Australian Government
Department of Health

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The NT PHN Mental Health and Suicide Prevention Needs Assessment

This template must be used to submit the Primary Health Network's (PHN's) Needs Assessment report to the Department of Health (the Department) by **30 March 2016** as required under Item E.5 of the Standard Funding Agreement with the Commonwealth.

Name of Primary Health Network

Northern Territory Primary Health Network

When submitting this Needs Assessment Report to the Department of Health, the PHN must ensure that all internal clearances have been obtained and the Report has been endorsed by the CEO.

Section 1 – Narrative

Needs Assessment process and issues

The Northern Territory PHN (NT PHN) Mental Health and Suicide Prevention Needs Assessment (MHSP NA) was undertaken over a six week period with support and ongoing collaboration provided by leading Northern Territory (NT) health peak bodies and key stakeholders. A working group was established with members including NT Government (NTG) Top End Health Services (TEHS), NTG Central Australia Health Services (CAHS), NTG Directorate of Mental Health, the NT Mental Health Coalition (NTMHC), the Aboriginal Medical Services Alliance Northern Territory (AMSANT) and the Association of Alcohol and Other Drugs Agencies Northern Territory (AADANT). The MHSP NA was undertaken in conjunction with the Drug and Alcohol Treatment Needs Assessment and the NT PHN Baseline Needs Assessment.

Limitations

Limitations were identified from the outset. Strategies to overcome many of these will be incorporated into the comprehensive Needs Assessment process in 2016-17. Key areas included:

Comprehensive consultations

The limited timeframe prevented a process of comprehensive regional level consultations. This was identified by all stakeholders as a substantial gap in the overall development of the MHSP NA. Comprehensive consultations are crucial when gathering accurate and representative information in the NT. Identification of specific regional and consumer-verified needs was limited in this process. To partially remedy this issue, NT PHN undertook high-level consultations via relevant peak bodies representing member/service providers and key stakeholders. Through this process, input was collected regarding identified mental health and suicide prevention needs and service delivery gaps.

Consumer and carer input

An additional limitation was that the MHSP NA was unable to include primary consumer and carer input due to the timeframes. Stakeholders indicated that this inclusion would help improve the reliability of future needs assessments in terms of providing understandings of user pathways. Future needs assessments would be strengthened by including an explicit consumer and carer input component when undertaking community level consultations.

Identified Regional Needs

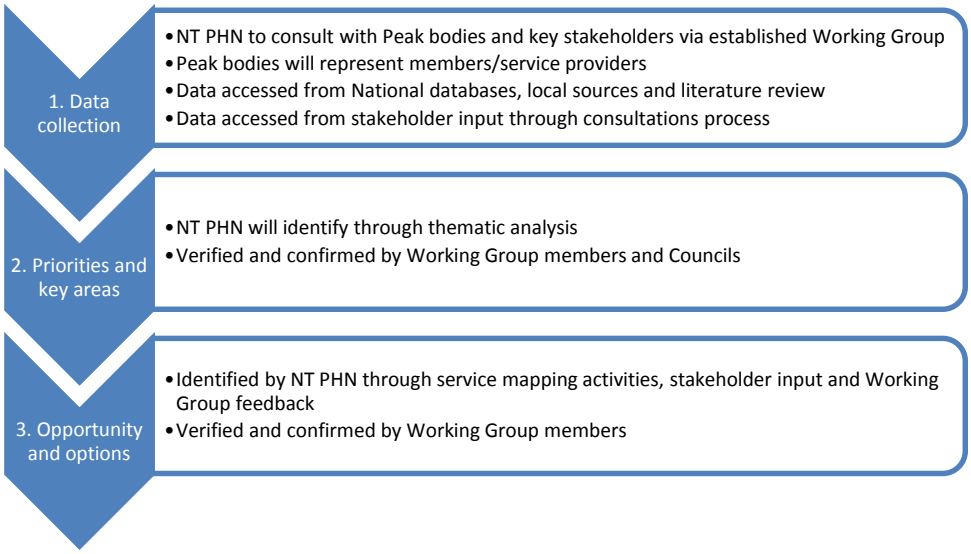
Due to the timeframes, inaccessible Local Hospital Network (LHN) data, and lack of comprehensive regional and consumer consultations, the identification of specific regional data trends were a challenge. While distinction is made between urban and remote geographic and demographic settings, the MHSP NA provides an overall representation of health status in the NT opposed to an assessment of each Health Service Delivery Area.

Exclusions

Inclusion and exclusion variables were not provided in template or guidelines. This was determined by NT PHN with suggestions provided by Working Group members.

Process

A rapid assessment framework and peak body, key stakeholder Working Group was developed at the outset. Three stages were identified and the output from each was presented to the Working Group members for feedback and confirmation. Additional input was provided by NT PHN's Community Advisory Council and Clinical Advisory Councils. Refer to Appendix 1 for further description of the MHSP NA process.



