported accommodation, employment, family and social support services, is a barrier to better mental health outcomes;*

26. A major barrier to mental health outcomes in the Northern Territory is the lack of supported accommodation services. There are very few beds in Darwin for people requiring support with mental health issues, and a waiting list for people with co-morbid behavioural difficulties. This means that some clients of mental health services are staying long term in acute facilities. For example, one client resided in an acute facility for three years.

27. A report into the accommodation needs of young people with mental illness<sup>7</sup> illustrates that there are no specialised facilities available for young people with mental health problems.

28. Clients accessing legal services who experience both mental health and domestic violence issues also report difficulty in accessing appropriate accommodation in Darwin. This is due to the fact that women's refuges have stated their inability to accept high risk clients with serious mental health issues, and the non government organisation which provides accommodation for clients of mental health services has expressed unwillingness to assist when a perpetrator is presenting a threat to the consumer because of a perceived threat to other clients. The needs of clients from remote communities are particularly acute because they have no other place to stay when in Darwin.

29. At present, clients in Darwin and Alice Springs may be discharged from acute care to facilities managed by organisations such as the Salvation Army. One such hostel evicts the person from the premises at 7.30 in the morning and only allows return after 4.30 in the afternoon. Clearly, this is not an environment that is conducive to recovery from an acute episode, and yet at present, this is all that is available for some clients of mental health services.

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<sup>7</sup> Mouthaan Jessica (2003) *How Young People With Mental Health Issues Access Independent Living in the Northern Territory*



- f. *the special needs of groups such as children, adolescents, the aged, Indigenous Australians, the socially and geographically isolated and of people with complex and co-morbid conditions and drug and alcohol dependence;*

## **Children and Adolescents**

### ***Specialist Youth Health Centre***

30. Service providers (school counsellors and non government organisations involved with child/youth services) have commented that the physical placement of child and youth services within adult mental health services results in young people refusing to attend the centre. The Northern Territory Youth at Risk Network provides opportunities for networking and information among service providers, however, there is no specialised youth centre with a health focus in the Northern Territory that could act as an alternative location.

### ***Specialist Inpatient Facilities***

31. Guideline 3.10 of the *Australian Clinical Guidelines for Early Psychosis*<sup>8</sup> states that

... it is considered inappropriate to place adolescents or young adults in an adult inpatient facility with clients with long-term mental illness. When hospitalisation is necessary and the facility is not considered appropriate, the involvement of an adolescent or youth specialist is recommended.

32. In the Northern Territory, the only inpatient options for young people are the adult mental health facilities. Young people under the age of 16 are assigned a nurse to stay with them at all times.

## **Co-morbid Acquired Brain Injury and Mental Illness**

33. In the Northern Territory, people who experience acquired brain injury associated with solvent abuse, and who experience co-morbid psychosis can require specialist accommodation aimed at restoring skills where possible and managing behaviour. These services are not available. The authors are aware of situations where consumers are left to be managed within the family environment, thereby causing high levels of stress. There needs to be suitable accommodation services in place to break the cycle of consumers being admitted to an inpatient facility for respite care. Those consumers without family support are particularly vulnerable, at risk of harm within the general community and at risk of imprisonment.

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<sup>8</sup> *Australian Clinical Guidelines for Early Psychosis* 1999 – 2000 p 40

34. It is likely that the incidence of acquired brain injury related to solvent abuse and its related problems is likely to increase, and planning and funding needs to occur now. Specific services with expertise in the management of people with co-morbid conditions will be required to ensure that the burden on families does not become too unbearable, or that the people affected do not suffer unnecessary incarceration.

## **Services for Indigenous Territorians**

### ***Interpreters***

35. Many indigenous clients speak English as their fourth, fifth or even sixth language. Interpreters are required to assist in order to ensure that a proper assessment is possible, particularly for consumers presenting for acute care. Interpreter assistance has been difficult to access within working hours in both Alice Springs and Darwin, and mental health workers report that it is not possible after hours to get assistance from interpreters.

