Northern Territory PHN Primary Health Care Workforce Needs Assessment

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NT PHN Acknowledges the Traditional Owners of the country on which we work and live and recognise their continuing connection to land, waters, and community. We pay our respects to them and their cultures and to Elders past, present and emerging.

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Glossary of Terms

AHP	Aboriginal Health Practitioner
AMSANT	Aboriginal Medical Services Alliance Northern Territory
AMHP	Aboriginal Mental Health Practitioners
ATAPS	Access to Allied Psychological Services
ACCHS	Aboriginal Community Controlled Health Services
AMHSW	Accredited Mental Health Social Workers
ANZSCO	Australia and New Zealand Standard Classification of Occupations
AOD	Alcohol and Other Drugs
AASW	Australian Association of Social Workers
ACMHN	Australian College of Mental Health Nurses
AHPHRA	Australian Health Practitioner Regulation Agency
AIHW	Australian Institute of Health and Welfare
CDU	Charles Darwin University
Fifth Plan/5th Plan	Fifth National Mental Health Plan
Flinders	Flinders University
FTE	Full time equivalent
GP	General Practitioner
HWNA	Health Workforce Needs Assessment
HWSG	Health Workforce Stakeholder Group
LHN	Local Health Networks
MBS	Medicare Benefits Scheme
MH	Mental Health
MHN	Mental Health Nurses
MHOT	Mental Health Occupational Therapists
MHSW	Mental Health Social Workers
NHWD	National Health Workforce Dataset
NT	Northern Territory
NT PHN	Northern Territory Primary Health Network
NT Health	Northern Territory Government Department of Health
OT	Occupational Therapist
Territorians	People of Northern Territory
PHNs	Primary Health Networks
RACFs	Residents of Residential Aged Care Facilities
RWA NT	Rural Workforce Agency NT
SEWB	Social and Emotional Wellbeing
the Framework	Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017-2023
VET	Vocational education and training

Executive Summary

The Health Workforce Needs Assessment (HWNA) is an activity under the Rural Health Workforce Support Activity funded by the Australian Government Department of Health and managed by Northern Territory Primary Health Network (NT PHN) incorporating the Rural Workforce Agency NT (RWA NT). The objective of the activity is to contribute to addressing health workforce maldistribution, quality, and shortages in rural and remote Australia. In the NT, workforce needs assessment informs RWA NT investment and activities addressing four overarching priorities:

1. Develop the Aboriginal workforce – clinical and non-clinical.
2. Develop pathways into and through health careers.
3. Attract, maintain, and retain workforce in the NT.
4. Develop locally responsive sustainable models of care.

Assessment of primary health workforce needs by RWA NT has been an iterative process, continually increasing in scope to improve upon our understanding of needs and priorities for our jurisdiction. In early 2020, pharmacy, GP training pathways and this report's subject - the clinical mental health workforce including psychology, mental health nursing, mental health occupational therapy and social work were prioritised by the Health Workforce Stakeholder Group for investigation.

The overarching policy and funding context surrounding the delivery of mental health services in the NT is complex. Nationally, the mental health and suicide prevention policy reform agenda has been in play since 2008 and has seen the emergence of at least 25 policies, frameworks and initiatives that influence current and future workforce needs. Funding is fragmented, with roles and responsibilities spread across numerous government and non-government agencies and the private sector. The result is a fragmentation of the workforce together with poorly coordinated and inefficient training and development initiatives to support them. Recommendation 23 of the Productivity Commission[1] and ensuing reform activity provide an opportunity to remedy this, aiming to achieve funding arrangements that "support efficient and equitable service provision". While the Northern Territory Government has introduced five-year funding cycles for mental health and suicide prevention, short-term Commonwealth funding cycles continue to impede on workforce retention.

The current policy environment has implications for the supply and skills needs of the specialised mental health workforce and generalist primary care workforce to keep up with mental health reform. A broader workforce including peer workers and other non-clinical roles will need to be integrated with traditional workforce and workforce models. Solutions are needed to realise the required increase the Aboriginal participation in, and to ensure the cultural competence of, the mental health workforce. Consideration of a workforce mix, skill set and models to meet the needs of consumers rather than conforming to historical ideas around professional roles is encouraged, while attracting a workforce will involve improving the status of mental health careers [1-4].

The impending National Mental Health Workforce Strategy and recent Federal Budget initiatives provide impetus and support for action. The proposed mental health and suicide prevention regional planning process provides an opportunity to integrate health service, systems and workforce solutions while reducing the fragmentation and short funding cycles of programs. This will improve workforce viability, resilience, retention, and sustainability.