Additional Data Needs and Gaps

In the initial stages of the MHSP NA, a table of required data sources and relevant variables was developed to inform analysis and assessment processes. Data sources specified on the Australian Government Department of Health's PHN website did not provide adequate data to undertake this activity in the context of mental health needs in the NT. It also became evident that much localised primary data would be unavailable due to lengthy request and access processes, and the limited comprehensive regional-level consultations. Available national data sets used for this process were also limited, as they were outdated by two to three years, contained variable errors (including confidence intervals) relating to sampling and responses, and in some cases did not provide NT data for relevant variables. It was also indicated by multiple stakeholders that conventional data sets do not provide a reliable representation of mental health issues experienced by Aboriginal and Torres Strait Islander peoples. To partially remedy this, the scope of data sources was expanded to include more qualitative and culturally relevant information (refer to Appendix 1).

It also became evident that national standards of measuring mental health severity may not be reliable for assessing culturally and linguistically diverse (CALD) groups, for example, the Kessler scale measurement for psychological distress in Aboriginal and Torres Strait Islander people. It was brought to our attention that the 2014/15 National Aboriginal and Torres Strait Islander Social Survey (due to for release late April 2016) will use a broad range of information

to identify Social Emotional Wellbeing (SEWB). These more nuanced and culturally relevant definitions will help inform frameworks for stepped care service delivery.

Additional comments or feedback

This MHSP NA is limited in terms of representing population health needs for reasons described above. However, it is worth noting that the identification process has helped inform the framework for more comprehensive needs assessments that can be utilised in the future.

Furthermore, the partnership building developments with relevant peak bodies as a result of this activity has provided a platform for greater collaboration and potential integration initiatives. As is indicated in Section 3 and 4 of the MHSP NA, 'silo' mentality and poor coordination tends to be a great impediment on service delivery.

Recommendations:

In terms of process, it is strongly recommended that a minimum of six-month timeframe with corresponding budget be granted for future Needs Assessments. The vast majority of limitations with this Needs Assessment could be mitigated with appropriate opportunity for comprehensive stakeholder consultation NT-wide.

Section 2 – Outcomes of the health needs analysis

Background	
Mental health burden of disease much higher in NT compared to national average: - Mental illness and substance use disorders are responsible for 7.4 per cent of total disease burden in Australia - Northern Territory mental health conditions contribute to 16.3 per cent of the burden of disease. Mental health disorders are often under reported, or under diagnosed in the NT.	- 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[1]. - 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[2]. By comparison, in the NT mental health conditions contribute to 16.3 per cent of the burden of disease[3]. - Mental disorders are under reported and under diagnosed nationally and in the NT[4].

Outcomes of the health needs analysis		
Priority Area	Key Issue	Description of Evidence
Child and Youth Mental Health	Low utilisation of available services: - Estimated 70 per cent of young people who experience mental health	- Several sources estimate 70 per cent of young people who experience mental health and substance use problems do not actively seek services[5]. - The 2007 survey of the Mental Health of Young People revealed that, whilst the prevalence of mental illness is relatively high in young people, this population group has a lower rate of accessing mental health services (23 per cent in the 12 months preceding the survey) compared to the 45-54 years age group (41 per cent)[6].

Outcomes of the health needs analysis		
	and substance use problems don't seek help. - Young Territorians are over represented within mental health services compared to other age groups and national average.	- However in NT, young people are over represented within mental health services compared to other age groups. The NT has the youngest population in Australia (37 per cent<25yrs), 2012/13 data indicates high rates of mental illness amongst young people aged between 15 and 24 years - they represent 25 per cent of all community based clients while this age group makes up only 15 per cent of the population. Similarly, this age group accounted for 24.6 per cent of admissions to mental health inpatient facilities[7].

Social and Emotional Wellbeing (SEWB) responses for Aboriginal and Torres Strait Islander people	- Inter-generational trauma associated with the impacts of colonisation, cultural dislocation and child protection practices contribute to mental health disorders.
	- High rate of mental health disorders in Aboriginal and Torres Strait Islander youth and children.
		- 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[8].
		- NT Government mental health services data for 2012/13 indicates that:
		  - 43 per cent of all consumers assisted by the community based (non-inpatient) mental health services are Aboriginal (13 per cent above the population proportion of 30 per cent); and
		  - 52 per cent of admissions to mental health inpatient facilities are Aboriginal (22 per cent above population proportion of 30 per cent)[9].

Outcomes of the health needs analysis		
	High rates of Psychological distress among Aboriginal and Torres Strait Islander people.	- Although the overall population in NT with high/very high psychological distress is less than national average (8.1 per cent vs 11.8 per cent respectively[10]), the Aboriginal and Torres Strait Islander high/very high psychological distress is almost twice national average at 23.3 per cent vs. 11.8 per cent respectively[11] - Over 75 per cent of Partners in Recovery (PIR) program clients are Aboriginal and Torres Strait Islander status. The highest ranked participant unmet need NT-wide in 2015 for PIR was treatment for psychological distress[12].
Access to mental health, suicide prevention and wellbeing services for identified vulnerable groups.	Migrant and Refugee - mental health and suicide risk - High levels of anxiety and depression in refugee populations.	There is a significant and growing population of refugees in the NT with very particular and specialised mental and physical health needs, which are sometimes difficult to access via mainstream services. The following was identified: - High levels of anxiety and depression in Refugee population. - Refugees are more likely to experience poorer health status, have higher rates of long-term medical and psychological conditions and visit health services more frequently. - Most health problems are largely due to physical and psychological trauma, deprivation of basic resources required for good health and poor access to health care prior to arrival.
	Remote and very remote population groups. - Remote locations as a barrier to service access. - Correlation with high proportion of population receiving clinical mental health service and	- 81 per cent of Aboriginal and Torres Strait Islander Territorians live in remote or very remote locations, and have reduced options for accessing mental health services[13]. - Data from AIHW indicates that the NT has the highest rate of people receiving clinical mental health services (2.7 per 100 population) compared to Australia (1.8 per 100). The rates for remote (2.8 per 100) and very remote (3.3 per 100) are also high and only surpassed by NSW rates (3.3 and 5.2 respectively)[14].

