



The Royal
Australian &
New Zealand
College of
Psychiatrists



Northern Territory Branch

RANZCP Northern Territory Election Advocacy Campaign

July 2020

Key Priority Areas

Introduction

The Northern Territory (NT) faces unique challenges in delivering comprehensive mental healthcare which meets the needs of the entire community. The NT has a relatively small population spread out over a vast geographic area making access to quality and appropriate care difficult and, in some cases, non-existent for many Northern Territorians.

A relatively modest investment in acute and community mental health has the potential to substantially reduce the economic burden of mental illness, with highly visible health benefits to the population. Undiagnosed and untreated mental illness is a major cost to the NT economy, ranging from \$20M per year for schizophrenia to an estimated \$200M per year for ADHD¹.

When compared with other States and Territories, the level of underfunding in NT's Mental Health Services is starkly apparent:

- The NT has 18 mental health beds per 100,000, whilst the national average is 42 per 100,000².
- Mental health contributes 16.3% of the burden of disease in the NT, compared to 7.4% nationally³.
- Mental health presentations to Emergency Departments average 280 per 10,000 in the Territory, compared to 115 nationally⁴.

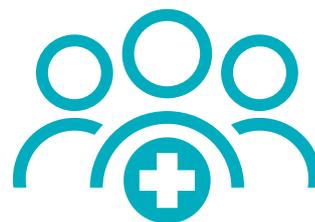
The simple interpretation is that, after decades of neglect, Mental Health Services in the NT require at least a 100% increase in infrastructure and staffing in the short term to meet national equivalents.

Recommendations

The Northern Territory Branch of the Royal Australian and New Zealand College of Psychiatrists recommends and supports:



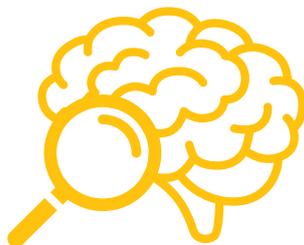
Immediate development of additional inpatient facilities and a purpose-built 24 hr comprehensive Community Mental Health Centre in Darwin.



Increased staffing across all Teams, both Inpatient and Community, with significant development of a Perinatal Team.



Purpose designed and built facilities for emergency mental health presentations and for acute alcohol and other drug presentations in the Royal Darwin and Alice Springs Hospitals.



Development of forensic mental health facilities for both adults and youth.



Design and initiation of 5 and 10-year plans to bring the Territory Mental Health Services into alignment with other States and Territories.



Funding and Infrastructure – Infrastructure grants

The Northern Territory mental health system would benefit from one-off infrastructure grants to strengthen and improve services within hospitals and the community.

Transition Ward

In order to reduce re-admissions to inpatient psychiatric units, the RANZCP Northern Territory Branch recommends the funding of a dedicated transition ward for those patients requiring extra time to adjust to community living⁵. Transitional discharge is a model of care which includes a mixture of peer support and staffing aimed at establishing a relationship between the patient and the community care provider⁵. The model offers continuity of care and overcomes fragmented support between inpatient programs and community practitioners⁶. We know patients who have experienced a brief psychiatric hospitalisation are re-admitted at a higher rates and are at higher risk of suicide⁷. Transition wards can guard against this ‘revolving-door’ of patients and offer a good return on investment for the NT, as well as reducing the risk of suicide for the most vulnerable members of our community⁷.

Secure Ward (“JRU”)

The secure ward, the Joan Ridley Unit (JRU), has a high rate of assaults and adverse patient events, largely due to poor design and inadequate facilities. A lack of experience and training amongst staff can also contribute to the high risks to patients and staff alike. The RANZCP Northern Territory Branch strongly supports re-development of the ward to provide a safe and therapeutic environment.

Child and Youth Forensic Ward

There is currently no child and youth forensic ward in the Northern Territory despite having the highest rate of children and young people in detention or under community-based supervision of all states and territories in Australia⁸. People with a mental illness or a cognitive disability are considerably more likely to be in contact with or under the care of the criminal justice system⁹ with some research suggesting over 75% of young persons in detention have one or more psychiatric disorders⁸.