There is evidence that mental health conditions and suicidality contribute significantly to the burden of disease in the Northern Territory and that needs often remain unmet. Acute mental health services in the NT are characterised by a high level of demand and limited inpatient capacity (acute mental health beds). While supporting the policy paradigm of increasing care 'upstream', the resultant throughput suggests that a higher burden of care rests with primary and community sectors.

While NT primary care responses are characterised by a larger proportion of bulk funded services in response to failure of MBS in remote Indigenous context and the AMS model of service delivery, MBS remains significantly underutilised. There is an opportunity to grow the private MBS funded workforce as a means to addressing unmet need.

The NT psychology workforce is decreasing against a backdrop of national increases. Improving graduate internship offerings, including supervision, is potentially the most significant contribution to the sustainability of this workforce. The number of nurses working in mental health is decreasing, and at a faster rate than that seen nationally. However, nurses working in mental health are a small proportion of a much larger workforce and therefore represent a large untapped potential workforce. Expanding opportunities for nurses to experience and develop skills in mental health while increasing the profile of mental health may encourage greater participation of nurses in mental health workforce. Given the relatively high supply of social workers in the Northern Territory, attention could be given to attracting more social workers to mental health. Good alignment of VET pathways into tertiary social work courses also provide opportunities for local and Aboriginal workforce development. Occupational therapists working in mental health are fewer although anecdotally this is increasing, and new local training pathways will soon see its first cohort of graduates. Given overall numbers, and the relatively small proportion currently working in mental health, occupational therapists may have a greater potential contribution to make to the future workforce. Local training pathways for psychology, nursing, social work, and occupational therapy through Charles Darwin University provide potential to influence student experience, skill development and career choices.

Several strategic considerations impact what is required of a mental health and suicide prevention workforce in the Northern Territory. A model of care driven by individual needs of consumers, remoteness, and the unique needs of Aboriginal people point to cultural competence, safety, and the ability to work in trauma informed ways as essential. Aboriginal participation in the workforce, non-clinical and lived experience workers will play an important role in successful workforce models and in maximising the value of clinical roles. Clinician understanding, value and support for these roles will be critical.

Training and development pathways that support 'growing our own' clinical mental health workforce is considered crucial to the development and retention of a sustainable workforce in the NT. Community-based training utilising VET pathways will be important both to growing the non-clinical and peer workforce and as a pathway to growing our own clinical workforce. Stakeholders emphasised community-based employed training programs and traineeships, coupled with supported entry and participation in tertiary studies, as the most appropriate and effective means to grow the Aboriginal mental health workforce. Improving mental health sector profile and creating opportunities for students and career health professionals to have positive experiences of working in mental health, particularly in remote settings were identified as a means to attract a future workforce. However, the

capacity of remote services to accommodate and support students is a key barrier. While tele-supervision models provide some solutions, there is a lack of 'on the ground' support and infrastructure required to enable student placements.

Retaining existing rural and remote workforce will continue to involve addressing professional isolation, access to professional development, workloads, workplace safety and vicarious trauma as well as social support. Increasing the capacity of the broader health and social care sector to support mental health needs of their clients will mitigate the impact of the undersupply of the specialist mental health workforce in the NT while continuing innovation in transforming care (and thereby workforce) models to meet community needs, address workforce shortages and maximise emerging opportunities will ensure the most is made of the workforce we have.

Both nationally and within the NT, there is much activity in this space. Coordination and integration will be critical, supporting and building on the measures already underway. Notably, in this environment of significant and swift reform, what we describe here as the current needs, challenges and opportunities will quickly change.

Introduction and Background

The Health Workforce Needs Assessment (HWNA) is an activity under the Rural Health Workforce Support Activity funded by the Australian Government Department of Health and managed by Northern Territory PHN (NT PHN).

The Rural Health Workforce Strategy Activity spans 1 July 2017 to 30 October 2021 and contributes to three broad activity areas:

- Access: improving access and continuity of access to essential primary health care.
- Quality of access: building health workforce capability; and
- Future planning: growing the sustainability of the health workforce.

The overarching objective of the activity is to contribute to addressing health workforce maldistribution, quality, and shortages in regional, rural, and remote Australia.

To develop the evidence-base for the distribution of funding, needs assessments are undertaken to identify priority areas for investment in health workforce development. This ongoing activity takes place in collaboration with the Rural Workforce Agencies Network (RWAN) at a national level and localized consultation with the Health Workforce Stakeholder Group (HWSG). The HWSG is made up of industry representatives and experts that guide the development of the HWNA in the NT and subsequent planning and implementation of activities to address identified needs.