Outcomes of the health needs analysis		
	remote/very remote status.	
	Prison Population with mental health and suicide risk	- Prison inmates tend to have poor mental health and high levels of health risk behaviours, such as drug and alcohol use and smoking[15] For people who had ever been incarcerated, nationwide census data indicates: - 41 per cent had a 12-month mental disorder, which is more than twice the prevalence of people who reported they had never been incarcerated (19 per cent). People who reported they had ever been incarcerated experienced almost five times the prevalence of 12-month Substance Use disorders (23 per cent compared with 4.7 per cent), more than three times the prevalence of 12-month Affective disorders (19 per cent compared with 5.9 per cent), and almost twice the prevalence of 12-month Anxiety disorders (28 per cent compared with 14.1 per cent). [16] - It is worth noting that the majority of individuals incarcerated in the NT are young Aboriginal and Torres Strait Islander males.
	Veterans - Multiple deployment to conflict zones and highly mobile group presents challenges providing ongoing mental health care (when required), especially for post-discharge period. - Stigma associated with seeking help.	- High reported instances of anxiety, depression, Post Traumatic Stress Disorder (PTSD) and suicide among current and former military personnel. - Since 2000, 96 serving members and 13 veterans have completed suicide nationwide[17]. - Often reluctance to seek services for mental health issues due to fear of damaging careers[18]. - Being treated differently (27.6 per cent) and harm to career (26.9 per cent) were the highest rated perceived stigmas. - Nationwide, the highest rated barrier to seeking help was concern it would reduce deployability (36.9 per cent)[19].

Outcomes of the health needs analysis		
	Lesbian, Gay, Bisexual, Transgender, Queer and Intersex (LGBTQI) community-mental health and suicide risk. - LGBTQI populations experience mental health disorders which can be attributed to societal stigma and the associated sense of isolation and discrimination.	- The Lesbian, Gay, Bisexual, Transgender, Queer and Intersex (LGBTQI) community is a very diverse group and capturing their specific needs is a complex task. In a review of the literature in relation to mental health and well-being amongst the LGBTQI community, Ritter et al (2012) found that LGBTQI populations experience mental health disorders and substance abuse at a significantly higher rate than the heterosexual population across both genders, and in both youth and adult populations. They are also at greater risk of suicide and self-harm (Beyond Blue, 2014). The causes for this are often attributed to societal stigma and the associated sense of isolation and discrimination which can result in risk-taking and self-harming behaviours[20].

	Homelessness - Up to 25 per cent of the Aboriginal population are considered to be living in inadequate circumstances in NT, including overcrowded households. - Aboriginal and Torres Strait Islander people make up over 90 per cent of people who are homeless in the Northern Territory.	- Homelessness is a major problem in the NT, with up to 25 per cent of the Aboriginal population considered to be living in inadequate circumstances or sleeping rough. (Shelter NT, 2016). Aboriginal people make up over 90 per cent of people who are homeless in the NT. 33.9 per cent of the NT's Aboriginal population is living in overcrowded housing which can contribute to a range of other social and health stresses. (overcrowding plays a significant role in the transmission of infectious disease, mental health issues and can contribute to family violence and injury). [21] - Access to adequate shelter is a key indicator of social well-being and considered to be an important factor in recovery from mental illness. A recent consultation paper (Department of Housing, 2016) [22] identifies a poor match between current public housing stock and demand, lack of affordable private sector housing, ageing stock and high levels of homelessness across the NT. [23]

Outcomes of the health needs analysis		
Targeted Suicide responses, including prevention, early intervention and postvention.	National statistics - National Suicide rate highest in 10 years - Suicide remains the leading cause of death in people aged 15-34, contributing to more than a quarter of all deaths in these age groups - The Aboriginal and Torres Strait Islander suicide rate is double that of non-Aboriginal people - Low self-esteem, feelings of grief and loss, cultural identity issues and involvement in the criminal justice system are additional significant contributing factors.	- The 2014 Cause of Death data by the Australian Bureau of Statistics (ABS) indicates that death by suicide has continued an upward trend, and is at the highest rate in ten years nation-wide and for gross population. The data also shows that men account for over three quarters of all deaths by suicide, and that suicide remains the leading cause of death in people aged 15-34, contributing more than a quarter of all deaths in these age groups. [24] - Low self-esteem, feelings of grief and loss, cultural identity issues and involvement in the criminal justice system are additional significant contributing factors to suicide[25]. - ABS data indicate very high number of male and child suicides in the NT (over three times the national average in regards to the latter). - Whilst over the last eight years, deaths from suicide have been decreasing, the NT continues to have the highest suicides numbers (standardised death rate/all ages) compared to any other state/territory and is significantly higher than the national average: 17.6 and 10.9 respectively, particularly with males: 27.9 and 16.7 respectively [26]. - The NT has the highest standardised death rate for children aged 5-17 years compared to any other state/territory and is significantly higher than national average: 8.2 and 2.1 respectively. [27] - Suicide standardized death rate (2010-2014) of females in the NT is much higher than any other state/territory and national average is 8.5 vs 5.4 respectively[28]. - The suicide rate for Aboriginal and Torres Strait Islander men is 3 times higher than non-Aboriginal and Torres Strait Islander men in the NT and is falling, but rates amongst young Aboriginal and Torres Strait Islander women began increasing in 2012[29]. - Darwin Urban has the highest number of suicides and the highest rate, followed by East Arnhem and Barkly. Figures supplied by the NTG Department of Health show that, during
	NT statistics - Very high number of male and child suicides compared to the national average.	

