1. Action	Existing resources / activity
1. Improve community and service understanding and attitudes through a sustained and comprehensive national stigma reduction strategy.	This action is a national responsibility, however locally: • The Northern Territory Government (NTG) provides funding support to *beyondblue*. • NTG provides funding support for MindMatters and KidsMatter, which are school-based initiatives and which are delivered by staff of the Department of Education. • NTG funds the Community Visitor Program to monitor compliance with the Mental Health & Related Services Act (MHARS Act) but also aims to promote greater community awareness and understanding of mental illness. • The Northern Territory Mental Health Service (NTMHS) funds a number of Non Government Organisations (NGO) to undertake MH promotional activities and community forums which aim to raise community awareness of mental illness, increase mental health literacy and to reduce stigma. • NTMHS is implementing the Recovery Model throughout the service. NTMHS is working with MH NGOs to ensure a Recovery Approach is used within their programs. • NTMHS provides joint education sessions to staff of NGOs to increase understanding of mental illness, and its effects. • NTMHS also provides education sessions to external agencies eg Police; Legal staff; GPs; Remote Health Centre staff on MH. • NTMHS produces and distributes Territory-wide a mental health newsletter *MHuses*. The MH NGO MHACA, which is based in Alice Springs, also produces a regular newsletter which is widely distributed. These newsletters assist in reducing stigma associated with mental illness by, including the viewpoints of consumers, carers and mental health employees and thereby raising awareness of mental health issues. • NTMHS annually conducts free community workshops on a range of topics eg in 2009, '*MH in the Workplace'* forums were held. These aimed to encourage the promotion of mental health supportive workplaces especially within NT organisations with high percentage of male employee's eg building industry. • NTMHS provides funding for Territory wide activities and events during Mental Health Week. Mental Health Week activities attract partners and sponsors including universities, legal firms, the Equal Opportunity Commission, local governments and small businesses. • MH First Aid training is delivered in the Top End & Central Australia by staff from NTMHS and funded NGOs. • The NT Suicide Prevention Action Plan 2009-2011 is a whole-of-Government response to guide future direction in suicide prevention over the next three years. One of the main aims of this plan is to strengthen wellbeing, optimism, connectedness, resilience, health and capacity across the NT community, with a particular focus on young people and their families.

2. Coordinate the health, education and employment sectors to expand supported education, employment and vocational programs which are linked to mental health programs.	• Some locally based individual programs are undertaken by MH NGOs in the Top End & Central Australia in relation to housing, but these are currently not coordinated Territory wide eg activity within the funded NGO sector assists MH clients to find employment & study eg MHACA. NGOs work with individuals to meet their needs.
3. Improve coordination between primary care and specialist mental health services in the community to enhance consumer choice and facilitate 'wrap-around' service provision.	• The weekly GP Clinic in the Top End Mental Health Service (TEMHS) Community MH Centre in Darwin established in the early 2000s, has resulted in regular physical health review for clients of the service. GP's bulkbill MH consumers whose attendance at the GP clinic is facilitated by TEMHS Case Managers. The GPs review the physical health of each consumer and Case Managers ensure that any follow up action occurs. This has improved client access to primary health care services and the care of clients with physical health problems and mental illness in Community MH Services. This service has now been established in Alice Springs. • The establishment of two *headspace* centres, one in the Top End and the other in Alice Springs has improved access for young people who have mental health issues to specialist care and strengthened the relationship between MHS & primary care providers. This collaboration has enhanced the capacity to respond to young people with more prevalent mental health problems (e.g. depression and anxiety) that are significantly impacting on personal and social functioning and wellbeing. The *headspace* consortium partners include public MHS, funded MH NGOs and other community sector organisations. • The newly established co-location of the TEMHS Community MH Team with a GP Practice in Palmerston is improving liaison. • The TEMHS & Central Australian Mental Health Service (CAMHS) Remote Teams continue to work very closely with Primary Health services in remote communities to provide expert secondary consultation, training and support for primary health care providers including remote medical officers to diagnose, and treat people with mental health problems. Increased staffing to NTMHS Remote MH Teams and Child & Youth MH services has augmented MH service delivery to the wider community & strengthened links between primary health care and social welfare agencies. • TEMHS & CAMHS Psychiatrists undertake sessional work with Aboriginal Controlled Organisations and remote health centres. Registrars also work with these primary health services through the expanded settings specialists training program. • In the NT, access to GPs is very difficult and to private practitioners very limited and several innovative initiatives have addressed this: GP Registrars (including Indigenous registrars) rotate into TEMHS for work placements; & Alice Springs Hospital & Royal Darwin Hospital medical interns rotate into public MHS for work placements. • The Commonwealth funded NT 'Perinatal Mental Health Project' aims to develop the framework that will support improved prevention and early detection of antenatal and postnatal depression, and better care, support and treatment for expectant and new mothers experiencing depression in urban and remote areas. A Territory wide Perinatal Reference Group has been established to progress work in relation to perinatal development priorities. Membership includes specialist MHS providers across the government and private sectors, maternity and child health services, and General Practitioners. This project aims to identify the specific needs of Northern Territory women and their families, and commence identifying and addressing the gaps in existing services in the areas of screening, workforce training and education and pathways to care. Currently two pilot projects have commenced to roll out the initiative in remote Top End & Central Australian sites. • Closer relationships between Top End schools and the TEMHS Child & Adolescent Team has been established via regular liaison

	between MHS & education staff in order to ensure a more integrated and comprehensive MH care approach for children and youth (0-16 yrs). This also facilitates early intervention when MH issues are identified.
	
	• NTMHS is currently planning an initiative to address the needs of people with chronic MH issues. This initiative relates directly to the NTG *Chronic Conditions Prevention & Management Strategy 2010-2020.* The NTMHS initiative aims to provide strengthened responses for people with severe and complex conditions requiring specialist MH treatment, by addressing lifestyle risk factors, identifying strategies to engage NTMHS clients to engage with their GP & generally providing additional support and interventions for people with chronic mental illness. Current NTMHS activities include:
	
	  • Development of a *Physical Health Screening Tool*, which will assist in increasing awareness amongst MH staff in their management of the physical health of mental health clients.
	  • Identifying Key Performance Indicators for use to measure progress of this initiative.
	  • Development of a framework and guidelines to assist NTMHS staff to provide physical health care for MH clients to ensure that people with chronic MH receive appropriate physical health care.
	  • Planning for development of resources for families, carers and GPs to support the role they play in improving the general health of people with mental problems.
	  • In conjunction with the staff of the NT Perinatal Mental Health Project & the Palliative Care Grant Project, development of guidelines & resources that are applicable to Indigenous Territorians, particular those living in remote communities.
	  • Development of education package for NTMHS staff on clinical assessment skills;
	  • Planning for consultation with consumers & carers and consumer/carer groups to identify the best approach to utilise in addressing the physical care of NTMHS clients.
	
	• Strong links between TEMHS and the Royal Darwin Hospital (RDH) continue. Two current initiatives are:
	  • The establishment of a project between the RDH Maxillo Facial Unit and the TEMHS Trauma Response Team ensures that Acute Care facial trauma patients are routinely screened for PTSD. Patients diagnosed with facial cancers are also able to receive initial counselling and support in similar fashion to the McMillan nursing model used in the UK.
	  • The commonwealth funded 'Palliative Care Grant Project' which aims to improve outcomes for people with end-stage illness who have co-morbid mental health problems. This will be achieved by up-skilling Territory Palliative Care (TPC) services and primary care services health professionals, strengthening professional relationships between TPC and NTMHS & improving referral pathways. Exploration of use of screening tools, particularly in relation to culturally specific tools, and the development of medication protocols will assist in the education process of health professionals.

4. Adopt a recovery oriented culture within mental health services, underpinned by appropriate values and service models.	• NTMHS is currently developing a *Mental Health Services Strategic Plan for 2010-2012* which will align with the Department of Health & Families Corporate Plan 2010-2012. This Strategic Plan will assist in orientating NTMHS to a recovery focused culture.
	
	• *Consumer & Carer Participation Review 2010.* NTMHS is currently conducting a review of the involvement of consumers and carers in the service. This review due to be completed in December 2010, is considering a range of options to ensure that the consumer and carer voice is central to the NTMHS. Public forums are being held across the Territory to obtain the views of the general community & to consult with consumers and carers. A review of all relevant policies & resources including information leaflets & guides will also occur. Submissions will be requested in order to obtain comprehensive feedback from key stakeholders. The principle areas that need to be addressed which identify key issues in service delivery which impact on consumer & carer engagement and participation in care are:
	  • Improve involvement of consumers, and where appropriate, carers, in decisions regarding assessment, treatment and care planning, monitoring and discharge planning.
	  • Improve the availability of information and education on topics of importance to consumers and carers.
	  • Increase consumer participation in mental health and generalist community support services.
	  • Increase consumer and carer involvement in local service planning, delivery and evaluation, and the provision of support to sustain this participation.