The mental health needs of young people and children are different from adults as their brains are still developing, and the effects of trauma and neglect continue to be contributing factors to the development and maintenance of mental disorders. A dedicated Child and Youth Forensic Ward will allow for targeted, appropriate care to reduce rates of recidivism and ensure transition of children and young people back into the community once they have served their sentence.



Emergency Departments

Emergency Departments in the Northern Territory play a vital role in the treatment of mental illness.

In 2017-18, the rate of mental health related emergency department presentations in public hospitals in the Northern Territory was the highest in the country with over 280 presentations per 10,000 population⁴. In comparison, South Australia has the second highest rate with 140 per 100,000, half that of the NT.

Emergency Departments are not appropriate therapeutic settings for individuals experiencing a mental health crisis and more must be done for those seriously unwell who require medical and mental health care, and to divert those less seriously unwell but who are experiencing a crisis from arriving at EDs.

There are two factors which result in increased mental health presentations to Emergency Departments. Firstly, a lack of appropriate care in the community means that individuals are not able to access early treatment and support for their mental health problems until they have reached crisis point. Secondly, when a crisis does unfold there is no alternative to Emergency Departments, especially outside of business hours.

The NT Branch encourages government to adequately fund and staff a 24-hour comprehensive Community Mental Health Centre which, together with a Transition Ward, would enable care of individuals becoming unwell and at moderate levels of acuity. This would significantly reduce the number of presentations to Emergency Departments. The nature and scope of such a centre is described below.

The assessment and management of those in crisis but not seriously unwell by a community centre must also be complemented by development of an ED based facility to more appropriately accommodate seriously unwell patients requiring medical and psychiatric assessment and treatment. This provides a safe interface between the community and mental health inpatient facilities.

24-hour comprehensive Community Mental Health Centre

A purpose-designed community facility is critical to delivery of the comprehensive services required for whole of life mental health care, and will reduce the demand on acute inpatient facilities and Emergency Departments. The centre should accommodate teams providing mental health care from perinatal psychiatry through to psychiatry of old age, together with outreach services, such as the Victorian PACER model, a joint crisis response from police and mental



health clinicians to de-escalate and support individuals experiencing a mental health crisis in the community. The centre would provide the base for outreach perinatal and child and adolescent services into rural and remote communities.

The Centre would provide the necessary physical health care, both specialist and primary health care, for this very vulnerable group, as well as support the lifestyle changes necessary to maintain good mental health. This lifestyle related mental health care would be extended by an after-hours, non-clinical therapeutic service for people with a mental health condition, staffed by a mixture of peer support workers and clinicians. This is illustrated by the Victorian St Vincent's Hospital 'Safe Haven Café' model (soon to be replicated in the ACT).

Alcohol and Other Drugs

The cost of alcohol and drug dependency for individuals and society is undisputed and substantial, with alcohol consumption being a causal factor in more than 200 disease and injury conditions¹⁰.

It is common for substance use disorders and serious mental illness (SMI) to co-occur^{11,12}.

The Northern Territory requires a dedicated alcohol and other drug (AOD) dual diagnosis capability to provide 24-hour service for those presenting with acute substance related issues and those with acute substance related and mental health related issues. This capability should be integrated across mental health in order to deliver seamless, holistic care for consumers and their carers, and have a significant 24-hour presence in Emergency Departments, where suitable facilities to assess and treat are established.

Gove, Katherine and Palmerston Regional Hospital Psychiatric Beds

There are currently no mental health beds outside of the Royal Darwin and Alice Springs Hospitals. The Northern Territory Branch recommends the three Top End Regional Hospitals become Approved Treatment Facilities in order to accommodate mental health beds. This will enable those presenting with moderate acuity to be managed closer to home, and for those requiring retrieval to be safely managed whilst awaiting transfer. There is also an urgent need for Aboriginal Mental Health Workers to staff regional hospitals and the local mental health teams. This will contribute substantially to better and safer care, and to reducing retrieval to Darwin and Alice Springs Hospitals.