Outcomes of the health needs analysis		
	- NT suicide rate for children 5-17 years is over three times the national average. - Suicide rates in NT are higher than any other state or territory for both males and females. - Latest ABS data (2016) indicates significant increase in NT suicides. - 50 per cent of suicides in Darwin (Urban). - Overall youth suicide is the highest in the nation.	the period 2006 to 2010, the Health Service Delivery Areas with the greatest number of suicides was Darwin Urban, with around 50 per cent of all suicides in the Territory. [30] - The youth suicide rate in the NT is approximately 3.5 times the national rate for 15-24 years. 2006-2010: 38 deaths per 100,000 (ABS death registration data)[31].
	Aboriginal and Torres Strait Islander suicide rates, particularly child and youth suicide: - 75 per cent of suicides of children from 2007 to 2011 in the Territory were Aboriginal and Torres Strait Islanders - Aboriginal children aged 14 years and under are 8.8 times more likely than non-	- The incidence of Aboriginal suicide in the NT has been increasing since the 1980s and has now exceeded the rates of suicide for non-Aboriginal people. Of particular concern is the increasing rate of youth suicide in the Aboriginal population 10-17 years old, with rates increasing from 18.8 per 100,000 in 2001-05 to 30.1 per 100,000 in 2006-10 - The NT Government's, Gone Too Soon Report into Youth Suicide in the NT, published in 2012 states: The suicide rate for Aboriginal Territorians is particularly disturbing, with 75 per cent of suicides of children from 2007 to 2011 in the Territory being Aboriginal. [32] In 1991, Aboriginal people in the NT represented 5 per cent of the suicide population and Non-Aboriginal people representing 95 per cent. In 2010, that number had increased from 5 per cent to 50 per cent for Aboriginal people and decreased from 95 per cent to

Outcomes of the health needs analysis		
	Aboriginal children to take their own life - Suicide was the second leading cause of death for Aboriginal and Torres Strait Islander children aged 14 and under in 2014	50 per cent for non-Aboriginal people. The greatest at-risk category is with 10 – 24 year olds who represent 80 per cent of the suicide population. [33] - Nationally, suicide was the second leading cause of death for Aboriginal and Torres Strait Islander children aged 14 and under in 2014. Aboriginal children in that age group were 8.8 times more likely than non-Aboriginal children to take their own life. It was the leading cause of death for Aboriginal people aged 15 to 35, where the Aboriginal suicide rate was more than three times the non-Aboriginal suicide rate. Nationally, the rate of Aboriginal suicide is 21.3 per 100,000 people. [34]
	Childhood trauma linked to suicide	- Childhood trauma including abuse and neglect was identified as an important public health challenge that has the potential to be largely resolved by appropriate prevention and healing. The impact of childhood trauma and the outcomes of trauma is strongly linked with suicide, alcoholism and other drug misuse/mental health issues. [35]
	Low use of available services - Less than 30 per cent of people who completed suicide had seen a MH professional in the NT	- Mental illness or distress is a contributing factor in many suicides, but this is not always identified or reported to services. <30 per cent of people who completed suicide had seen a mental health professional at least once. <10 per cent of people who completed suicide were clients of NTG mental health services. [36]
	Suicide contagion effect	- One of the key issues that impacts upon suicide in Aboriginal communities is the occurrence of 'copycat' suicides. This is also known as a 'contagion effect' or 'cluster'. Queensland's Commission for Children and Young People and Child Guardian states that "contagion", or copycat suicide, is a key factor in 60 per cent of suicides among children and adolescents, who took their own lives after the suicide or attempted suicide of a friend, relative or community member" (Senate Enquiry Submission 2009). Research by Hanssens (2007) [37] from Charles Darwin University found that young, unmarried, unemployed males aged between 15-45 are at the highest risk of copycat suicide. This research also cited that the use of alcohol and drugs had been found to be a factor in approximately 70 per cent of the suicides in the NT. The co-morbidity of risk factors