### ***Projects***

36. One positive development in the Northern Territory has been the creation of the Australian Integrated Mental Health Initiative (AIMHI) a project aimed at integrating mental health assessment and treatment into primary care by embedding mental health treatment and care into the NT chronic disease strategy. The project is developing and trialling culturally appropriate resource materials, including an animated computerised stories and flip charts.
37. AIMHI is working closely with a project hosted by the Top End Division of General Practice, where Aboriginal Mental Health Workers receive mental health training and work alongside GPs and community health services in remote communities, which has increased access to mental health services by indigenous people. When interviewed by the Australian Division of General Practice as a finalist for the 2003 Division's Achievement Awards<sup>9</sup>, program manager Sandy McConachy stated that the

...program is yielding results, with the indigenous workers providing early intervention and breaking down the stigma associated with mental health issues. ... The incidence of air evacuations [to Darwin] for acute mental illness has been reduced markedly in many of the communities.

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<sup>9</sup> Australian Division of General Practice: Web Page: Joining Forces Division Achievement Awards 2003

38. The CVP has been informed that the Top End Division of GP project is experiencing significant funding difficulties, and the number of remote communities receiving support has therefore been reduced. In order to continue its work, and to expand its operations to remote communities in Central Australia (where there is only one Aboriginal Mental Health Worker who lives and is employed in a remote community) this project requires an established and ongoing funding base.

### **Other groups**

39. The Melaleuca Refugee Centre is the only service in the whole of the Northern Territory to receive funding from the Department of Immigration and Multicultural Affairs (DIMIA) to provide counselling to newly arrived refugees. The Director of that Centre states that the funding provided is inadequate to fund even one full time counselling position, let alone provide a service which effectively caters for the special needs of refugees affected by trauma. For example, in the African context, the very concept of counselling is foreign and a counsellor would need to be funded to take the time to develop other therapeutic ways of engaging with people affected by trauma. Mainstream mental health services lack expertise in the specific issues relevant to refugees who have experienced trauma and are therefore not able to provide an appropriate service.

*g. the role and adequacy of training and support for primary carers in the treatment, recovery and support of people with a mental illness;*

40. ARAFMI and NT Carers play the major role in the support and training of carers in the Northern Territory. NTLAC and CVP have received complaints from carers about the lack of information and education provided to them.

41. At least one carer has contacted NTLAC with concerns about the focus on psychiatric medication as the primary form of treatment. For example, one carer has been lobbying to no avail for the last five years for orthomolecular medicine to be trialled by public mental health services as an alternative treatment for schizophrenia.

*h. the role of primary health care in promotion, prevention, early detection and chronic care management;*

42. The Northern Territory has fewer GPs per capita than elsewhere in Australia, and very few bulk billing GPs. As a result, the outpatient clinic in Darwin holds a GP clinic once per week, however, a complaint from a consumer and GP reports to the CVP indicate that this does not necessarily translate to independent links with GP's post involvement with mental health services. Similarly, in Alice Springs consumers have poor access to primary health care due to the lack of GPs who are prepared to bulk bill their patients.

