Committee Secretary
Senate Select Committee on Mental Health
Department of the Senate
Parliament House
Canberra ACT 2600
mental.health@aph.gov.au
27th May, 2005

Dear Sir/Madam,

In our efforts to address the above Committee's inquiry into mental health, the Northern Territory State Peak Body for the mental heath sector, the NT Mental Health Coalition, recently organized two public forums.

The first was held in Alice Springs on 27th April 2005 and the second was in Darwin on 9th May 2005, and both were administered and reported on by professional facilitators. The general public, as well as service providers, were invited to attend by way of newspaper advertisements and the emailing of a flyer through numerous email networks.

Attendance was good in both locations, with the Alice Springs forum attracting 28 participants and the Darwin one attended by 38 participants. These were apportioned as follows:

Politicians	=	2%
Carers	=	14%
Consumers	=	18%
Service Providers	=	66%

The sixteen Terms of Reference were grouped into like interest areas and participants were asked to comment in their areas of interest. From these verbal comments at both forums, our written Submission has been prepared. Provision was also made for written submissions to be accepted by the Coalition either in casual emails, often just outlining an individual concern, or in a more formal style usually addressing each of the Terms of Reference. These individual Submissions are also included (either as an attachment to this email or individually printed and enclosed in the envelope of this written Submission)

The Coalition members thank you for providing this valuable opportunity for residents of the Northern Territory to have effective input into the future direction taken by our ultimate policy makers, the Federal Government.

Regards,

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Submission to Senate Select Committee on Mental Health

From
NT Mental Health Coalition

May 2005

EXECUTIVE SUMMARY:

- Position Mental Health with the same fervour that Aged Care, Dementia & Breast Cancer etc have received to develop better community understanding and acceptance through education and promotion;

- Re-think the conventional ways of psychiatry and psychology to provide options and choices other than a medical model;

- Educate and resource clients, families/carers, the community and service providers including increased opportunities for support groups, self-help groups, booklets, special interest groups;

- Improve the range of supported accommodation and respite options for mental health clients and their families;

- Implement appropriate mental health strategies into the criminal justice and prison system;

- Share information and develop strong management teams whose common goal is to assist and support mental health clients;

- Improve coordination of service providers at all levels, including government, non government organisations and private providers;

- Focus all service provision on the whole person not just the condition;

- Lack of prevention and early intervention and the reality that clients have limited support until there is a crisis situation;

- Continuity of care is a critical concern of clients and carers.

INTRODUCTION:

The NT Mental Health Coalition (the Coalition), is the Peak (Non Government) Body representing and promoting the interests of people with mental health support needs and people with psychiatric disabilities and their carers in the NT and the organisations providing services to them.

The Objectives of the Coalition are to: -

- Provide a forum in the NT to discuss mental health matters
- Identify and promote the rights and needs of people with mental health support needs and people with psychiatric disabilities and their carers in the NT
- Provide advice to the NT and Commonwealth Governments
- Disseminate information on mental health matters in the NT
- Promote consumer, carer and community empowerment in mental health matters
- Provide a means of maximising the participation of clients, carers, non government service providers and other organisations providing services and support to people with mental health support needs and people with psychiatric disabilities and their carers in the NT
- Facilitate strong relationships, cooperation and coordination between clients, carers, non government and government service providers within the mental health sector in the NT

SUBMISSION:

In line with its objectives the Coalition has informed Northern Territory clients, carers and organisations of the current Senate Inquiry into Mental Health. The input to this submission has been gathered independently from;

- Coalition members using a questionnaire
- Key community stakeholders using a questionnaire
- General public at Public Meetings in Darwin (9 May 2005) and Alice Springs (27 April 2005)

Critical areas of concern

B. the adequacy of various modes of care for people with a mental illness, in particular, prevention, early intervention, acute care, community care, after hour's crisis services and respite care;

It is generally agreed that a re-think of conventional psychology and psychiatry is the key to unlocking any improvements in the mental health of Australians. The current focus on a medical or 'illness' model as the prevailing model is limiting and clients and carers want more choice. Mental Health research and overseas experience reveals that the days of 'prescriptions, pills and psychiatrics' and the chemical treatment of human problems should be the exception rather than the rule. In the

Northern Territory, clients, carers, service providers and the community are most interested in expanding existing services to include holistic models of mental health which may include biopsychosocial[1] frameworks, alternative models that are diverse and culturally appropriate.