Outcomes of the health needs analysis		
		therefore seems to be a significant issue influencing suicide in many Aboriginal communities. [38]
Consideration of social and cultural determinants of health and intersectoral collaboration	Social and Cultural Determinants- Family and relationships - Domestic and family violence is a significant factor that is contributing to suicide, along with prior exposure to suicide in close family members. - The most commonly reported family stressors in the Aboriginal and Torres Strait Islander population were the death of a family member or friend. - Aboriginal and Torres Strait Islander people were considerably more likely than non-Aboriginal people to have been affected by family stressors. - People experiencing family violence are over-	- Domestic and family violence is a significant factor that is contributing to suicide, along with prior exposure to suicide in close family members and substance abuse emerging as the main factors contributing to suicidal behaviour[39]. - In 2012–13, almost three-quarters (73 per cent) of Aboriginal and Torres Strait Islander people aged 15 years and over reported that they, their family or friends had experienced one or more stressors in the previous year. The most commonly reported family stressors in the Aboriginal and Torres Strait Islander population were the death of a family member or friend (37 per cent), a serious illness (23 per cent), inability to get a job (23 per cent), and mental illness (16 per cent). - Research consistently finds that people experiencing family violence and survivors of child abuse are over-represented in adults with mental illness and drug and alcohol problems. Breckenridge et al (2011) identify the potential impact as a chronic form of traumatic stress disorder manifesting in a range of psychological stresses and increased suicide rates and self-harm. The NTG Department of the Attorney-General and Justice reports that more than 60 per cent of assault offences in the NT are associated with domestic violence, and that 82 per cent of domestic violence victims in the NT are women. Aboriginal females represent 73 per cent of domestic violence victims in the NT. The Department has developed a comprehensive strategy offering an integrated response by Government and non-government agencies to reduce the negative impacts of service fragmentation on vulnerable victims. [40]

Outcomes of the health needs analysis		
	represented in adults with mental illness in NT.	
	Social and Cultural Determinants- Unemployment - Nationwide, 29 per cent of people unemployed had a 12-month mental disorder. - Much higher unemployment in NT remote areas.	- The second highest unmet need for the PIR program NT-wide in 2015 was employment. [41] - From the National Survey for Mental Health and Wellbeing, of the 413,600 unemployed people, 29 per cent had a 12-month mental disorder. In comparison, 20 per cent of the 10.4 million people who were employed had a 12-month mental disorder. [42] - The poor health effects are linked to psychological consequences, financial problems (debt) and reduced life opportunities, with outcomes worse in regions where unemployment is widespread. - Four Statistical Local Areas (SLAs) have rates of people claiming unemployment benefits of between 17.7 per cent and 24.6 per cent. Further analysis highlights the differences between urban and remote/very remote regions, as demonstrated by Darwin (1.6-3.8 per cent) and Alice Springs (4-5 per cent) having low levels of people claiming unemployment benefits. [43] - Lack of employment is a major contributor to mental illness and suicide. [44],[45]
	Social and Cultural Determinants- Physical Health - People with severe and enduring mental illness also experience poor physical health outcomes and reduced life expectancy. - 12 per cent of people living with a mental illness	- People with severe and enduring mental illness also experience poor physical health outcomes and reduced life expectancy[46]. The National Mental Health Commission found that approximately 12 per cent of people living with a mental illness are also living with a chronic health condition and high risks of diabetes and metabolic syndrome. Contributing factors include the impact of psychotropic medications, smoking and lifestyle factors. Poor oral health and lack of access to dental care was also identified as a major issue. [47]

Outcomes of the health needs analysis		
	are also living with a chronic health condition.	
Consumer and carer consultation and engagement	Limited and inadequate consultation processes. - Limited Aboriginal and Torres Strait Islander consultation. - Limited consumer consultation.	- There is an evident lack of comprehensive consultation process with lived experience, carers, family and friends, service providers and community members when determining needs or designing programs. This is particularly relevant in regards to Aboriginal and Torres Strait Islander consumer consultation [48]
Links between substance abuse and mental health	There is a very strong relationship between alcohol and other drug abuse, mental ill-health and suicidality.	- 24.8 per cent of all mental health inpatient separations in the NT in 2012/13 had a diagnosis of mental health and behavioral disorders due to psychoactive substance use. 25.5 per cent of NT adults exceed the risk guidelines for alcohol consumption in 2011/12 compared to 19 per cent for Australians overall[49]. - There is also estimated to be a higher than average incidence of Acquired Brain Injury (ABI) in the NT due to alcohol and volatile substance use. There are no specialist ABI services in the NT and limited access to assessment services[50]. - A study of completed suicides in the NT in the decade to December 2010 found that alcohol was present in the blood, or alcohol abuse was mentioned in 64 per cent of all suicide reports, including 72 per cent of suicide reports by Aboriginal people and 55 per cent of suicide reports by non-Aboriginal people[51].
Stigma and discrimination	There are high levels of stigma associated with Mental Health issues in the NT	- Low understanding in some communities of mental health conditions vs “shame” or “blame” can increase stigma and unwillingness to identify and address problems. - People now more willing to talk about their mental health challenges however, discrimination in the work place still occurs (and has increased to be biggest cause of complaints in NT Anti-Discrimination Commission Annual Report)[52].

Section 3 – Outcomes of the service needs analysis

Outcomes of the service needs analysis		
Priority Area	Key Issue	Description of Evidence
Mental Health funding	Mental health funding 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 more per capita than the national average: $222.81 vs $210.59 respectively[53]. However, in terms of treatment costs, the NT is exceedingly high. For example, the NT had highest average cost per patient (acute) bed day than any other jurisdiction in 2013 - 2014. The average cost nationally is $996; the Northern Territory is $1,571.[54] - 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 average, 30.2 vs 16.7 respectively. [55]
	Inadequate funding to ACCHS SEWB Programs in NT.	- Insufficient and limited funding to Aboriginal Community Controlled Health Service (ACCHS) SEWB programs in NT. [56]
Mental Health services in and Primary Health Care setting.	Service gaps identified in Elders report include: - Mental health ATSI services specifically for young men in Primary Healthcare	- Very few gender-specific mental health services in primary health care - Very few after-hours services for men (when they are most needed)[57].