Assessment of primary health workforce needs by RWA NT has been an iterative process, continually increasing in scope to improve upon our understanding of needs and priorities for our jurisdiction. in 2017-2018, the focus of the first needs assessment included general practitioners (GPs) remote area nurses (RANs) and Aboriginal and Torres Strait Islander health practitioners (AHPs). In 2018-2019 allied health professionals were incorporated, and in early 2020, pharmacy, GP training pathways and the subject of this report - the clinical mental health workforce, including psychology, mental health nursing, mental health occupational therapy and social work were prioritized for investigation. The findings of needs assessment activities will inform the RWA NT Activity Work Plan in coming years.

This report documents the key findings relating to the needs of the clinical mental health workforce, including psychologists, mental health nurses (MHNs), mental health occupational therapists (MHOTs) and social workers. It should be read in conjunction with the 2018-2019 HWNA, noting that there are a number of workforce needs and challenges pertaining to the broader allied health workforce in the NT that also apply to the specific clinical mental health professions discussed herein. This report does not seek to duplicate this content. Rather, it provides a lens over the specific needs of the clinical mental health workforce in the context of mental health reform and the unique characteristics of the NT mental health and social and emotional wellbeing (SEWB) service delivery context.

Scope

The key focus of this iteration of needs assessment is the clinical mental health workforce, in particular:

- Psychologists
- Mental Health Nurses (MHNs)
- Mental Health Occupational Therapists (MHOTs)
- Social Workers
- Aboriginal Mental Health Workers

While these professions are the key focus of this report, it is acknowledged that primary mental health care and social and emotional wellbeing services in the NT are delivered by a multi-disciplinary workforce comprising a range of specialist, generalist, clinical and non-clinical roles.

Methodology

A range of data sources were utilised to conduct this need's assessment, including:

- Relevant literature from academic, government and other sources.
- Quantitative data from national and NT sources.
- Qualitative insights drawn from key informant interviews.
- Feedback from the Health Workforce Stakeholder Group on the draft need's assessment report.
- Feedback from key stakeholder representatives identified by the Health Workforce Stakeholder Group.

Literature

Literature informing the needs assessment included:

- Published peer-reviewed literature (sourced from databases such as PubMed, CINHAL, EMBASE, etc.).
- Federal and Territory strategic policies, plans and frameworks.
- Government reports and independent inquiries.
- Consultant and stakeholder reports and other relevant grey literature that included NT specific insights.

Literature published in Australia was sourced primarily for this study. The date range of literature sourced included: 2016-2020. Exceptions were made if key insights, theories, government reports or cross-referenced literature were required to fill gaps or connect concepts.

Quantitative Data

A range of quantitative data sources have been used to assist with understand trends in the supply and demand for the clinical mental health workforce. These include:

- The National Health Workforce Dataset
- Australian Association of Social Worker Registrations
- Medicare data
- Australian Institute of Health and Welfare (AIHW) data tables
- NT PHN recruitment data

Detail for each data source, including limitations and interpretive considerations, is provided in Appendix A.

Stakeholder Consultation

A series of semi-structured interviews were conducted with a cross section of health organisations, service providers and university representatives with expertise in mental health. Upon the development of a draft, broad consultation occurred with open circulation of the draft document to key stakeholders. Stakeholders were provided with a range of vehicles through which feedback could be provided. This feedback was collated and considered in further compilation of the report.

Mental Health Policy and Funding Context

For a number of years, there has been and continues to be ongoing Mental Health reform in Australia[2, 5]. Here we provide a summary of this prolific activity as it pertains to the clinical mental health workforce. In the context of significant reform, there are implications for RWA NT in ensuring the NT workforce context is considered and addressed in the national reform agenda and that this activity translates to local benefits.

The national mental health reform agenda is reflected in a progression from the *National Mental Health Policy 2008*[5] through to the development of the 5th National Mental Health and Suicide Prevention Plan (The Fifth Plan) (2017)[2]. The 2020 Mental Health Productivity Commission Inquiry Report provides the impetus for present activity with an imminent National Mental Health Workforce Strategy. It also offers expectations that a new "national strategy that integrates services and supports that are delivered in health and non-health sectors should guide the efficient allocation of government funds and other resources to improve mental health outcomes over the long term"[1]. A number of common themes characterise this policy and strategy environment.

Impending or present workforce shortages are acknowledged, particularly a shortage of mental health nurses and concerns for the psychology pipeline with continuing changes to the training structure [1]. Health professionals will need the skills and confidence to deliver person- centred, holistic and personal recovery care[1, 2]. Group therapy, short course, structured therapy and telehealth will be more widely used, while non-pharmacological interventions and social prescribing will be encouraged[1]. Holistic care will require mental health professionals to care for people with physical and substance use co-morbidities[1, 2]. This will require a reorientation of undergraduate training and continued professional development, including screening and assessment skills, attitudes to peer and community workers, engagement with a person-centred ethos and evidence-based clinical practices[1].