Those involved in consultations in Darwin believed that over the past few years the federal government has funded some very innovative and effective 'pilot projects'. However the lack of ongoing funding for these projects from either the federal or NT governments has resulted in the loss of good services and clients having expectations raised only to be disappointed.

Crisis and acute care are the major focus in the Top End and Central Australian Regions. After hours crisis services are characterised by; lengthy time delays, answering machines, visits to Accident and Emergency and under resourcing of staff. Police intervention can be used, however, this is not the most appropriate intervention and is often used in a 'last resort' situation.

There was a strong view across the Northern Territory that prevention and early intervention programs are not readily available and the reality is that clients have limited support until there is a crisis situation. Discharge and relapse plans are either non existent nor followed up with psychosocial support. Private services are expensive and out of the reach of many clients. There is a need to further expand funding to these modes of care and at the same time access data to demonstrate the reduction in mental illness through prevention and early intervention activities.

There are some prevention programs being implemented in high schools; however general consensus believed that high school is too late and that prevention programs are required at the primary and early primary levels to maximise impact and to compliment programs later in schools.

There is a lack of beds available in acute care, the need for extra beds in hospitals was continually raised as a major concern. The lack of access to GP's and other health services that bulk bill makes affordable care for many out of reach.

[1] Consideration of body, individual's psychology and social factors

Clients that have low income employment and do not qualify for Health Benefits struggle to pay for private services and as a consequence can end up "falling through the cracks".

Community care is seriously under-resourced, services in Darwin are considered quite good but beyond that there is a lack of access available. For example there is currently no GP in Tennant Creek despite efforts by the NT Government to recruit.

There are no respite options available to carers and clients of mental health in any region of the Northern Territory.

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;

There is general agreement that there is a need for all mental health services to improve the co-ordination and delivery of funding and services.

Working in isolation is not effective or efficient practice given the current state of the mental health system. Decisions are being made without full and accurate information and without adequate consultation. Sensitive and confidential information is scattered and often cannot be sourced from one common point. The system lacks a co-ordinated approach that is firmly supported by checks and balances that protect the client and at the same time is able to assist the client.

Service providers are willing to consider joint or shared case management, bi-lateral MOUs, etc to improve service standards and for better mental health outcomes.

There is a view that too much money is swallowed up in bureaucracy, there is no accountability by state/territory governments on how much money actually is used in service provision.

Carers and clients want improved case management teams who share information, work towards a common goal and show respect for each other regardless of qualifications.

At national and state levels, should consider the tri-border model used for across Northern Territory, South Australia and Western Australia to improve mental health services to remote communities.

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

NGOs play an important role in facilitating access to services for mental health clients, especially outreach, prevention, early intervention and sub-acute care; fostering mental health awareness and supporting recovery and rehabilitation.

The non government sector is perceived as able to do more with less and provide more value for money in terms of outcomes.

In Alice Springs, the NGO sector provides non-clinical support. This is most appropriate and critical to the recovery of the client that a community setting is used wherever possible. The community is the place where we all live our lives and learn to cope and wellness does not happen as a result of a pill or in a hospital setting.

NGOs role is to complement government and private sector - (not to replace them or to duplicate them) and to have a closer connection with the community and individual clients.

The essential role of private sector is to provide individual support towards psychosocial recovery and promotion of mental health to reduce the stigma attached to mental disorders in the community.

Private sector may also be used for "occupational therapy", whereby clients would not identify activities with treatment and as potential employers of people being supported to find and participate in employment.

A coordinated approach to recruitment and retention of quality staff was seen as something that needs to be aimed for in the Northern Territory given the difficulties associated with our isolation and small population base. A possibly centralised system which made best use of the small amount of recruitment resources available could be investigated.

It was agreed that government has a responsibility to monitor the use of funding, however it was felt that the amount of monitoring in many instances is disproportionate to the level of funding. Processes should be established to minimise the amount of government monitoring required.

Public Servants in decision making roles are often less skilled and have less awareness or education of mental health issues than those working in the non government sector. High staff turnover in the public sector can exacerbate this situation.