	• Involve consumers and carers in systemic planning, policy development and evaluation. • Promote mental health research, mental health information and good practices in consumer treatment and care and consumer and carer support and participation. The outcomes/recommendations of the *Consumer & Carer Participation Review 2010* will be used to guide the adjustments that are required to ensure that NTMHS is oriented to a recovery culture. • NTMHS has committed to facilitate an effective collaborative partnership with consumers & carers to ensure participation in embedding a recovery oriented culture within the organisation. • NTMHS staff have received a considerable amount of training in relation to the Recovery Model & this is ongoing. Intensive training on recovery principles, pragmatic approaches and recovery planning are currently being embedded into the mandatory core training program for mental health service staff. Consumers & carers can also participate in these sessions. NTMHS has funded visits to the NT by acknowledged experts in recovery for more intensive training for both public MHS staff and funded community sector organisations. • Recovery principles are currently being embedded into all NTMHS policies and protocols. NTMHS is currently developing a Recovery Framework. • Ongoing recovery support is also available through NT MHS funded programs via Non Government Organisations which provide support & advocacy services, this includes both non profit and for profit organisations. This also includes those provided by MH Consumer & Carer led organisations which provide essential support for individuals experiencing mental illness. • A funded NT MH NGO has commissioned a recovery based tool to assist staff in applying recovery approaches with consumers. • TEMHS - the Adult Community Mental Health Team (ACMHT) have adopted a recovery model & are in the process of clearly articulating this approach; & the inpatient units have implemented the Tidal Model. • The *CAMHS Consumer Engagement & Participation Review 2008* aimed to review and revise Consumer Participation policies, seeking input from key stakeholders to assist in identifying: how CAMHS can implement better policy and strategies, which facilitate improved participation in on-going development and evaluation of mental health services in Central Australia
5. Develop integrated programs between mental health support services and housing agencies to provide tailored assistance to people with mental illness and mental health problems living in the community.	• Limited action has been undertaken in this area, however plans are underway to strengthen the relationship between NTMHS & Territory Housing in order to build a closer working connection between the public housing sector & MH. Development of a Memorandum of Understanding is planned. • Some locally based individual programs are undertaken by MH NGOs in the Top End & Central Australia in relation to housing, but these are currently not coordinated Territory wide eg activity within the funded NGO sector assists MH clients to find employment & study eg MHACA. NGOs work with individuals to meet their needs. • MHACA in Central Australia have recently completed a needs analysis on accommodation & support in Alice Springs and published a report on the housing situation. • CAMHS has MoUs with several organisations in which the issues of housing, accommodation and employment are itemised. In Central Australia plans are underway to work with these sectors to establish stronger links. • TEAMhealth in the Top End has a close partnership with Territory Housing which has resulted in a productive model for MH clients. TEAMhealth has been successful in gaining allocations of units from Territory Housing. These units were renovated and then allocated to MH consumers and support is also provided. • The NTG also funds MH NGOs to provide accommodation for people with mental illness which includes supported group

	accommodation, rehabilitation, respite and step-up step-down facilities. • NTMHS funds 13 NGOs to provide psychosocial services for MH consumers. NTMHS has contracted service agreements with these organisations.
6. Develop integrated approaches between housing, justice, community and aged care sectors to facilitate access to mental health programs for people at risk of homelessness and other forms of disadvantage.	• The *Shared Client Case Management Framework* & accompanying Practice Guidelines articulate the delivery of case management services to clients concurrently engaged with two or more of the following programs: Alcohol and Other Drugs; Aged and Disability; Families and Children & MH. The Framework provides direction for program staff in the case management of shared clients in line with relevant legislation, standards, departmental policies and best practice principles. The focus is the development of a joint case plan under a shared client case management framework that informs the assessment, planning, delivery and review of services to clients concurrently accessing more than one service. Clients accessing multiple concurrent services receive a shared client case management response aligned to the intensity and complexity of their individual needs. Multi-service clients including multi-service families, receiving targeted and coordinated services that enable provider knowledge, ideas and resources to be pooled, resulting in more effective service responses and better client outcomes. The guidelines are sufficiently broad to facilitate shared case management responses to clients engaged with two or more of the above named programs and another government department and/or non-government organisation. • The *Shared Client Case Management Framework* aims to achieve better client outcomes including: maximised service continuity; reduced service duplication; proactive rather than reactive service responses; more shared responses with a preventative focus; improved client risk management; articulating clear expectations of how providers should work together to deliver shared service responses to multi-service clients; reinforcing the practice of providers working together rather than in parallel to one another; reinforcing the exchange of client information between providers in accordance with established client information legislation and protocols; holistic assessment of client need, including risk; & the development and implementation of shared care plans for mutual clients with an assessed level of complexity and risk. • Recent amendments to the MHARS Act have provided additional diversion options at court for individuals with MH issues. • Work with North Australian Aboriginal Justice Agency has commenced to facilitate a trauma based legal framework that will assist an optimal approach by that legal service to clients as well as assist them to continue recovery processes throughout their work with clients of TEMHS. Larrakia Nation via the HEAL program are currently working in collaboration with NTMHS in providing education programs on trauma informed care for all workers. • Specifications for a 25 bed Mental Health and Behavioural Unit to be built adjacent to a proposed new Prison in Darwin are completed. • *Secure Care Initiative*. Secure care residential facilities will be built in Darwin and Alice Springs to create an additional 5 beds at Royal Darwin Hospital and 6 beds in Alice Springs Hospital. This accommodation will cater for individuals with complex behavioural and cognitive problems, whose needs cannot be meet in a less restrictive environment. Assessment and treatment will be provided in a safe environment, in addition to management of high risk behaviour Facilities will be available for young people, and adults with a disability, who exhibit high risk behaviours. These clients may engage in high risk taking, aggressive or disturbed behaviours that are likely to result in serious harm to themselves and/or others. These additional beds will also enable care to be provided in separate environments for young people and other people with special needs who require admission for their mental illness, for example mothers and babies and frail aged people. Medium to long term care will also be provided in secure care facilities in the community. Separate accommodation will be established for 8 young people and 8 adults with a disability in both Darwin and Alice Springs (total of 32 beds). Clients will receive intensive daily support and therapeutic intervention as part of a multi-disciplinary case management approach. The anticipated reduction in their high risk behaviours will mean that many clients will be able to safely return to living in the community. • NTMHS & MH NGOs in a joint initiative are working with forensic clients to provide support during transition from custody in relation to employment and accommodation. Offenders in Top End & Central Australia correctional facilities with MH issues have increased

	access to mental health risk assessment following an increase in staff resourcing. • NTMHS staff work with Territory Housing when individuals are at risk of losing accommodation.
7. Lead the development of coordinated actions to implement a renewed Aboriginal and Torres Straits Islander Social and Emotional Well Being Framework.	• The NTG fully supports development of coordinated action on this national framework. • Locally, the following initiatives are being undertaken in relation to the needs of Indigenous Territorians. Currently the NTMHS is undertaking a range of initiatives both as part of the DHF and as a separate program. • The NTMHS *Consumer & Carer Participation Review 2010.* The NTMHS review of the involvement of consumers and carers in the service includes obtaining the perspectives of the Indigenous people of the NT. This is pivotal to the Review. This review, due to be completed in December 2010, is considering a range of options to ensure that the consumer and carer voice is central to the NTMHS. Public forums are being held across the Territory including some in remote areas, to obtain the views of the general community & to consult with consumers and carers. Particular effort is being made to obtain the views of Indigenous consumers and carers. A review of all relevant policies & resources including information leaflets & guides will also occur – with a view of making current NTMHS documentation more accessible to Indigenous people & to develop resources that avoid the requirement of basic English literacy eg manually activated posters & books with information provided verbally in Indigenous language. • *One Talk Technology*: Several NTMHS initiatives involve the development of information posters, albums & other media utilising One Talk Technology to facilitate knowledge and understanding by Indigenous users of NTMHS. This is one element of a larger plan to develop Indigenous friendly materials across NTMHS to ensure that information is provided in a culturally user friendly format regardless of media eg in print form, via technology, in policies, & in staff training and education. eg Translation of NTMHS 'Legal rights and responsibilities' posters into A3 size, 'talking posters' currently being translated into 9 Central Australian languages. eg Perinatal MH information including Edinburgh Depression Scale will be translated into Top End & Central Australian languages & installed into a 'talking' album for use by staff working with mothers. • Aboriginal and Torres Strait Islanders (ATSI) represent 30% of the Territory's population and in rural and remote settings this can be up to 90%. This demographic brings with it additional challenges and unique opportunities for the DHF service delivery and employment strategies. As a substantial proportion of NTMHS clients are Aboriginal, understanding more clearly how Aboriginal people's culture intersects with the services is an important knowledge base from which better outcomes can be reached. • NTMHS has a commitment to strengthening the ATSI workforce & investment in the health and community services ATSI workforce is a priority for DHF and NTMHS. The strength of an organisation is held in its ability to reflect the population within which it is embedded. A workplace that reflects the diversity of the community will understand its clients better and will lead to improved service delivery and communication, based on a deep understanding of the needs of the community. NTMHS aims to empower Aboriginal staff to reach their full potential by encouraging and providing internal and external development opportunities including, higher duties, temporary transfers and access to training. Gainful employment is one of the key social determinants of health. By strengthening employment outcomes, particularly in rural and remote areas, there will be positive influence on the broader health and wellbeing of the community. • An *Aboriginal and Torres Strait Islander Strategic Workforce Plan 2008-2011* has been developed by DHF. This plan, with the *DHF Strategic Workforce Plan 2008-2011,* has a key focus on building and strengthening ATSI employment, opportunities and outcomes. One of the most valued qualities Aboriginal people bring to the DHF is their ability to network. Through those networks, NTMHS develop rapport with consumers & this assists in delivering improved services and outcomes. Aboriginal people generally feel safer and more comfortable accessing services if their first contact is with Aboriginal staff. Recruitment of Aboriginal staff to positions that provide services to Aboriginal individuals, families and communities assists NTMHS to provide safe and effective services & employing Aboriginal people also helps address service issues surrounding consistency of services.