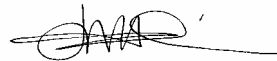
43. GPs who do have an interest in mental health have commented that liaison with mental health services can be difficult, and that they are often not notified of their patient's medication or changes in medication, even when the GP has referred the client to mental health services for specialist follow up.
44. There is a particular lack of trained primary health care staff in remote areas, which makes detection of any early signs of mental illness difficult and leads to people coming to the attention of their communities only once they have reached crisis point. As stated earlier, the programme operated by the Top End Division of General Practice was an attempt to address this issue, however it is experiencing funding issues.
- i. opportunities for reducing the effects of iatrogenesis and promoting recovery-focussed care through consumer involvement, peer support and education of the mental health workforce, and for services to be consumer-operated;*
45. There is no peer support program in the Northern Territory.
- j. the overrepresentation of people with a mental illness in the criminal justice system and in custody, the extent to which these environments give rise to mental illness, the adequacy of legislation and processes in protecting their human rights and the use of diversion programs for such people;*
46. There is no diversion program for people with mental illness in the Northern Territory. There is currently no separate psychiatric facility within the Northern Territory correctional facilities. While prisoners can receive some psychiatric attention from forensic mental health workers, they may be housed either alongside other prisoners where they are at risk of being harmed, or more often, forced to be imprisoned in higher grade security settings than their sentence would normally prescribe for their own protection. People housed in high security settings do not necessarily gain access to pre-release programmes.
47. It is the view of the authors that the overrepresentation of persons with a mental illness in prisons may relate to the severe shortage of safe and secure housing for people with mental health issues and the lack of vocational rehabilitation support in the community. Without these lifestyle safeguards in place, people are arguably more likely to be imprisoned than they would otherwise be.
48. In these circumstances, tragic situations occur. For example, where very unwell people have been violent against their carers and have nowhere suitable to be housed, they run the risk of being made the subject of a restraining order which they may not understand, and on breaching that order may then be imprisoned. As a consequence of the way mandatory sentencing operates in the Northern Territory, people stand to spend many months in jail for offences such as this.

49. Mandatory sentencing applies in the NT if a person is convicted of a second assault, for second and subsequent breaches of restraining orders, for aggravated property offences and for sexual offences. Many people who suffer from a mental illness are not suitable for community work or home detention which leaves jail as the only option.
50. The shortage of accommodation for people with acute mental health problems means that bail applications for such persons are rarely able to be made by their legal representative. One useful strategy that could be implemented would be a bail accommodation scheme for people with mental illness who have court matters pending. As stated above, where there is co-morbidity of substance abuse and mental illness, accommodation services will not accept people because of the potential risk of endangering other residents or employees. Clients without family support are particularly vulnerable to being remanded in the prison rather than being bailed into the community.
51. While the defence of mental impairment exists in the Northern Territory, it is not an approach favoured by representatives of mentally unwell persons charged with criminal offences, due to the lack of resources. It is often too risky to raise mental impairment because mental health services are not perceived to have the resources to adequately monitor and treat offenders. Without those resources, the client faces the prospect of indefinite detention.
  - k. *the practice of detention and seclusion within mental health facilities and the extent to which it is compatible with human rights instruments, humane treatment and care standards, and proven practice in promoting engagement and minimising treatment refusal and coercion;*
52. The Mental Health and Related Services Act outlines the conditions under which detention and seclusion can take place, and is compatible with the requirements of the UN Principles and the Mental Health Strategy. All persons detained to an approved treatment facility receive an independent review within seven days, and have access to legal representation.
53. Seclusion registers are inspected by community visitors at least once every six months, and Top End Mental Health Service has recently conducted an internal audit of its seclusion records. Practices in the NT are not benchmarked against the national clinical indicators outlined in the Australian Council of Health Care Standards, and the CVP has recommended that this is instituted to ensure best practice in seclusion and restraint in the NT.

- o. the adequacy of data collection, outcome measures and quality control for monitoring and evaluating mental health services at all levels of government and opportunities to link funding with compliance with national standards;*
- 55. The community visitors panels have reported that outcome measures are used at best spasmodically in the Northern Territory. The authors are aware that a Consumer Outcomes Measures Embedding Team (COMET) has been funded to introduce and support the implementation of both clinician and self-report instruments throughout the Territory.
  - p. the potential for new modes of delivery of mental health care, including e-technology.*
- 55. In the Northern Territory, the Youth at Risk Network (YARN) provides good liaison between services, and the Life Promotion Program has been recognised for its work in suicide prevention. Other programs mentioned earlier in this submission, such as the AIMHI programme and the project auspiced by the Top End Division of General Practice provide alternative ways of working with indigenous Australians. Outcomes from the development of culturally appropriate resource material by AIMHI, and its use of MARVIN technology should become apparent over the next 12 months.



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