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

A lack of supported accommodation during recovery, relapse and return from the ward has been identified as a major barrier to better mental health outcomes within the Northern Territory. In addition, the unique situation of clients coming from outlying remote communities who also find it difficult to access supported accommodation in Alice Springs and Darwin.

As stated previously there are no designated mental health respite beds in the Northern Territory, with families receiving respite only in times of acute or crisis interventions. The carers who attended the public workshop have concerns for their loved ones as they (the carers), are ageing and becoming worn out.

Employment can play a pivotal role in breaking down the stereotyping that occurs of people with mental health issues., In particular men have strong needs to be employed in meaningful work that is tailored their needs as recovering individuals and herein are some opportunities for the private sector employers.

The recent federal government policy of encouraging Disability Support Pensioners into the workforce is seen as having the potential to impact on mental health services. The stresses of entering the workforce and the enormous change in lifestyle could have an effect on the health of many people thus creating an increased need for services.

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

The Northern Territory has a relatively young population but specialist support services for children throughout the Territory is lacking. Families require coordination of information, family support and young adolescent support.

Adolescents seems to be the group most "at risk" of depression, suicide, early signs of psychosis etc and these signs are often misinterpreted and taken as an inevitable sign of "growing up".

The NT Legislation does not allow adolescents (young adults under the age of 18) to be accepted into the MH Unit in hospital and there is no

special youth unit in any of the major centres of the Territory. The alternative is paediatrics or "isolation" which does not help their recovery.

School counsellors and related professions may detect early signs with adolescents and it is critical to support school initiatives and programs.

Aged

There is a lack of services and funding for psycho geriatric service throughout the Northern Territory.

Indigenous Australians

Indigenous clients seem to be predominantly Aboriginal men complicated by a fallacy that Aboriginal 'culture' some how replaces psychological make-up and the mistaken belief that Aboriginal clients do not experience the same levels of grief, anxiety, sense of hopelessness etc that other Australian's would experience in similar circumstances.

The cultural aspect of the mentally ill, associated with the difficulty of isolation in bush communities, poor English communication skills, lack of education and understanding of their medical condition, reliance on family to provide essential comfort, makes it rather difficult to access and benefit from Mental Health Services.

In working with co-morbidity clients the necessity for an Aboriginal understanding of the emotional state of the client coupled with western knowledge cannot be overstated. A regional network approach incorporating collaborative arrangements between agencies funded to deliver in specialized areas with agreed case management protocols in place is needed to achieve optimum client outcomes.

Culturally appropriate services need to be provided throughout the Northern Territory. There are little or no services provided to remote communities resulting in intervention and diagnosis only occurring at a late stage of a person's mental illness.

Single Men

Single men also are an area of high need. Many of whom are classified as homeless but in fact they are homeless because of their mental illness. Their mental illness/ homelessness is further heightened by the fact that they are highly mobile. i.e. they stay in one location long enough to start receiving treatment, when illness come about they move on to another location where the process may or may not be started all over again.

Isolation

Northern Territory has many areas that are geographically isolated and all the factors that contribute to lack of access, low socioeconomical, and disadvantaged communities impact this region and our community. Isolation can bring a lack of social cohesion and extended family support, geographical dislocation and isolation from the country, language and culture of origin and has generated a society where mental disorder may occur more easily than in society where stability is the norm.

Complex, co-morbid and drug and alcohol

Treatment for co-morbid conditions and drug & alcohol issues are not treated in a holistic manner and services tend to treat each separately. There is significant data that shows the increase in substance abuse over the past 3 years. Long processes are involved and this is not always possible in critical border situations between life and death. It seems that the path to recovery is seldom successful.

Refugees

The special needs categories should be expanded to include refugees, many of whom are suffering post traumatic stress. Little or no funding is being provided to assist refugees in the Northern Territory.

Other Issues

Difficulties in recruiting and retaining specialist staff to the Northern Territory have always hampered the availability and continuity of service. Many episodes of illness are left for GP's to diagnose, however in most cases the GP's are often not adequately trained to detect or diagnose mental illness properly. This along with the lack of support and availability of education and training for staff within services results in poor service delivery for person affected by mental illness.