	• An environment that acknowledges and respects the diversity of Aboriginal culture will retain its staff. All NTMHS staff, are mandated to undertake the *DHF's Aboriginal Cross Cultural Awareness Program.* The *DHF Aboriginal Cultural Security Policy* was launched in 2007; this Policy represented a significant step forward for the Territory's health and community services sector. DHF has made a commitment that the services offered to Aboriginal Territorians will respectfully combine the cultural rights and values of Aboriginal people with the best health and community service systems. Providing culturally secure services requires health and community service providers to: identify those elements of Aboriginal culture that affect the delivery of health and community services in the NT; review service delivery practices to ensure that they respect and value Aboriginal people's culture; act to modify service delivery practices where necessary & monitor service activity to ensure that our services continue to meet culturally safe standards. • NTMHS are currently restructuring several parts of the service in order to improve the efficiency & effectiveness of service delivery. One important change is the implementation of a supervisory and mentorship structure in TEMHS for Aboriginal and Torres Strait Islander staff, students and cadets. • Enhancement of locally based MHS to Tiwi Islands. Provision of outreach psychiatrist services to Tiwi Islands has resulted in: increased communication between TEMHS & Tiwi Island primary health care providers; increased the amount of service provided to Tiwi Islands; & improved standard of treatment & care for the Indigenous community.
8. Work with schools, workplaces and communities to deliver programs to improve mental health literacy and enhance resilience.	• Funding is provided by NTG for the provision of Applied Suicide Intervention Skills Training (ASIST) to the NT community. • NTMHS conducts annual forums for the NT community which aim to impro*ve MH lit*eracy. eg in 2009 a 2 day event *Mental Health in the Workplace Forum* was held which aimed to promote mentally *healthy workplaces* and prevent suicide*. The provision of* presentations, workgroup activities, & advice on actions to be taken to promote workers' MH, & education to the general community on MH issues. The forum was particularly targeted at male dominated industries & participants included NT major industry representatives. The forum aimed to improve understanding of the importance of promoting MH in the workplace & to achieve greater uptake amongst Industry HR staff of strategies to use in the workplace to promote MH. It provided participants with guidance on the most effective ways to support and maintain good MH. • TEMHS employs an educator who regularly provides MH education sessions to a range of participants including community sector organisations & services including Police, Fire & Ambulance staff & workers in remote communities. These sessions include education about the symptoms and management of mental illnesses, and how to access services, thereby increasing community understanding & reducing stigma. • The NTMHS Child & Adolescent Teams work closely with counsellors in Top End & Central Australian schools; staff from Family & Children Services; with *headspace &* with Strong Men & Strong Women Groups in Indigenous communities across the Territory. NTMHS aims to strengthen partnerships between school communities and child and adolescent MH services to improve the early detection and management of MH problems in children and young people. • *KidsMatter*, the primary school mental health promotion, prevention and early intervention initiative developed in collaboration with the Commonwealth Government is offered in schools in the NT. The KidsMatter initiative aims to: improve the mental health and well-being of primary school students; reduce mental health problems among students (e.g., anxiety, depression and behavioural problems) & achieve greater support and assistance for students experiencing mental health problems. • *The Triple P* program is used in NT schools & communities. This evidence-based parenting and family support strategy aims to prevent behavioural, emotional and developmental problems in children (or halt their progression and reduce their severity) and provide support for parents and families. The *Triple P* system helps parents develop a safe, nurturing environment and promote positive, caring relationships with their children, and to develop effective, non-violent strategies for promoting children's development and dealing with common childhood behaviour problems and developmental issues. • The NTG Department of Education and Training continues to implement *MindMatters*, the national MH initiative funded by the Commonwealth for secondary schools which aims to use a whole-of-school approach to create environments where youth can feel

	both valued & safe. *MindMatters* assists schools & colleges to provide resources to undertake MH promotional activities within the school curriculum.
	
	• *Indigenous Mental Health promotion activity in Top End*. TEMHS Aboriginal MH Promotion Officer provides Mens Health camps in remote areas to improve MH amongst Indigenous males living in urban & remote communities; increases collaboration between MHS, non government organisations and community controlled Indigenous organisations.
	
	• Enhanced capability for provision of clinical outreach visits to remote stations has been facilitated by use of a camper trailer in the remote Barkly Region. This has provided accommodation for MH clinicians & has increased the capacity of Barkly Region MH staff to supply outreach services to remote outstations & provide better MH service support & education for communities based in remote areas of the Barkly region.
	
	• In the Top End, TEMHS staff provide post-vention support for individuals & communities after suicide & other traumatic events have occurred. Funding is provided by NTMHS to MHACA to coordinate response to suicide and undertake suicide prevention programs in Central Australia.
	
	• The *NT Suicide Prevention Action Plan 2009-2011* provides a whole-of-Government response to guide future direction in suicide prevention. It converts the NT Strategic Framework for Suicide Prevention into actions and initiatives to reduce self-harming behaviour and enhance the resilience and capacity of the NT community. The Action Plan reflects the suicide prevention priorities of those NT Departments that are members of the NT Suicide Prevention Coordinating Committee. Some activities contributing to the Action Plan may be part of core services or projects funded by relevant Departments. There are others that are new initiatives or may involve the formation of partnerships outside of NT Government. These partners may include the Australian Government and local and national non-Government agencies.
	
	• The main aims of *NT Suicide Prevention Action Plan 2009-2011* are to:
	
	  • Strengthen wellbeing, optimism, connectedness, resilience, health and capacity across the NT community, with a particular focus on young people and their families;
	  • Support initiatives that reduce risk factors and promote positive protective factors for suicide and self-harm;
	  • Improve the ability of a wide range of services, systems and support networks to meet the needs of groups at increased risk of suicide and self-harm through prevention, recognition and response;
	  • Strengthen effective responses to individuals at particular risk to reduce and respond to suicidal and self-harming behaviour;
	  • Provide culturally appropriate programs that support community response to high rates of suicide and self-harm in Indigenous communities; and
	  • Build the evidence base, share good practice and provide education and training.
	
	• NTG funds community sector organisations to provide *Mental Health First Aid* training to the NT community generally and this includes staff from health, welfare & emergency organisations, including Police, Fire, Ambulance services, & Acute Care staff. *Mental Health First Aid* aims to increase awareness in the community of MH problems, to develop environments that promote safety and resilience for all. It assists participants to effectively help individuals who are experiencing a MH crisis prior to the involvement of MH professionals. *Mental Health First Aid* training educates participants on symptoms, causes & treatments for mental illness.
	
	• NTMHS continues to fund and work with Beyondblue on a number of initiatives.
	
	NTMHS is collaborating with Lifeline NT to develop psychiatric First Aid program specific to NT.