Outcomes of the service needs analysis		
	- Limited Mental health services after hours	
	Limited services to meet need in remote locations	- Many remote NT communities have no or limited mental health services to address the identified need. Those that exist are 'very thin' in many remote communities[58] - Recent closure of the Child and Adolescent Mental Health Service (CAMHS) in remote NT regions has caused significant distress to the primary health care providers in the region as the patients are discharged back into their care, irrespective of risk or severity of illness. [59]
	Referral process can be fragmented and ineffective: - Estimated that as many as 50 per cent of referrals are not effectively engaged to the referring service provider.	- Multiple sources indicated General Practitioner (GP) referral processes present challenges and barriers to access. One provider estimated that as many as 50 per cent of referrals are not successfully engaged to the referring agency due to the lack of clarity of the referral pathway. [60]
Further establish and strengthen culturally appropriate mental health and social emotional wellbeing services	Culturally appropriate service provision: - Clinical setting sometimes not appropriate. - Greater need for community led processes. - Programmes designed for the general population are not culturally appropriate within a broader context of	- Several providers and other stakeholders noted that for many Aboriginal people, appropriate service provision would be delivered in less formal/non-clinical settings, in groups and would address the social context of issues, in particularly family contextual issues[61]. - Multiple providers indicated clinical settings are not conducive to mental health treatment for Aboriginal and Torres Strait Islanders[62]. - The Mental Health Commission notes that the significant mental health gap between Aboriginal and Torres Strait Islander peoples and non-Aboriginal people exists "in part because services and programmes designed for the general population are not culturally appropriate within a broader context of social and emotional wellbeing as understood by

Outcomes of the service needs analysis		
delivered by Aboriginal Community Controlled services	social and emotional wellbeing as understood by Aboriginal and Torres Strait Islanders. Service providers needs to incorporate Aboriginal and Torres Strait Islander understandings of health: - Mainstream does not include 'Two way learning model' of understanding wellbeing and holistic models of healing	Aboriginal and Torres Strait Islander peoples. Furthermore, such services do not ensure a connected transition through the mental health system for Aboriginal and Torres Strait Islander peoples." [63] - The significance of the role that the Aboriginal community controlled sector can play in delivering high quality, effective, culturally appropriate SEWB, MH and AOD programs has been clearly acknowledged by the Mental Health Commission – but the funding of these programs is haphazard, regionally inconsistent and significantly inadequate. [64] - "Delivery of effective health care for Aboriginal and Torres Strait Islander people requires service providers to orient their responses toward Aboriginal and Torres Strait Islander understandings of health, investing in mutual partnerships and to work from a strengths based foundation. Without effective personalised communication, social and health inequities remain."[65] - Delivery of effective care should include two ways of understanding wellbeing and holistic models of healing. [66]
A sustainable and supported workforce in the Primary Health Care and Aboriginal Community Controlled sector across	Utilisation of Aboriginal Mental Health Workers (AMHW). - AMHW roles are wide-ranging in their scope and highly complex in their practice - AMHW impact often unrecognized and/or underutilised	- AMHW impact is valuable and culturally appropriate, though often unrecognised/ underutilised and not available NT-wide. - AMHW are an aging workforce and younger workers are not coming through. There is an inadequate pathway for developing the Aboriginal mental health workforce. [67] - Two-ways model of mental health care should underpin all mental health services for Aboriginal people in the NT, and should include a skilled and well-supported mental health workforce, as this is a key factor in achieving positive, equitable outcomes for Aboriginal consumers of mental health services. The roles of AMHW are wide-ranging in their scope and highly complex in their practice. AMHW demonstrate an extraordinary array of skills, and their contribution to a holistic approach to mental health care, which is adaptive to the complex socio-cultural contexts of their clients, is remarkable.[68]

Outcomes of the service needs analysis		
the Northern Territory.	- AMHW under resourced and comprised of aging work force - AMHW are able to generate additional referrals.	- AMHW are also able to establish relationships within community, and generate additional referrals for mental health treatment with General Practitioners (GPs). [69]
	GP capacity - Remote GPs generally face greater challenges compared to their urban counterparts - Quality of GP mental health care plans reported as highly variable - High GP turnover and limited consulting timeframes - Some GPs have limited knowledge of available mental health programs	- Multiple service providers reported that the quality of GP mental health care plans was highly variable. This appears to be related to both high turnover of GPs within the NT, as well as the limited time GPs can spend with patients, which may sometimes lead to incomplete assessments. - Peak bodies and service providers reported that some GPs have very limited knowledge of available mental health programs and how they work (among the range of other mental health treatment options), with the result that patients have the potential to be inadequately screened and referred. - Remote frontline doctors and other health professionals face greater difficulties and challenges with their work, and are often the first contact into the mental health system.[70] - Limited service provider capacity to initiate GP Mental Health Care Plan due to unavailability of GP and/or Mental Health professionals has been identified.[71]
	Utilisation of GP services - NT has less than half the number of Medicare-subsidised mental health-related GP services	- NT has a very low rate of uptake for preparation of GP Mental Health Care Plans and mental health service utilisation (NT rate of <150 per 10,000 compared with >350 per 10,000 for Australia) [72] - In terms of Medicare-subsidised mental health-related GP services per 1,000 population in 2013-2014, the NT has less than half compared to the national average: 47.9 vs 113.7