Services need to be more strategically integrated to begin to look at the treatment in a holistic way. Alcohol and Other Drugs, Mental Health, Aged Care, and Indigenous Health are all stakeholders in providing sufficient support and care to the people of the Northern Territory with a mental illness and their carers.

Palliative Care services are another area that is in need of more funding to provide adequate service to people with terminal illness and the depression associated with the illness.

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

The question was asked here "what training and support?" carers felt that there was very little if any of either available to them.

There is an enormous role that training and support for primary, (indigenous and non-indigenous) carers can play in the treatment, recovery and support of people with a mental illness. Primary carers do not receive training as an automatic part of their role, carers often become carers because they are put into this situation by life and family circumstances and they learn on the job.

Training for primary carers needs to be relevant, coordinated, and affordable and offer beneficial outcomes that will assist in the caring processes.

Carers require more support with respect to a lack of information and lack of consultation and support around their role during the delivery of mental health services.

Specific areas of concern requiring support include;

- consultation and planning with family and carers upon discharge from the ward,
- consultation and planning with family in development of management and well being options,
- direct support and intervention during severe episodes within the home or community,
- availability and counselling support for family and carers,
- lack of support between crisis,
- availability of appropriate training for family and carers, and
- clear understanding of carer rights and responsibilities.

Carers can also be a valuable source of information and offer an insight to what has often been repetitive behaviour from people with a mental illness. This should not be overlooked in relapse and recovery processes.

Carers expressed frustration at the dilemma of patient confidentiality versus carer responsibility. The issue of confidentiality is sometimes taken to extremes even when a patient has given consent for information to be given to his/her carer.

Carers expressed disappointment at the lack of recognition of the importance of their role. It was felt that the role of carers of people with disabilities and the frail aged had a much higher level of recognition and support than those caring for those with mental illness. Organisations such as NT Carers have difficulty catering for this group. Carers of those with mental illness felt that they got little support as all funding was directed toward the aged care and disability sectors.

Some carers of mental health clients carry the burden of caring for many years and acknowledge that they are tired and ageing themselves. Carers are concerned for the future of their loved ones and hope to see change within the mental health system that will make their lives easier.

A key element where there was strong hope for change was in continuity of care. Continuous changes in case workers and health professionals causes enormous stress on carers and clients.

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

Primary health care could be pivotal in the promotion and prevention of mental health providing GPs are resourced, skilled and kept up to date with mental health issues. The general community access their GPs for standard aliments and GPs are well placed to detect early signs. GPs are also a good source of history and social information and there is less stigma in visiting a GP.

However, GPs are not the only source of early detection with other professionals such as school counsellors, school based constable, school nurse also play an important role in early intervention and the referral process.

Mental Health services are not promoted well throughout the Territory resulting in people not being aware of the existence of services until there is a crisis situation. More agencies and services in the Health area need to be aware of what services are available and when a person needs to be referred to a Mental Health service.

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;

The Mental Health system may see real reforms for mental health clients if policy is based upon the principles that reduce the likelihood of dependency on the system as result of exposure to the system.

It is critical that clients have the supports to acquire the knowledge, skills, information about the illness to be empowered through early identification of symptoms so they may maintain and have a level of control over their life and have minimal constraints due to their illness.

The non-clinical services operating in the Northern Territory offer services that promote recovery-focussed care through the involvement of their clients and recognise that there are limits to the level of true participation in decision-making that might be reached. Experience shows that approaches can be developed that enable clients to be actively shaping our programs rather than being cast in the role of passive recipients of a delivered service.

These approaches include:

- A significant proportion of the membership of committees and steering groups to be consumer representatives;
- Mentoring support for clients to enable a suitable level of participation in meetings;
- Consumer forums and business lunches to provide comments on services;
- Strategic planning workshops for clients;
- Governance and other training.

Managing these processes requires clarity of purpose, sensitivity to the needs and capacities of participants and an ability of staff to manage conflict.

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;

Community visitors to correctional services are adamant that there is an over-representation of people with mental illnesses in custody. Similarly there are people with acute mental disorders (possibly due to torture and trauma) in immigration detention centres.

The stress associated with being incarcerated is likely to cause depression and other related anxiety. There is also no diagnosis or treatment of pre-existing mental health problems prior to convictions.