9. Implement targeted prevention and early intervention programs for children	• Funded by the Commonwealth Government, *headspace* Top End & *headspace* Central Australia provide treatment & support for youth experiencing MH problems. In both locations NTMHS is a consortium member along with community sector organisations & the GP divisions. This has led to closer service integration and better coordination as a result of the partnerships between NTMHS & other involved organisations.

and their families through partnerships between mental health, maternal and child health services, schools and other related organisations.	• The Commonwealth funded NT 'Perinatal Mental Health Project' aims to develop the framework that will support improved prevention and early detection of antenatal and postnatal depression, and better care, support and treatment for expectant and new mothers experiencing depression in urban and remote areas. A Territory wide Perinatal Reference Group has been established to progress work in relation to perinatal development priorities. Membership includes specialist MHS providers across the government and private sectors, maternity and child health services, and General Practitioners. This project aims to identify the specific needs of Northern Territory women and their families, and commence identifying and addressing the gaps in existing services in the areas of screening, workforce training and education and pathways to care. Currently two pilot projects have commenced to roll out the initiative in remote Top End & Central Australian sites. Support & treatment is being provided for women identified women as at risk of or are experiencing perinatal depression. • Currently guidelines & resources for use in the Perinatal MH Project are in development. These will be applicable to Indigenous Territorians & culturally accessible, particular to those living in remote communities. Perinatal MH information including Edinburgh Depression Scale will be translated into Top End & Central Australian languages & installed into a 'talking' album & posters for use by staff working with mothers. • NTMHS Child & Adolescent teams provide community based treatment for children, adolescents and their families experiencing emotional, psychological, behavioural, social & MH problems. An outreach service is also provided to regional centres and select remote communities in the Top End & Central Australia. Increased provision of Child & Adolescent MH services has been made to both urban and rural and remote areas in the NT.
10. Expand community-based youth mental health services which are accessible and combine primary health care, mental health and alcohol and other drug services.	• Funded by the Commonwealth Government, and supplemented by the NT Government *headspace* Top End & *headspace* Central Australia provide treatment & support for youth experiencing MH problems. In both locations NTMHS is a consortium member along with community sector organisations & the GP divisions. This has led to closer service integration and better coordination as a result of the partnerships between NTMHS & other involved organisations. The two NT *headspace* programs provide integrated, multidisciplinary early intervention, prevention and promotion services for young people with emerging mild to moderate MH & substance use problems. The provision of the services by the two *headspace* programs has augmented care for young people in the NT. • The *Shared Client Case Management Framework* & accompanying Practice Guidelines articulate the delivery of case management services to clients concurrently engaged with two or more programs: Alcohol and Other Drugs; Aged and Disability; Families and Children & MH. Clients accessing multiple concurrent services receive a shared client case management response aligned to the intensity and complexity of their individual needs. Multi-service clients including multi-service families, receiving targeted and coordinated services that enable provider knowledge, ideas and resources to be pooled, resulting in more effective service responses and better client outcomes. The *Shared Client Case Management Framework* aims to achieve better client outcomes including: maximised service continuity; reduced service duplication; proactive rather than reactive service responses; more shared responses with a preventative focus; improved client risk management; articulating clear expectations of how providers should work together to deliver shared service responses to multi-service clients; reinforcing the practice of providers working together rather than in parallel to one another; reinforcing the exchange of client information between providers in accordance with established client information legislation and protocols; holistic assessment of client need, including risk; & the development and implementation of shared care plans for mutual clients with an assessed level of complexity and risk.
11. Implement evidence-based and cost-effective models of intervention for early psychosis in young people to provide broader national	• This is a relatively under developed area in the NT. • NT MHS works collaboratively with *headspace* and accepts clinical responsibility for young people if early psychosis is suspected. • NT MHS Child and Youth Teams, Inpatient Services and Community Mental Health Teams are alert for young people demonstrating early psychosis, and put into place management plans that provide support for their recovery.

coverage.	
12. Provide education about mental health and suicide prevention to front line workers in emergency, welfare and associated sectors.	• The *NT Suicide Prevention Action Plan 2009-2011* is a whole-of-Government response to guide future direction in suicide prevention over the next three years. It converts the NT Strategic Framework for Suicide Prevention into assessable actions and initiatives to reduce self-harming behaviour and enhance the resilience and capacity of the NT community. The Action Plan reflects the suicide prevention priorities of those NT Departments that are members of the NT Suicide Prevention Coordinating Committee. Some activities contributing to the Action Plan may be part of core services or projects funded by relevant Departments. There are others that are new initiatives or may involve the formation of partnerships outside of NT Government. These partners may include the Australian Government and local and national non-Government agencies. • Workshops on a range of topics have been provided to the professional community in the NT as a product of the activities associated with elements of the *NT Suicide Prevention Action Plan 2009-2011.* Currently workshops on '*Self-Harming Behaviour in Young People'* are being held across the Territory. Hundreds of staff from Police, Ambulance, & Fire services; Education department; Family & Children Services; Acute Care; & Remote Health have attended these workshops. • Funding is provided to NGOs by NTG for the provision of Applied Suicide Intervention Skills Training (ASIST) to the NT community & particularly for front line workers. • *Disaster Response*. Disaster response capacity has been developed & equipment purchased for Disaster Response Team to enhance safety; and regular provision of training to NGO's eg; Lifeline and Red Cross. • NTMHS work closely with Melaleuca Refugee Centre (NGO which assists refugees and people from CALD background). Currently planning to increase links between TEMHS, MH funded NGOs, & trauma and torture services. • The TEMHS educator provides regular education to all new Police recruits on a range of MH related matters. The TEMHS educator and Director of Psychiatry attended the NSW Police Mental Health Intervention Team training program in order to gain knowledge relating to this training initiative. Subsequent to this, a new Police training program for NT recruits and an on-line refresher course has been developed by NTMHS. This training aimed to provide the Police with the knowledge & skills to more effectively manage people presenting with challenging behaviour. • NT MHS Forensic Teams offer support and education for correctional officers on request. • NT MHS remote mental health teams implement a consultation liaison model in which education of remote clinic staff is a primary goal. • NT Child & Adolescent services provide mental health education to NT Family & Children services workers.
13. Coordinate state, territory and Commonwealth suicide prevention activities through a nationally agreed suicide prevention framework to improve efforts to identify people at risk of suicide and improve the effectiveness of services and support	• The *NT Suicide Prevention Action Plan 2009-2011* is a whole-of-Government response to guide future direction in suicide prevention over the next three years. It converts the NT Strategic Framework for Suicide Prevention into assessable actions and initiatives to reduce self-harming behaviour and enhance the resilience and capacity of the NT community. The Action Plan reflects the suicide prevention priorities of those NT Departments that are members of the NT Suicide Prevention Coordinating Committee. Some activities contributing to the Action Plan may be part of core services or projects funded by relevant Departments. There are others that are new initiatives or may involve the formation of partnerships outside of NT Government. These partners may include the Australian Government and local and national non-Government agencies. The *NT Suicide Prevention Action Plan 2009-2011* is aligned with the National Suicide Prevention Strategy's *Living is for Everyone (LIFE)* Framework (2007). The main aims of this plan are to: • Strengthen wellbeing, optimism, connectedness, resilience, health and capacity across the NT community, with a particular focus on young people and their families; • Support initiatives that reduce risk factors and promote positive protective factors for suicide and self-harm; • Improve the ability of a wide range of services, systems and support networks to meet the needs of groups at increased risk of