Outcomes of the service needs analysis		
	compared to national average (per pop.) - NT has less than half of Medicare-subsidised mental health-related GP patients compared to national average (per pop.)	respectively. In terms of Medicare-subsidised mental health-related GP patients per 1,000 population in 2013-2014, the NT has less than half compared to the national average: 31.2 vs. 65.4 respectively. [73] - Medicare item numbers are not routinely claimed within ACCHS, this together with the use of occupational health services by some of the population may explain the low numbers of GP Mental Health Plans. [74]
	Average rate of Medicare Benefit Schedule (MBS) funded psychologist and psychiatrist services in NT are much lower than national average: - Psychologists: 14 services per 1,000 vs 48 per 1,000 respectively. - Psychiatrists: 12 services per 1,000 vs 95 services per 1,000 respectively.	- In 2013-14 the NT had by far the lowest rate of MBS subsidised GP mental health services at 48 per 1,000 population, compared to a national average of 114 per 1,000. Geographic differences were also evident in the MBS subsidised mental health services provided by psychiatrists and allied health professionals (psychologists, social workers and occupational therapists). In 2013-14, the average rate of MBS funded psychologist services was 94 per 1,000 population whereas in the NT it was 14 per 1,000. Similarly, psychiatrists provided an average of 95 services per 1,000 population nationally. In the NT, the rate was 12 services per 1,000. Contrary to the national pattern of a slow but steady growth (1 per cent per annum average) in the numbers of MBS funded services delivered by psychiatrists, the numbers of services provided in the NT have declined by one third over the last five years. [75] - In 2013, only 14 psychiatrists were registered in the NT, and none of these were registered as having any advanced subspecialty. Very few psychiatry trainees are undertaking their training in the NT, so there is unlikely to be an appreciable influx anytime soon. The vast majority of psychologists reside and practice in Darwin, while many of the remote regions of the NT have no resident psychologist[76].

Outcomes of the service needs analysis		
		- In the NT, the use of MBS funded services delivered by psychiatrists has declined by one-third over the last five years, whilst the number of psychiatrists has remained stable. This is the opposite of the national pattern[77].
	Mental Healthcare staff retention - High turnover of mental health staff in the NT - Most staff unfamiliar with the significant contextual issues of the NT Models of 'fly-in, fly-out' create a disincentive for staff to seek more permanent positions	- The high turnover of the NT population requires agencies to invest considerable resources into constant induction and training of new staff, as well as a lack of knowledge in knowing other referral agencies. Most staff recruited to work in the NT health system train elsewhere and can be unfamiliar with the significant contextual issues of the NT. With large numbers of relatively new staff, a significant number of employees at any one time within an agency may have limited or reduced knowledge of programmes, or protocols. [78] - Consumers see the turnover in clinical staff as a barrier in repetition of their clinical history and establishing trust. Models of fly-in, fly-out health service providers create a disincentive for staff to seek more permanent positions, or remain over a longer term, as conditions are more favourable for the fly-in, fly-out worker. [79] - The Northern Territory Medicare Local (NTML) Needs Assessment (2013) indicates the need to look at a variety of incentives, outside of salary, to attract and retain skilled health professionals. Price-Robertson and McDonald (2011) also emphasised having a focus on attracting and retaining the right staff. Competent and capable staff members are key to the success of service delivery, and especially so for services working with Aboriginal populations. For these services, success is dependent on cultural competence and the development of trusting relationships with the community (Price-Robertson & McDonald 2011). Comcare's guide (2013) lists the challenges faced by supervisors of remote workers in facilitating an environment to maximise productivity, health, safety and wellbeing. Key inhibitors to work-life balance in the remote setting include the absence of traditional boundaries (spatial, temporal and social) between work and social life, the

Outcomes of the service needs analysis		
		decrease in communication and the lack of visibility driving a need to over-perform and over-communicate to ensure presence. [80] McKenzie's (2007) and Garnett et al (2008) comprehensive reports also look at the challenges of recruiting and retaining staff in remote areas, offering solutions for consideration. Service co-ordination along with the development of clear care pathways contributes to retention and recruitment of specialist staff. Although concerns remain around infrastructure and training, many respondents spoke about the need for more Aboriginal staff along with constructive engagement with Aboriginal organisations. Dudgeon et al (2014) [81] outlines effective strategies to strengthen the mental health and wellbeing of Aboriginal and Torres Strait Islander people. There is evidence that agencies who adhere to the Closing the Gap service-delivery principles of engagement, access, integration and accountability are more effective than those that do not (Dudgeon et al 2014).
	The average number of public sector mental health hospital beds much lower than national average: - 16.8 vs 29.2 respectively	- In terms of public sector specialised mental health hospital beds per 100,000 population, the NT has less than any other state/territory and the much lower than the national average 16.8 vs 29.2 respectively. [82] - There are extremely limited inpatient facilities across the NT with less than 50 mental health beds available, with no facilities available in remote areas. [83]
	Lack of after-hours service access for mental health	- The most commonly mentioned need for allied health services was around acute mental presentations in hospital Emergency Departments (EDs) across Nhulunbuy, Katherine and Tennant Creek where the ED is the primary after-hours health provider. In these regional centres there is no after-hours mental health team and patients admitted on a Friday night can spend a weekend in ED waiting for a mental health assessment on Monday. Equally as undesirable, in many cases where ED staff are unable to manage the patient or patient load in general, these patients are evacuated off country to the Royal Darwin or Alice Springs Hospital[84].