Police, judiciary and correctional service officers are not medical officers and often use a different model to resolve any critical situation as long as it fits within the criteria of Law and Order.

Any detention environment, particularly in isolation, can only produce further deterioration of a pre existing mental condition or trigger a new mental disorder which was not initially present (escalating from depression, to self-harm, to suicide).

Prisons are not equipped well enough to cater for those with mental health issues. The prison system has very few trained mental health staff, no specialty facilities with some acute care cases placed in prisons because there is inadequate accommodation available for these people. People with a mental illness or psychiatric disorder are rarely transferred from prisons to hospitals

Medical and psychological checks are to be made mandatory, before, during and after any form of detention. Appropriate assessment and follow up of mental illness is necessary for those entering the jail system and whilst they are incarcerated.

There are limited forensic psychiatry units in the Northern Territory, so that even if a person is found not guilty by reason of mental impairment, they are still housed within the jail system. There needs to be further specialized mental health units for those people. There is a lack education and training for all prison and parole officers in dealing with people with a mental illness and very few have the necessary skills to provide adequate service to detainees. Legislation is not adequate, nor is there an infrastructure to place people in such a facility.

Detention (in custody or in correctional centres) and withdrawal of civil liberties will not, in itself, rehabilitate a criminal and even less so a mentally ill person. There are no psychiatric wards in the prisons in the Territory. Treatment, diversionary programs and education are the only way to re-invest people back in the community.

Diversionary programs are also seen as playing an important role in keeping people with mental illnesses out of prisons. Special legislation needs to be in place in the NT which provides specific measures for people with mental illnesses/ and diversion programs. The lack of a range of appropriate accommodation and community support services is seen as playing a significant role in people becoming more ill, resulting in people ending up inappropriately in prisons and detention centres. This includes the lack of safe and supported community accommodation options, insufficient outreach and life skill programs, or crisis responses services, as well as excessive caseloads.

The process of case planning for the release of a person from detention needs to be put into practice when the person is admitted and revised throughout their incarceration to achieve a more positive outcome upon release. A new model of case planning should be developed that incorporates the need for cooperation of service providers, formal and informal carers and better integration of services to produce the desired outcomes for the detainee's release.

There is a need for Case Management Teams to work with people with complex needs eg "Assertive case management teams" with case loads of a maximum of 10 was seen as being a good model. The case load for these teams should be realistic and therefore more resources and specialist staff will be needed to undertake these roles.

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;

There is a strong perception by community visitors, people with mental illnesses and their carers that seclusion is used as a way of managing difficult behaviour. Detention and seclusion within mental health facilities should only be considered when patients are aggressive and become a danger to themselves and to others and not as punishment for people with difficult behaviours. A strong watchdog organisation needs to be formed to address issues regarding detention and seclusion. The Community Visiting Service is seen as taking on this role. However the legislation in the NT needs to be reviewed, to strengthen the watch dog role of the Community Visiting Service and to enforce compliance. This organisation should also have a role in the education and training of all prison staff and in auditing of practices in the prison system.

Training for all prison and detention staff in mental illness awareness and in working with people with a mental illness or a psychiatric disorder should be mandatory including managing perceived difficult behaviours, early detection and intervention strategies etc. This should occur at induction and be cyclical.

The "least restrictive" methods are to be used. Coercion is seldom needed, as most patients have voluntary status. However this may change if their condition deteriorates and treatment is provided through a court order. Registrars, psychiatrists and MH nurses must cooperate in assessing each situation for the best interest of the patients.

Throughout the Territory the Mental Health Service has been in a process of accreditation for the past 3-4 years. This is the only means in which the community and consumers can ascertain what the benchmark of service should be in relation to best practice. The whole area of quality service and standard guidelines are very grey and seem to be not monitored effectively.

There is a need to develop a service model which is more responsive to people with dual diagnosis, in particular A&D and mental illness. This needs to include specialists in dual diagnosis.

Mental Health Legislation needs to be reviewed and implemented throughout the judicial system to enforce humane treatment and care standards, especially for those under the age of 18 years or where dual diagnosis is required. The current legislation excludes people with personality disorders or alcohol and drug dependence and should be re-examined.

There is no separate facility for the detention of young people with mental illness in the Northern Territory. A caring therapeutic environment will foster more humane treatment and better outcomes for these young people rather than hospital or a secluded house in the community.