available to them.	suicide and self-harm through prevention, recognition and response; • Strengthen effective responses to individuals at particular risk to reduce and respond to suicidal and self-harming behaviour; • Provide culturally appropriate programs that support community response to high rates of suicide and self-harm in Indigenous communities; and • Build the evidence base, share good practice and provide education and training.
14. Expand the level and range of support for families and carers of people with mental illness and mental health problems, including children of parents with a mental illness.	• DHF provides funding to NGOs who provide specific support services for carers, including young carers. • The NT Consumer Advisory Group (CAG) provides a mechanism for consumer and carer input into MH policy decision making processes. Within this broad framework, the NT CAG provides advice to the Minister for Mental Health on matters which affect the rights, needs, interests and the welfare of people with mental health problems/disorders and their carers. NTCAG also liaises with national peak bodies e.g. the National Mental Health Consumer and Carer Forum (NMHCCF), to ensure that the needs and concerns of NT consumers and carers are represented at this level. • The NT has a Carers Recognition Act. • *Consumer & Carer Participation Review 2010.* NTMHS is currently conducting a review of the involvement of consumers and carers in the service. This review due to be completed in December 2010, is considering a range of options to ensure that the consumer and carer voice is central to the NTMHS. Public forums are being held across the Territory to obtain the views of the general community & to consult with consumers and carers. A review of all relevant policies & resources including information leaflets & guides will also occur. Submissions will be requested in order to obtain comprehensive feedback from key stakeholders. • Several of the funded MH Non Government Organisations provide support & activities for children with parents who have a mental illness. eg TEMHCO provide workshops for children; MHACA run activities & camps for children. • The MHARS Act education 'Roadshow' delivered NT wide during March to May 2009 included sessions specifically aimed at informing consumers and carers of their rights under the legislation. Education also reinforced, to staff, the importance of use of consent process. Prior to the Roadshow, guides for MHS consumer & carers were developed to enhance understanding of these processes for both staff and others. Widely publicised educational sessions were held for consumers, carers, NGOs and NTG agencies in all major NT areas. For the first time a variety of targeted guides on the MHARS Act were produced: In addition to those for consumers & carers, guides were developed for MHS clinicians, for primary care Remote staff and for General Hospital staff. Leaflets around various aspects of the MHARS Act were also developed. • Central Australia MHS (CAMHS) 'parents of people with mental illness group' conducts activities in relation to the reduction of stigma and increasing community understanding by sharing personal stories about mental illness and recovery. • MH Carers NT (formerly ARAFMI) is the peak mental health NGO in the NT representing families and carers of people with a mental illness. NTMHS provides funding for this organisation. Carers NT provides support for all carers in the NT.
15. Develop tailored mental health care responses for highly vulnerable children and young people who have experienced physical, sexual or emotional abuse, or other trauma.	• The *Shared Client Case Management Framework* & accompanying Practice Guidelines articulate the delivery of case management services to clients concurrently engaged with two or more of the following programs: Alcohol and Other Drugs; Aged and Disability; Families and Children & MH. This enables NTMHS to work closely with Families and Children services when the client is a vulnerable young person. • C&Y in TEMHS offer education programs throughout the NT relating to suicide and self harm behaviours. They recognise that many children in remote areas have experienced forms of trauma. • *Secure Care Initiative*. Secure care residential facilities will be built in Darwin and Alice Springs to create an additional 5 beds at Royal Darwin Hospital and 6 beds in Alice Springs Hospital. This accommodation will cater for individuals with complex behavioural and cognitive problems, whose needs cannot be meet in a less restrictive environment. Assessment and treatment will be provided in a safe environment, in addition to management of high risk behaviour Facilities will be available for young people, and adults with a

	disability, who exhibit high risk behaviours. These clients may engage in high risk taking, aggressive or disturbed behaviours that are likely to result in serious harm to themselves and/or others. These additional beds will also enable care to be provided in separate environments for young people and other people with special needs who require admission for their mental illness, for example mothers and babies and frail aged people. Medium to long term care will also be provided in secure care facilities in the community. Separate accommodation will be established for 8 young people and 8 adults with a disability in both Darwin and Alice Springs (total of 32 beds). Clients will receive intensive daily support and therapeutic intervention as part of a multi-disciplinary case management approach. The anticipated reduction in their high risk behaviours will mean that many clients will be able to safely return to living in the community.
16. Develop a national service planning framework that establishes targets for the mix and level of the full range of mental health services, backed by innovative funding models.	• This action is a national responsibility. • Currently the development of a new NT Mental Health Services Strategic Plan is in the planning stage. This will detail the medium to long term strategic goals for NTMHS.
17. Establish regional partnerships of funders, service providers, consumers and carers and other relevant stakeholders to develop local solutions to better meet the mental health needs of communities.	• There are very few NGO non-clinical support services in smaller communities and in regional & remote areas. This issue will be considered in the NTMHS strategic planning process. Further development is required for a service model that addresses the particular challenges & needs of remote regions, and reduces potential for confusion and duplication. • Currently NTMHS staff in remote areas work closely with primary health care providers & staff from other social welfare agencies to provide MH care. A Consultation Liaison model is used in recognition that 24 hour provision of health care occurs via the primary health staff based in most remote communities, & that MH staff generally operate on a drive-in, drive-out, fly-in fly-out basis. Provision of support, & treatment advice as well as assistance with operationalising MH legislation usually occurs via telephone and video conferencing & only occasional direct contact when MH staff are visiting the communities. This model requires MH staff to work closely with workers from a range of agencies & organisations.
18. Improve communication and the flow of information between primary care and specialist providers, and between clinical and community support services, through the development of new systems and processes that promote continuity of care and the development of cooperative service models.	• *Digital Regions Initiative* aims to increase use of video-conferencing and video-diagnostics by clinicians. The NTMHS is the sole providers of public MHS to the people of the NT. 30% of the NTMHS target population live in remote and rural settings & a high percentage of these are Indigenous. Historical and modern cultural factors compounded by the remote setting, increase morbidity and complicate the delivery of effective treatment to this target population. Services are provided by remote mental health teams who are based in urban centres. The geographical isolation and dispersal of remote communities means that the population does not receive the service it requires as specialist MHS to this population are limited to a visiting service, the frequency of which is dependant on the size of population and need. This makes timely attention to unwell people problematic and follow-up for patients discharged from MH inpatient units difficult. • Poor infrastructure, including the lack of availability of functioning, quality units in remote communities has meant that videoconferencing is infrequent. This has also resulted in a lack of staff expertise and understanding of the benefits that could result. More effective use of videoconferencing technology will improve clinical service delivery, remote team support and professional development. Videoconferencing is an effective and relatively inexpensive avenue to providing MH services across the clinical, administrative and educational domains in remote and rural settings. Jointly funded by the Commonwealth and the NTG, the *Digital Regions Initiative* will enhance NTMHS service delivery & provide improved clinical, administrative, & professional development and staff satisfaction/retention outcomes via: • Earlier availability of specialist clinicians to provide clinical review of patients • Improved support to remote clinic staff

	• Decrease in patient trauma associated with emergency evacuation and dislocation from home supports • Reduced patient admission rates & improved discharge planning • Increased family and community education/enhancement • Improved participation of patient's family and carers, both in the community & when remote patients are in a an inpatient unit • Increased professional development opportunities for remote clinic and mental health staff • Remote mental health, remote clinic and NTMHS administrative staff trained to expert videoconferencing user level • Reduced isolation for specialist mental health and remote clinic staff Improved support to remote based specialist mental health staff • Improved engagement of remote managers with urban peers and supervisors • Reduction in demand for aero medical flights • Decreased administrative burden for clinical staff • Improved administrative support to remote mental health teams • Decreased financial costs including cost of travel & carbon footprint • It will enhance cross–border collaboration with other jurisdictions, especially for those in the APY Lands • In the NT, progress on e-Health initiatives such as Secure Electronic Health Record (SEHR) and Secure Electronic Messaging Service (SEMS) has offered active connectivity between Primary Health Practitioners (private and public) and Hospital Information Systems to share electronic patient health summaries – this coverage includes a significant portion of the NT medical community. However, Mental Health and other specialist community health programs utilising a separate client information management platform are excluded from SEHR AND SEMS because of complex technical issues that are a barrier to systems connectivity. At a departmental strategic level a business case is being drafted as a proposal to resolve the system connectivity issue through development of an over-arching 'consolidated client view' portal that will enable a shared access point for key summary-level clinical information on a designated client/patient. The development is expected to be long-term. • Increased access to clinical benchmarking and service performance and planning information will support improved decision-making and monitoring of service standards. NTMHS continues to develop its capacity to report a range of service and clinical data using web-based reporting tools in a standard that is accessible, meaningful and relevant for use by clinical leaders. • The *Shared Client Case Management Framework* & accompanying Practice Guidelines articulate the delivery of case management services to clients concurrently engaged with two or more of the following programs: Alcohol and Other Drugs; Aged and Disability; Families and Children & MH. The Framework provides direction for program staff in the case management of shared clients in line with relevant legislation, standards, departmental policies and best practice principles. The focus is the development of a joint case plan under a shared client case management framework that informs the assessment, planning, delivery and review of services to clients concurrently accessing more than one service. Clients accessing multiple concurrent services receive a shared client case management response aligned to the intensity and complexity of their individual needs. Multi-service clients including multi-service families, receiving targeted and coordinated services that enable provider knowledge, ideas and resources to be pooled, resulting in more effective service responses and better client outcomes. The guidelines are sufficiently broad to facilitate shared case management responses to clients engaged with two or more of the above named programs and another government department and/or non-government organisation. • *PCIS-CCIS Interface*. Currently NTMHS uses CCIS for electronic client record keeping. PCIS is used by the NTG Remote Health Program for the same purpose. 'Shared' clients who live in remote communities but also have MH issues have to have clinical notes kept in two different databases. As part of the service agreements between NTMHS and the Remote Health Program, there is an expectation that clinical information will be shared in a contemporary fashion. Remote Health & MH Programs have implemented a documentation sharing trial that ensures clinical reports are uploaded to PCIS within 3 days of receiving them. • *e-messaging* – TEMHS are currently experimenting with SMS messages from Computers to mobile telephones. This is being done initially with medical staff but will include Remote MH Teams eventually.
19. Work with emergency	• The *Shared Client Case Management Framework* & accompanying Practice Guidelines articulate the delivery of case management