Outcomes of the service needs analysis		
Coordinated Care	Poor coordination of service delivery.	- Service providers indicated that there is much room for improvement to coordinate with other service providers[85].
	Service providers unable to provide input into planning process.	- Service providers indicated that there was very little opportunity to have input into program design[86].
	Failure to share information and/or collaborate (silo mentality).	- Service providers indicated that they feel there is no uniform/central planning process or strategy, rather each peak body (NT PHN, NTG , AMSANT) develop strategy with little or no alignment with other peak bodies[87].
Ensure national initiatives are implemented in appropriate ways NT-wide.	Stepped care - Implementation of the proposed digital mental health gateway: - Mental health technologies may be underutilised if patients are expected to access e-mental health applications on their own - Having a common gateway for people to be directed to services is unlikely to work for the majority of Aboriginal people in the NT.	- An academic review found that the great majority of e-applications had not been evaluated and that this was very concerning because there was a real risk of harm with poorly designed applications (Torous et al. 2016). The methodologies for evaluating applications are still under development and it is somewhat unclear how to rate effectiveness of these applications. What is clear is that more research is needed. [88] Having a common gateway for people to be directed to services is unlikely to work for the majority of Aboriginal people in the NT. A high proportion of people have English as a second or third language. A high proportion of people do not have access to a computer or iPad, although remote community members do have mobile phones, there is limited internet access depending on location. If clinicians are involved in the assessment of community members, these clinicians will need to be trusted by community members and will need to have both mental health and cultural expertise, that is, clinicians will need to be competent in cross-cultural mental health practice, in order to make a valid assessment[89].
	National Disability Insurance Scheme (NDIS)	- NDIS and mental health/psychosocial disability are still in development and require greater clarity

Outcomes of the service needs analysis		
		- Currently no clear indication about what gaps in service provision will exist in the community for those people who are not eligible for NDIS. - Currently there is no NT bilateral agreement and no NT implementation plan[90]
Research and Evaluation	Evaluation framework: - Mental health programs in NT generally have very poor M&E frameworks. - Program evaluation should be based on outcomes rather than activity focused.	- Few evaluations effectively and accurately measured the extent to which a program affected Aboriginal mental health and wellbeing outcomes. Most evaluations attempted to measure the number of clients and their level of engagement in a program, without regard to the perceptions of clients and the reasons for some programs not achieving their targets. Very few evaluations attempted to measure the relationship between the cultural appropriateness of programs and services, the level of individual or community engagement, and the effectiveness of mental health and wellbeing outcomes.[91]
	The use of conventional data for needs assessments and operational planning is limited.	- The reliability of regional data is limited. Census data has often not been collected outside of major centres and even though the latest Census data did sample people from remote regions, numbers are likely to be small and confidence intervals wide[92].

APPENDIX 1
NEEDS ASSESSMENT FOR MENTAL HEALTH AND SUICIDE PREVENTION - PROCESS

(1) Data collection output

Inclusion/exclusion criteria and attainable/unattainable status was identified, data sources assessed[1]. This provided some value, though not a comprehensive representation of health and service needs. This process was supplemented with the National Mental Health Commission's Contributing Lives, Thriving Communities (2014), The Elders' Report into Preventing Indigenous Self-harm & Youth Suicide (2014), relevant intersectoral reviews and reports, peer reviewed academic journal articles and publically available cabinet submissions. Finally, service provider feedback was gathered via relevant peak bodies and key stakeholders with key issues categorised and incorporated into established data tables. From this, both health and service needs analysis was undertaken with data grouped under 'populations with unmet needs', 'significant statistical variances' (compared to national averages), and 'individuals and groups at risk of poor health outcomes'. On the request of multiple stakeholders, individual input is not identified, rather it is collectively grouped and referenced as a single information source.

(2) Identified key areas and priorities

Themes synthesised from data were relayed back to working group members, who provided feedback and eventual consensus on priority areas and validity of supporting data.

(3) Options and opportunities

Options and opportunities were determined through service delivery gaps identified in data collection process and through service provider feedback. This was triaged with the NT PHN mental health service mapping database developed in early 2016. This was again provided to the working group members for feedback and confirmation.

[1] This included the Australian Institute of Health and Welfare's (AIHW) four Mental Health Care National Minimum Data Sets (NMDS), the National Survey of Mental Health and Wellbeing (2007), National Health Survey (2014-15), National Aboriginal and Torres Strait Islander Social Survey (2008), the Australian Aboriginal and Torres Strait Islander Health Survey (2012-13) and Australian Bureau of Statics data cubes.

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