Staffing (Workforce)

Doctors, nurses and clinicians from a wide range of disciplines provide care to mental health patients. They are the frontline and, like soldiers in battle, bear the burden of the stress of meeting needs with inadequate resources. This stress leads to burnout and fatigue, which in turn increases the risk of adverse patient outcomes. This stress also significantly increases the risk of suicide amongst doctors.

Retention

It is the view of the NT Branch, that psychiatrists practising in the Northern Territory are at increased risk of burnout and poor morale.

The public system must do more to reward experience and longevity of service to maintain stability and corporate knowledge, and reduce training costs. This includes moving away from short-term contractual arrangements and into permanent, appropriately remunerated positions. Increasing staff retention reduces the need for locums to cover staff vacancies, as well as associated costs with recruitment, short-staffing and retraining.

Staff retention may also be improved by programs to assist partners and spouses find meaningful employment after relocating to the NT, supported accommodation, along with changes within hospital administration and management which create a culture of empathy and flexibility.

Specialist Training Programs (STP) and Integrated Rural Training Pipeline Programs

The Specialist Training Program (STP) is an Australian Government initiative that provides funding to health organisations to support specialist medical training experiences in settings beyond traditional public teaching hospitals¹³. This includes regional, rural and community health settings. The Integrated Rural Training Pipeline (IRTP) program is a Commonwealth Government initiative aimed at increasing the number of psychiatry trainees and specialists in rural and regional areas¹⁴.

The Northern Territory has benefitted significantly from these programs, with 50% of Registrar positions in Alice Springs and 30% of Registrar positions in Darwin funded under these arrangements. The NT Branch believes that the Territory requires approximately another 5 to 10 trainee positions, but there is insufficient capacity to supervise more than 2 to 4 of these. In the Northern Territory there is current capacity to supervise another 2 to 4 trainees, but insufficient specialists to cover all potential new trainee positions.



Subspecialty shortages: child and adolescent psychiatrists

A significant number of children and adolescents experience some form of mental illness, with three quarters of all mental health problems first arising in people under 25 years¹⁵. The development and implementation of early intervention programs and strategies for the prevention of mental illness in adolescents is imperative to addressing any adverse outcomes and preventing or reducing mental disorders in adulthood¹⁶. [In our submission to the Productivity Commission into Mental Health](#) the RANZCP noted:

Research clearly indicates that the most cost-effective way to prevent the development of mental health problems and promote mental wellbeing is to target childhood and adolescence including the perinatal period. Subsequent Australian Child and Adolescent Surveys of Mental Health and Wellbeing (2000 and 2015) have shown that the last 15 years of reform are not delivering significant improvements to the mental health of children and adolescents. Notably, in 2016 suicide was the leading cause of death of children between five and 17 years of age. Symptoms, disorders and reduced social and academic function usually emerge before the age of 18 and early intervention may therefore substantially reduce the risk of downstream comorbidity, suicide,

deliberate self-harm, disease burden, unemployment and costs of medical care and welfare support.

It is important to consider that children develop and thrive within the spectrum of their families and communities, and support and prevention for children entails a family and systemic focus. Effective prevention and intervention require resourcing and training that recognises and ensures collaboration and service integration across health, mental health, including adult mental health, child development and child protection sectors. On this basis, the RANZCP strongly encourages investing and intervening in early life, from prenatal periods to adulthood.

For further information on the RANZCP position on prevention and early intervention of mental illness in children and adolescents, please see [RANZCP Position Statement 63](#).

The RANZCP recently reviewed national and international workforce recommendations and found the ideal range of child and adolescent psychiatrists is between a minimum of 2.5 to 18 FTE per 100,000 population. The NT Branch reports only 1 FTE psychiatrists for the entire population of around 189,000. This issue can only be improved by dedicated, ongoing funding which prioritises the mental health of children and young people. It must be a priority of the NT Government.