and community services to develop protocols to guide and support transitions between service sectors and jurisdictions.	services to clients concurrently engaged with two or more of the following programs: Alcohol and Other Drugs; Aged and Disability; Families and Children & MH. The Framework provides direction for program staff in the case management of shared clients. The focus is the development of a joint case plan under a shared client case management framework that informs the assessment, planning, delivery and review of services to clients concurrently accessing more than one service. Clients accessing multiple concurrent services receive a shared client case management response aligned to the intensity and complexity of their individual needs. Multi-service clients including multi-service families, receiving targeted and coordinated services that enable provider knowledge, ideas and resources to be pooled, resulting in more effective service responses and better client outcomes. The guidelines are sufficiently broad to facilitate shared case management responses to clients engaged with two or more of the above named programs and another government department and/or non-government organisation. • *Police/NTMHS Protocols.* The existing MoU between Police and NTMHS has been reviewed and a revised document which features a suite of protocols is nearing completion. The revised protocols will form the basis of an agreement between Northern Territory Police Force and Northern Territory DHF to work in cooperation to promote a safe and coordinated system of response and care for persons known or suspected to be suffering from mental illness or disturbance or exhibiting behaviours that may be indicative of a mental illness or disturbance. The revised protocols will be part of a framework of continuous improvement to ensure the effective and efficient delivery of services to meet the needs of individuals with a known or suspected mental illness and is to be used as the basis for the development of standard operating procedures within each organisation, including local procedures in regional and remote communities. • *Provision of 24 hr MH 'hot line' telephone triage and enhanced response.* $930,000 has been allocated for a 24 hour mental health triage number linked to a triage and referral service. The hotline will provide specialist advice, support and referrals to professionals and carers helping people with mental illness. The service should help reduce the time taken for a mental health response. It is anticipated the service will commence at the beginning of the 2010/11 financial year. This new 24 hour phone line will facilitate the provision of MH information, advice and referral to consumers, carers, service providers & the NT community generally. It will provide advice and support to callers in relation to management of MH emergencies & enable callers to talk directly to experienced MH professionals. Advice on referral to local specialist services will be provided. MH education can be provided to other health staff including those form primary and acute care. It will provide needed additional support for NT's rural and remote population. This initiative is predicated on the National Emergency Mental Health Principles. • Significant numbers of external agencies – government & non government – receive education from TEMHS at least equivalent to 1.5 FTE weekly. • Increase in training hours for Police Officers will be provided by MH services, specifically for Cadet training, Police Negotiators and Aboriginal community policing officers. • A community outreach worker is employed by TEMHS. Currently this worker spends three days a week with the NGO - MH Carers NT. • Development of NTMHS transport p*rotocols based on National Safe Transport Principles* These have been trialled in Darwin urban area and about to be translated to the regional areas of Katherine, East Arnhem, Barkly.

20. Improve linkages and coordination between mental health, alcohol and other drug and primary care services to facilitate earlier identification of, and improved referral and treatment for, mental and physical health	• NTMHS is currently planning an initiative to address the needs of people with chronic MH issues. This initiative relates directly to the NTG *Chronic Conditions Prevention & Management Strategy 2010-2020.* The NTMHS initiative aims to provide strengthened responses for people with severe and complex conditions requiring specialist MH treatment, by addressing lifestyle risk factors, identifying strategies to engage NTMHS clients to engage with their GP & generally providing additional support and interventions for people with chronic mental illness. Current NTMHS activities include:
	  • Development of a *Physical Health Screening Tool*, which will assist in increasing awareness amongst MH staff in their management of the physical health of mental health clients.
	  • Identifying Key Performance Indicators for use to measure progress of this initiative.
	  • Development of a framework and guidelines to assist NTMHS staff to provide physical health care for MH clients to

problems.	ensure that people with chronic MH receive appropriate physical health care. • Planning for development of resources for families, carers and GPs to support the role they play in improving the general health of people with mental problems. • In conjunction with the staff of the NT Perinatal Mental Health Project & the Palliative Care Grant Project, development of guidelines & resources that are applicable to Indigenous Territorians, particular those living in remote communities. • Development of education package for NTMHS staff on clinical assessment skills; • Planning for consultation with consumers & carers and consumer/carer groups to identify the best approach to utilise in addressing the physical care of NTMHS clients. • The weekly GP Clinic in the TEMHS Community MH Centre established in the early 2000s, has resulted in regular physical health review for clients of the service. GP's bulkbill MH consumers whose attendance at the GP clinic is facilitated by TEMHS Case Managers. The GPs review the physical health of each consumer and Case Managers ensure that any follow up action occurs. This has improved client access to primary health care services and the care of clients with physical health problems and mental illness in Community MH Services. This service has been established in Alice Springs. • The newly established co-location of the TEMHS Community MH Team with a GP Practice in Palmerston is improving liaison. • NTMHS is currently developing a system to ensure that all clients of Public MHS have an annual physical primary health care checks via the appointment of a clinic nurse who will be responsible to link clients with GPs, Community Health Centres as well as undertaking regular checks for metabolic syndrome. • NTMHS is currently exploring the development of a physical health screening for MH consumers tool. Ths will be developed for use across NTMHS. • Guidelines for mental health staff have been developed to guide the provision of physical health care for mental health patients to ensure that people with mental illness receive physical health care in line with the care provided to the general population. • An inter agency integrated comorbid care workshop is held regularly between MHS & AOD & all NGOs and primary care services are invited to these The intention is to develop, implement and evaluate integrated care pathways between all sectors and all regional areas. The end plan is to incorporate NTFC and Aged & Disability into this network, • Exploration of joint conduit entry (MH & AOD) with new 24 hour service between 1600 – 0800 each day. • NTMHS staff currently undertake joint training with Alcohol & Other Drug service staff in order to enhance knowledge and skills of staff in both programs. MH & AOD staff undertake placements in the respective services. Jointly delivered to govt and non govt workers. Experiential and familiarisation placements.
21. Develop and implement systems to ensure information about the pathways into and through care is highly visible, readily accessible and culturally relevant.	• *One Talk Technology*: Several NTMHS initiatives involve the development of information posters, albums & other media utilising One Talk Technology to facilitate knowledge and understanding by Indigenous users of NTMHS. This is one element of a larger plan to develop Indigenous friendly materials across NTMHS to ensure that information is provided in a culturally user friendly format regardless of media eg in print form, via technology, in policies, & in staff training and education. eg Translation of NTMHS 'Legal rights and responsibilities' posters into A3 size, 'talking posters' currently being translated into 9 Central Australian languages. eg Perinatal MH information including Edinburgh Depression Scale will be translated into Top End & Central Australian languages & installed into a 'talking' album for use by staff working with mothers. • Development of AIMHi cultural assessment project in TEMHS inpatient unit. Aboriginal Mental Health workers are implementing assessment and discharge planning using AIMHi instrument with Indigenous clients. This will assess changes in outcomes with the use of culturally appropriate processes and tools; provide more culturally appropriate assessment tools & ensure more involvement of Aboriginal Mental Health Workers in assessment and discharge planning. • Community- Inpatient liaison nurses specifically address the discharge needs of complex and/or remote clients. Remote workers are