L. the adequacy of education in de-stigmatising mental illness and disorders and in providing support service information to people affected by mental illness and their families and carers;

Overwhelmingly people recognise the value of education in de-stigmatising mental illness and disorders. This requires a multi-faceted approach to include the client, the client's family, the community and those working in the mental health industry and health professionals.

This was viewed as important because more often than not the stigma associated with mental health deters potential users from accessing mental health and support services. The stigma of mental illness is so great that a public meeting will only attract those who have accessed the mental health system.

There are many people who may never access the mental health system choosing to remain outside of the system due to the stigmatising nature of mental illness and the negative pictures associated with mental health services. There are also many who just are not aware of services that are available and where they can go to get help.

These people remain functional, working people until crisis point when chaos enters and they find themselves in a system that is foreign and unfamiliar.

Prevention and early intervention programs in the form of self-help, problem-solving, survival skills, building community, living skills, etc may encourage people to contribute their stories.

There is a very clear message around the timeliness of education to young people regarding the links between drugs and possible mental illness – this was that high school is too late to be exposed to this message. Primary school mental health programs are necessary for initial exposure and to complement the high school programs. It was noted that the anti-drug campaign has recommenced.

Mental health clients usually frequent low cost accommodation and there is the added need to provide adequate mental health training to low cost accommodation providers to ensure that mental health clients are treated appropriately and/or receive the appropriate treatment and support.

M. the proficiency and accountability of agencies, such as housing, employment, law enforcement and general health services, in dealing appropriately with people affected by mental;

There is a perceived lack of coordination between services in dealing with people that access a range and number of services. This situation is heightened by the transient nature of people within the Northern Territory. The services outside the Mental Health sector that are dealing with people with a mental illness, such as employment agencies or Centrelink, do so without sufficient staff skills or support.

Accountability has a cost. In most cases it is not a component of a funding agreement and it cannot be countered as an output of service provision so it is up to the service provider's culture to include accountability as part of service provision.

N. the current state of mental health research, the adequacy of its funding and the extent to which best practice is disseminated;

There was agreement that the level of funding for mental health research needed to increase.

Some consumers and carers expressed concern that they were unaware of the outcomes of research which they may have been involved in or shown interest in. Better dissemination of information is required.

Carers stated that they would like more carer involvement in determination of treatment options. Carers are a valuable resource in research that is often overlooked.

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;

As was the case for research, some consumers and carers expressed concern that they were unaware of the outcomes of data collections which they have been involved in, they feel they are forever giving information and receiving none in return.

There was a view that many collections were repetitive and resulted in very few tangible outcomes.

There was strong support for the linking of funding with compliance to national standards; however the unique characteristics of the Northern Territory must be taken into consideration. Compliance to national standards is unrealistic in many remote locations.

P. the potential for new modes of delivery of mental health care, including e-technology;

The Mental Health Sector needs an increase in the coordination of service delivery and integration of services. This would result in improved information sharing and communication between service providers. The Commonwealth Carelink service should play a greater and more pivotal role in the coordination of services.

Services should be encouraged to be more innovative in their approach to service delivery. This, however, takes time and resources that are already, in most cases, stretched to the limit. Information regarding what innovations have been successful in agencies around Australia should be available. Agencies should be funded and encouraged to publish results of new modes of delivery in any form of Health Care.

E-technology has limited application for rural and remote communities throughout the Territory at this stage. Generally, consumers and carers have limited access to computers and find it difficult to utilise the technology if they are from a non-English speaking background or have literacy concerns, but developments in this field are encouraged. Some really good work has been done in this area already, for instance the development of the AimHi programme. These developments in e-technology provide hope that access to some effective services may become a reality in remote areas.

CONCLUSION:

In comparison to its health sector competitors, Mental Health is politically lagging, significantly under funded and severely stigmatised.

Clearly, the present situation is unsustainable and the future is the focus for change and improvement. Clients, their families and the community at large demand better of the Mental Health system to break down the barriers that prevent people from participating in society.

In light of recent media coverage of mental health matters and the effect on the general public, the Coalition is eager to provide this submission in the hope that some change may result as an outcome of the Senate Committee's Report in October.