Community Mental Health Services

Outreach Teams

There is currently limited resourcing in the Northern Territory to support Community Mental Health Services which offer appropriate coverage of the NT population. There is particular need to address acute alcohol and other drug presentations in the community, and an unmet demand for old age and perinatal mental health services. In parallel to perinatal services, outreach child and adolescent mental health services into rural and remote communities are required.

Recommendations for funding include:

- 24-hour, comprehensive, purpose-built Community Mental Health Centre in Darwin (see infrastructure above)
- Long term low-to-medium acuity supported accommodation (e.g. Team Health)
- Perinatal Team with outreach service (to rural areas)
- Psychiatry of Old Age Team
- Child and Adult Rural Outreach Team (to rural areas)
- Alcohol and other Drug and Dual Diagnosis 24-hour Team

Physical health

People with serious mental illness typically die between 10 and 32 years earlier than the general population. Around 80% of this mortality gap can be attributed to the much higher rates of physical illnesses, such as cardiovascular and respiratory diseases and cancer experienced by this population. We believe that much more needs to be done to address the gap in physical health and life expectancy between those who live with a mental illness and those who don't¹⁷.

In 2016, the RANZCP released a report; The economic cost of serious mental illness and comorbidities in Australia and New Zealand. The report shows for people with mental disorders, physical illness comorbidities and their risk factors are the rule rather than the exception. This adds significantly to the health and economic burden of serious mental illness in the Northern Territory¹⁸.

The NT would benefit greatly from:

- Community Mental Health Centre GP Clinic
- Community Mental Health Centre Specialist Clinic (e.g. endocrine, immunology, etc)
- Community Mental Health Centre SENSE Clinic (Exercise, Nutrition, Smoking Cessation, Lifestyle Modification, etc).

Private Psychiatry

Private psychiatry plays an important role in the provision of mental health services in the community.

The NT Branch report there being only 1.5 – 2 FTE private psychiatrists for the entire NT, an unacceptable number given the size and geographical distribution of the population.

MBS data for 2018-19 reveals that consumers in the Northern Territory are accessing benefits at much lower rates compared to other states, particularly for items 300, 302, 304, 306 which are for ongoing psychiatry care. Instead there is a preference for 291 and 293 items which provide for the assessment and development of mental health care plans which are managed by GPs. The NT Branch believes this is due to a lack of referral options, particularly around subspecialties like child and adolescent psychiatry or addiction.

In order to address the shortfall, the NT Branch recommends the commissioning of a mental health workforce strategy. This should determine benchmarks required to meet the needs of the population, including subspecialties and provide a target to work towards.

The strategy should also examine ways in which to make the region a more appealing option for psychiatrists to establish their practices. Our private practice members in the NT report the work as being rewarding and flexible, with the possibility of rapid career progression and opportunities to diversify practice. The NT Branch would be happy to provide advice on the development of any workforce strategy which examines ways to promote the professional and personal lifestyle benefits of working as a psychiatrist in private practice in the Top End.

We also recommend the NT work with the Federal Government to develop and deliver MBS loadings for psychiatrists working in rural and remote areas.

Summary

We are fortunate those living in the Top End are so resilient and resourceful, without this strength and sense of community we would be far worse off.

The issues we have identified within the NT mental health system are evidence of pervasive structural inadequacies and the neglect of successive governments. Piecemeal policy solutions and tokenistic budget promises will not fix these fundamental problems.

We hope those reading this document will realise that investment and reform of our mental health system shouldn't occur just because it makes good economic sense but because it is the just and moral thing to do.