	involved in these activities as well as in ward rounds. • Development of DVD in language to provide consumer and carer information in a format that can be easily accessed. Consultation process undertaken and decisions made in regard to format and languages which would be used on the DVD. Script written and agreed to. DVD has been developed to the 'First Concept' stage and is being reviewed by NTMHS. AHWs/AMHWs ensure that format and script will meet the requirements of Indigenous consumers.
22. Better target services and address service gaps through cooperative and innovative service models for the delivery of primary mental health care.	• A Consultation Liaison service is provided to rural and remote areas via the NTMHS Remote Teams usually on a drive-in, drive-out, fly-in, fly-out basis. NTMHS works closely with other agencies, particularly remote health clinic primary staff utilising videoconferencing, teleconferencing and other technologies to ensure delivery of services. • Service Agreements with Remote Health and MoU's are in place with the Primary Mental Health Care sector (GPNNT).
23. Review the Mental Health Statement of Rights and Responsibilities.	• This is a national initiative, & the NT will participate with other jurisdictions in the review. However locally: • The *Mental Health Statement of Rights and Responsibilities* has formed the basis of NTMHS policy development & strategic planning for many years. As a result many MH Program existing elements & initiatives address consumers and carers rights and responsibilities. Examples of these include: • Part 12 of the MHARS Act specifically addresses the rights of patients & carers – particularly in relation to information provision (especially to medication or treatment); disclosure of information; discharge planning; access to records; involvement of adult guardian or representative; access to telephone, letters and postal articles; & restriction or denial of entitlement. • Part 14 of the MHARS Act specifically addresses the Community Visitor Program – who have inquiry & review functions in relation to the adequacy of services for the assessment & treatment of consumers in NT Approved Treatment Facilities (ATF) or Approved Treatment Agencies (ATA). A community visitor may, at any time without notice, enter an ATF or premises occupied by an ATA & inspect any part of the facility or the premises. They can visit consumers who are receiving treatment or care; & inspect documents, medical records or registers relating to those persons at the facility or from the agency. They can monitor & inspect the standard and appropriateness of facilities; the physical well-being and welfare of consumers; the adequacy of information relating to the rights of consumers & the accessibility and effectiveness of complaint procedures under the Act; the failure of persons employed in ATFs or by ATAs to comply with the Act; & any other matter that a community visitor considers appropriate having regard to the principles and objectives of this Act. • Part 15 of the MHARS Act specifically addresses the role of the Mental Health Review Tribunal whose role under the MHARS Act is to review voluntary & involuntary patients in accordance with legislation. • Part 17 of the MHARS Act specifically addresses the role of the Approved Procedures & Quality Assurance Committee - The functions of the Committee are: to monitor and review the Approved Procedures and forms & to assess and evaluate the quality of MH services, including clinical practices and privileges, & to recommend amendments to them if required. • The production of leaflets, posters & guides for consumers & carers. • The Office of the Director of Mental Health undertakes periodic reviews of various aspects of the MH Program, monitors standards in funded NGO services & regularly conducts internal reviews in relation to specific delivery of clinical MH care. • The MHARS Act education 'Roadshow' delivered NT wide during March to May 2009 included sessions specifically aimed at informing consumers and carers of their rights under the legislation. Education was also provided to staff to reinforce the importance of use of the consent process under the MHARS Act. MH clinicians guides were provided for staff, to enhance understanding of these processes. This resulted in increased understanding by NTMHS staff of their legislative responsibilities in regard to the consent process. The widely publicised educational sessions were also delivered to consumers, carers, NGOs and NTG agencies in all major NT areas. For the first time a variety of targeted guides on the MHARS Act were produced: these included guides for consumers,

	carers, Remote staff, & General Hospital staff. Information materials were also provided on various aspects of the MHARS Act. • The NT had produced a 'Statement of Legal Rights' poster which is based on elements of the national document. This has been widely disseminated. • NTMHS is currently translating the poster 'Statement of Legal Rights' into nine Indigenous languages.
24. Review and where necessary amend mental health and related legislation to support cross-border agreements and transfers of people under civil and forensic orders, and scope requirements for the development of nationally consistent mental health legislation.	• The Northern Territory currently has cross-border agreements for the transfer of people under civil orders with South Australia. • The NT MHARS Act contains the necessary provisions to support cross border agreements. On 3 March 2009 new regulations commenced which prescribes corresponding laws and includes the MH Acts of the 7 other jurisdictions. • NTMHS is currently in the process of developing or making arrangements to develop cross-border agreements for the transfer of people under civil orders with the remaining seven other jurisdictions. • In relation to forensic transfers, Part IIA of the NT Criminal Code is relevant to this issue. The Department of Justice is responsible for that legislation and are aware of the need to include the capacity for cross border agreements when the Criminal Code is next amended. • *Increased diversional options - Voluntary Treatment Orders – Amendments to MHARS Act (Part 10 Division 3)*. This amendment which includes provision for Voluntary Treatment Plans is a diversionary mechanism, which allows postponement of sentence while treatment occurs and progress is monitored. The policy intent of this provision is to divert individuals with mental illness from the criminal justice system and into a voluntary treatment arrangement within the community to enable treatment and support to occur and to assist the individual to function more effectively within the community. • Currently informal arrangements are made on an ad hoc basis between jurisdictions when decisions/action is required in relation to the transfer of consumers.
25. Develop and commence implementation of a National Mental Health Workforce Strategy that defines standardised workforce competencies and roles in clinical, community and peer support areas.	• The responsibility for the action is at national level, & senior NTMHS staff are currently engaged with other jurisdictions in the development of a national MH workforce strategy. • The NTMHS is currently developing a Workforce Development Strategy & Framework. • DHF has undertaken considerable work in the area of workforce development with strategic workforce plans developed for the Indigenous population as well as non Indigenous workers. Nursing has specifically focused on requirements at various levels of the career structure introduced two years ago and will reflect the broad competencies for nursing staff accepted by the National Board of Nursing. • *Mental Health Nurse Practitioners.* NTMHS is committed to implementing MH Nurse Practitioner position. Currently 2 are completing study to become Nurse Practitioners in July 2010. Plans to further increase the numbers of Nurse Practitioners are underway. Prospective Nurse Practitioners in the NT undergo an authorisation process through the NT Nurses and Midwives Board. To become a Nurse Practitioner they are required to complete a Master of Nursing [Nurse Practitioner] program and have a minimum of 5 years in their designated speciality. • The NT is one of the pilot sites for the implementation of the Mental Health Professional Online Development (MHPOD) program (2010). • National competencies for MH workforce – the NT participated in the trial of framework and are awaiting the final National outcomes of this trial. The need for *Core Competencies* for public Mental Health Workforce consistent with the *National Practice Standards for the Mental Health Workforce* is a recognised need and hence the participation in the National trial. • The two major NT MH funded NGOs have made a commitment to ensuring their community based workers have a minimum

	qualification of Cert IV Mental Health. • NTMHS supports Indigenous workforce development via employment of Aboriginal MH Workers and the provision of ongoing support for their continuing education. NT MHS also supports an Indigenous cadet program by employing professional level Aboriginal employees and provide for their support and guidance. NT MHS offers placement for GP registrars and RMO placement, placement for medical staff from Aboriginal medical organisations & clinical supervision and placement for psychology, social work and OT students/graduates. • All disciplines in MH have clinical supervision available to them. • All mental health service employees can access financial and leave support to undertake qualifications relevant to their field.
26. Increase consumer and carer employment in clinical and community support settings.	• The NT Consumer Advisory Group (CAG) provides a mechanism for consumer and carer input into MH policy decision making processes, and NT MH policies and processes. Within this broad framework, the NT CAG provides advice to the Minister for Mental Health on matters which affect the rights, needs, interests and the welfare of people with mental health problems/disorders and their carers. NTCAG also liaises with national peak bodies e.g. the National Mental Health Consumer and Carer Forum (NMHCCF), to ensure that the needs and concerns of NT consumers and carers are represented at this level. • *Consumer & Carer Participation Review 2010.* NTMHS is currently conducting a review of the involvement of consumers and carers in the service. This review due to be completed in December 2010, is considering a range of options to ensure that the consumer and carer voice is central to the NTMHS. Public forums are being held across the Territory to obtain the views of the general community & to consult with consumers and carers. A review of all relevant policies & resources including information leaflets & guides will also occur. Submissions will be requested in order to obtain comprehensive feedback from key stakeholders. A range of issues are being considered in this review and this includes consideration of paid consumer and care participation in NTMHS.
27. Ensure accreditation and reporting systems in health and community sectors incorporate the National Standards for Mental Health Services.	• NTMHS has recently undertaken NT wide accreditation review via the Australian Council on Healthcare Standards (ACHS) review process. Following this review it was confirmed that NTMHS continues to be an accredited health care organisation. The ACHS Evaluation and Quality Improvement Program (EQuIP) accreditation standards are used for conducting the review & are mapped to the 1996 National Standards for Mental Health Services. • *MH NGO review Process*. The NTMHS is committed to ensuring the that appropriate standards of MH care are provided to consumers and carers throughout the Territory, including services provided by NGOs. Consequently in 2010 NTMHS established a process whereby NGOs funded through the MH Program are required to participate in a systematic quality review of services provided. Nationally, the Office of the Chief Psychiatrist in Western Australia has the most developed NGO quality review process, based on compliance with the National Mental Health Standards. The establishment of this review process was underpinned by the development of a framework of Service Standards against which organisations could be evaluated. This review process was developed in WA in 2004, and has been successfully implemented over the past four years. This process has been trialled in the NT & found to be useful. This review process will be mandated for all MH funded NGOs in the NT. The Office of the NT Director of Mental Health monitors NGO compliance with these WA NGO Standards. • Improvement of the contract management and monitoring of NTMHS funded NGOs in order to improve their efficacy and development of the community services sector in responding to mental health issues – still ongoing • Comprehensive review of contracts and reporting for all NTMHS funded NGOs • Introduction of new tracking system to ensure compliance with service agreements • All funded NGOs visited by NTMHS service development officers to ensure mutual understanding of obligations • Increased clarity in relation to activities of funded NGOs • More oversight of NTMHS NGO funding arrangements to achieve maximum effectiveness of service provision
28. Further develop and progress implementation of	• In 2006 the National Mental Health Benchmarking Project began. Mental health teams from the states and territories participated in

the National Mental Health Performance and Benchmarking Framework	demonstration benchmarking programs for child and adolescent, adult, older persons and forensic services. • *Benchmarking in the Northern Territory.* The development of service profiles for submission to the National Benchmarking project provided a good model for producing a standard service description profile that could be developed for each NTMHS team. The NT initially did not participate further in benchmarking activities due to limited information reporting capabilities and staff capacity. • In 2009 the Business Objects reporting facility made MH performance reports accessible to NTMHS staff. In the same year NTMHS appointed a project officer for 6 months to develop a process/plan to establish benchmarking. The aims of the project were to develop a proposal for benchmarking for the MH Executive; identify and assemble the available information that can be used for benchmarking & production of a report containing findings and recommendations for progressing benchmarking in the NT. • Business Objects reporting is a web-based reporting tool that has been implemented across the DHF that provides performance reports for NT Managers. The delivery of the Business Objects reports to NTMHS Managers via their computers provides a backbone from which to develop benchmarking activity. The reports contain both descriptive and performance information which teams can then use to begin to examine their own performance. As teams become more familiar with using information in this way they can begin to compare themselves to similar or upstream services eg. Remote teams; Community and inpatient teams. • Access to this information establishes a platform from which to implement benchmarking. Teams are able to review descriptive information of their client population and their needs, the types of frequency of interventions and the outcomes of that treatment. By comparing this information to their clinical experience and knowledge clinical teams can identify areas of good practice and areas requiring improvement. • The NT Benchmarking Project was developed as a series of stages which could be implemented according to resource availability. The stages are: Stage 1: Consultation and Development Phase; Stage 2: Business Objects Roll Out & Stage 3: Benchmarking Phase. Currently the NTMHS is currently at Stage 2 – consolidating use of Business Objects. • *Participation in the National Forensic Benchmarking Program.* In March 2009 the National Forensic Benchmarking Program began a second round of Benchmarking and the NT participated in this. Participation in the National Forum proved to be a valuable experience as this demonstrated that the NT could provide the data necessary to generate indicators in the National Benchmarking set. The outcomes indicated that: the NT is on par or ahead of other jurisdictions across indicators of National Standards compliance; & models that the NT can successfully participate in National Benchmarking programs. • Internal benchmarking activities has commenced between NT Remote & Child and Adolescent teams in the Top End & Central Australia. Planning for external benchmarking is underway. • Future activities include: plans to undertake Service Mapping and Performance Reporting; the NTMHS executive will identify the key strategic and policy development issues to be addressed by benchmarking; & the development of an NT MH Population Model. The latter will be used to provide a validated description of the resources required to meet the future mental health needs of the community. • The NT continues to support the establishment of a national remote benchmarking project operated from the NT - if resources are available.
29. Develop a national mental health research strategy to drive collaboration and inform the research agenda.	• This is a National issue for development. • In the NT, NTMHS funds some MH research eg: exploration and identification of culturally appropriate tools and processes associated with assessment, admission and discharge from the acute MH inpatient unit. Joint funding by NTG and Beyondblue of the BEAT Project. • NTMHS plans to establish a more coordinated approach to MH research. Currently an NT MHS Strategic Plan is under development. This will detail the medium to long term strategic goals for NTMHS & research utilising NTMHS data will be addressed. A Policy framework in relation to research into MH is also under development. Plans to create an NTMHS Research Group are underway. Via its partnerships with the Charles Darwin University, Menzies School of Health & other academic institutions, NTMHS aims to enhance

	its research potential. This will encourage MH staff to identify new & innovative ways to enhance service delivery and achieve evidence based best practice in the field., ultimately for the benefit of MH consumers. • Currently the service supports clinical and social research undertaken by individuals – particularly around Indigenous MH & trauma. • An Associate Professor in Mental Health – a joint appointment between CAMHS & the Centre for Remote Health - is working with all teams on service development and service evaluation. He liaises with Central Australian NGO's and is assisting CAMHS in defining and acquiring funding for research projects.
30. Expand and better utilise innovative approaches to service delivery including telephone and e-mental health services.	• NT's geography adds to the complexity of delivering an effective and accessible MH service. In response to the specific challenges of providing services for remote communities, tele-psychiatry is frequently utilised by NTMHS staff as a clinical tool. Video conferencing and teleconferencing are used during inpatient unit ward rounds & the technology is particularly important to facilitate clinical consultation for remote teams. Staff supervision & development is also provided using this medium. • *Increased use of videoconferencing for psychiatric registrar training and supervision*. The NT Director of Training encouraged medical staff to utilise videoconferencing facilities more often when undertaking education/supervision activities. This has resulted in: increased access to interstate expertise for training/supervision purposes; increased medical officer knowledge of & ability to utilise videoconferencing; increase in communication options for clinical staff & enhanced consumer & carer communication. This has also increased options for consumers as assessment undertaken via video conferencing which can result in reduced need for consumer & carer travel, & prevention of admission to hospital. • *Provision of 24 hr MH telephone triage and enhanced response.* $930,000 has been allocated for a 24 hour mental health triage number linked to a triage and referral service. The hotline will provide specialist advice, support and referrals to professionals and carers helping people with mental illness. The service should help reduce the time taken for a mental health response. It is anticipated the service will commence at the beginning of the 2010/11 financial year. This new 24 hour phone line will facilitate the provision of MH information, advice and referral to consumers, carers, service providers & the NT community generally. It will provide advice and support to callers in relation to management of MH emergencies & enable callers to talk directly to experienced MH professionals. Advice on referral to local specialist services will be provided. MH education can be provided to other health staff including those form primary and acute care. It will provide needed additional support for NT's rural and remote population. • *Amended MHARS Act* enhanced consumer assessment options for clinical staff. Amendments to specific elements of the MHARS Act enabled and facilitated increased use of video and teleconferencing to assess consumers in rural & remote areas & increased range of options for consumers & carers living in remote & rural Northern Territory. • *Digital Regions Initiative* to provide best available technology & thereby increase use of video-conferencing by clinicians. The NTMHS are the sole providers of public MHS to the people of the NT. 30% of the NTMHS target population live in remote and rural settings & a high percentage of these are Indigenous. Historical and modern cultural factors compounded by the remote setting, increase morbidity and complicate the delivery of effective treatment to this target population. Services are provided by remote mental health teams who are based in urban centres. The geographical isolation and dispersal of remote communities means that the population does not receive the service it requires as specialist MHS to this population are limited to a visiting service, the frequency of which is dependant on the size of population and need. This makes timely attention to unwell people problematic and follow-up for patients discharged from MH inpatient units difficult. • Funded by the Commonwealth, the *Digital Regions Initiative* will enhance NTMHS service delivery & provide positive outcomes. Poor infrastructure, including the lack of availability of functioning, quality units in remote communities has meant that videoconferencing is infrequent. This has also resulted in a lack of staff expertise and understanding of the benefits that could result. More effective use of videoconferencing technology will improve clinical service delivery, remote team support and professional development. Videoconferencing is an effective and relatively inexpensive avenue to providing MH services across the clinical, administrative and educational domains in remote and rural settings. • *Restructure of access point, triage, response and recovery services.* Restructure of TEMHS community service to optimise crisis response, case load coordination, recovery focused service. This restructure will provide: a dedicated team of staff with skills in

	telephone triage and response; introduction of flexible work hours to enhance community based recovery service to clients; enhanced liaison with GPs and consideration of shared care arrangements; introduction clear referral guidelines and clinical pathways to guide staff at first point of contact; introduction of a standardised triage and intake assessment process; introduction of access processes which integrate Remote access as much as possible with the TEMHS single access system; & introduction of a wider range of staff grades to the community teams including AMHWs. All staff to be trained in brief intervention, crisis response, triage, initial assessment. Each staff member will be supported to embrace a recovery 'subspecialty' either within the service area (eg early intervention, specific therapy) or within discipline (eg work skills training, specific assessment). • *The development and implementation of integrated strategies for supporting consumers who receive services from one or more DHF program.* Introduction of the DHF 'shared client case management' notification system in CCIS. CCIS now electronically informs MH service providers of other cross program service providers in order to facilitate & exchange data on consumers. This achieves better client outcomes through: enhanced case management responses to multi-service clients, particularly those identified as being at high to extreme risk of harm. • Creation and use of selected shared drives between CAMHS, TEMHS & MH Policy Branch to facilitate transfer of information between staff who are working on activities and projects. By changed access permissions on computer drives quality and education NTMHS staff were able to share documents more easily. NTMHS Quality Coordination Group embedded new information exchange processes into work practices this resulted in improved communication between NTMHS Quality & Education staff across the NT.