References

- 1 Deloitte Access Economics. The social and economic costs of ADHD in Australia: Report prepared for the Australian ADHD Professionals Association 2019. Available from: <https://www2.deloitte.com/content/dam/Deloitte/au/Documents/Economics/deloitte-au-economics-social-costs-adhd-australia-270819.pdf>.
- 2 Hospital beds [Internet]. 2019. Available from: <https://data.oecd.org/healthqt/hospital-beds.htm>.
- 3 Northern Territory Primary Health Network. The NT PHN Mental Health and Suicide Prevention Needs Assessment. Canberra, ACT: Department of Health; 2016. Available from: <https://www.ntmhc.org.au/wp-content/uploads/2016/09/2016-NT-PHN-Needs-Assessment-Mental-Health-and-Suicide-Prevention.pdf>.
- 4 Mental health services provided in emergency departments [Internet]. Department of Health. 2018. Available from: <https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/hospital-emergency-services>.
- 5 Reynolds W, Lauder W, Sharkey S, Maciver S, Veitch T, Cameron D. The effects of a transitional discharge model for psychiatric patients. *Journal of psychiatric and mental health nursing*. 2004;11(1):82-8.
- 6 National Institute for Health and Care Excellence (NICE). Transition between inpatient mental health settings and community or care home settings 2016. Available from: <https://www.nice.org.uk/guidance/ng53/evidence/full-guideline-pdf-2606951917>.
- 7 Loch A A. Discharged from a mental health admission ward: is it safe to go home? A review on the negative outcomes of psychiatric hospitalization. *Psychology research and behavior management*. 2014;7:137.
- 8 Royal Commission and Board of Inquiry into the Protection and Detention of Children in the Northern Territory. Final Report 2017. Available from: <https://www.royalcommission.gov.au/royal-commission-detention-and-protection-children-northern-territory>.
- 9 Department of Health. Report on the review of Forensic Mental Health and Disability Services within the Northern Territory. Northern Territory: Northern Territory Government; 2019. Available from: https://health.nt.gov.au/_data/assets/pdf_file/0007/727657/Report-on-the-Forensic-Mental-Health-and-Disability-Services-within-the-NT.pdf.
- 10 The Royal Australasian College of Physicians and The Royal Australian and New Zealand College of Psychiatrists. Alcohol Policy 2016. Available from: https://www.ranzcp.org/files/resources/college_statements/practice_guidelines/alcohol-policy.aspx.
- 11 The Royal Australian and New Zealand College of Psychiatrists. Position Statement 87: Recognising and Reducing Alcohol-Related Harm 2016. Available from: <https://www.ranzcp.org/news-policy/policy-and-advocacy/position-statements/recognising-and-reducing-alcohol-related-harm>
- 12 Temmingh H S, Williams T, Siegfried N, Stein D J. Risperidone versus other antipsychotics for people with severe mental illness and co-occurring substance misuse. *Cochrane Database of Systematic Reviews*. 2018(1).
- 13 Royal Australian and New Zealand College of Psychiatrists. About the Specialist Training Program in psychiatry 2020 [Available from: <https://www.ranzcp.org/practice-education/specialist-training-program/about-stp>].
- 14 Royal Australian and New Zealand College of Psychiatrists. Integrated Rural Training Pipeline (IRTP) Program 2020 [Available from: <https://www.ranzcp.org/practice-education/specialist-training-program/irtp>].
- 15 Telethon Kids Institute. Young Minds Matter 2017. Available from: <https://youngmindsmatter.telethonkids.org.au/our-research/>.
- 16 Royal Australian and New Zealand College of Psychiatrists. Report from the Faculty of Child and Adolescent Psychiatry. Prevention and early intervention of mental illness in infants, children and adolescents: Planning strategies for Australia and New Zealand. 2010. Available from: <https://www.ranzcp.org/files/resources/reports/prevention-and-early-intervention-of-mental-illness.aspx>.
- 17 Royal Australian and New Zealand College of Psychiatrists. Physical health and mental illness [Available from: <https://www.ranzcp.org/practice-education/guidelines-and-resources-for-practice/physical-health/physical-health-and-mental-illness>].
- 18 Royal Australian and New Zealand College of Psychiatrists. The economic cost of serious mental illness and comorbidities in Australia and New Zealand 2016. Available from: <https://www.ranzcp.org/files/resources/reports/ranzcp-serious-mental-illness.aspx>.



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