The importance of the broader primary and social care sector[1, 2] in supporting the mental health needs of consumers is evident with a focus on building the capacity of GPs in particular[1, 2, 4]. The role of GPs in mental health care is clearly described, including assessment of mental health and comorbid conditions, providing initial diagnosis and mental healthcare, connecting patients to specialist services and other non-clinical supports, and coordinating the patients ongoing mental and physical care. Current policy also advocates a role for a much broader workforce, including peer workers, counsellors, and psychotherapists, Aboriginal and Torres Strait Islander mental health workers, community mental health and support workers[1, 2, 4].

There is an increasing understanding of the impact of mental illness and suicide among Aboriginal and Torres Strait Islander peoples. Addressing this as a priority involves improving the cultural competence of mental health providers and services[1, 2, 4], expanding the Aboriginal and Torres Strait Islander workforce[1, 2, 4] and acknowledging and addressing intergenerational trauma and social and economic disadvantage. Clinicians' ability to interpret mental health symptoms within the cultural context and understanding how to incorporate culture into therapy are acknowledged as critical to outcomes for Aboriginal and Torres Strait Islander consumers[1].

Innovation in care and workforce models to improve sustainability[4], choice and delivery of services closer to home [4] are heavily featured, including multi-disciplinary approaches, shared care arrangements, co-located services, partnerships, alliances and networks[1, 2]. Rethinking the required workforce mix[1, 4], challenging assumptions about the credentials and skills required by the mental health system, and considering potential substitution between occupations is encouraged[1]. There is also significant focus on the potential for a range of digital initiatives, including low-intensity digital services, supported online treatment and telehealth as solutions. These solutions not only increase accessibility and choice for consumers but have the potential to address workforce shortages or mal-distribution[1, 2, 4].

It is acknowledged that increasing the mental health workforce will involve reducing the negative perception of mental health and promoting mental health as a career option[1, 4]. Ensuring more supportive environments to work and train in, including management of workload, work-life balance, clinical risk, physical safety, psychological stress and resource limitations, are also identified as critical[1]. Addressing factors contributing to mal-distribution in rural and remote areas, including professional loneliness, personal costs of isolation, access to clinical supervision [4] and heavy workloads, will help retain health professionals while initiatives to provide training in rural and remote areas may help develop a future workforce for rural and remote communities[1].

The need for more coordinated actions by both levels of government to support the integration of mental health and related services is repeatedly articulated, acknowledging that the diversity of government funding, policy frameworks and service systems negatively impacts the ability of services to address need[1, 2].

Funding barriers and enablers

The structure of funding for mental health in Australia is comparable with the broader health funding environment in that there is no one consistent funding mechanism. Roles and responsibilities within the mental health system are divided amongst the federal and state governments, Primary Health Networks, Local Health Networks, the private and non-government sectors (including ACCHSs), Medicare Benefits Scheme, Pharmaceutical Benefits Scheme and Veterans' mental health services [1, 6]. Over the last 15 years there have been more than 25 national programs and initiatives funded by the Commonwealth Government.[7]

The Senate Committee heard that fragmented funding programs impact on the capacity for smaller remote regions to achieve culturally capable workforce models, enable services to be delivered close to home, provide efficiencies of scale and capacity for peer support, supervision and mentoring[7]. Stakeholders also noted the flow-on impact of short-funding cycles on communities where resulting

poor workforce retention prevents the development of relationships that are crucial in the delivery of consistent, culturally safe, and trauma-informed services. While the Northern Territory Government has recently implemented five-year funding cycles for NGOs to address some of these challenges, there remains a need for a whole of government approach in which funding arrangements and policy are not in conflict [7, 8]

The Productivity Commission recommends "funding arrangements to support efficient and equitable service provisions". The recommendations advocate for clarity around responsibility for psychosocial supports and the integration of Territory and Commonwealth funding with resource allocation driven by collaborative LHN/PHN regional planning. This is currently playing out across the sector, with NT PHN leading regional mental health and suicide prevention planning across the NT and recent Federal Budget announcements involving activities that will be jointly funded with States and Territories. This provides significant opportunity to influence the system impacts on workforce viability and sustainability.

Regional Planning

The first action from the Fifth Plan[2] outlines the commitment of Commonwealth, State and Territory Governments to joint regional planning for integrated mental health and suicide prevention services[9]. This commitment requires Local Hospital Networks and Primary Health Networks to work together to develop a shared plan for mental health and suicide prevention. The plans aim to address the fragmentation of services, service gaps, duplication and inefficiencies and improve the delivery of person-centred care. The plans should encourage a whole of system approach, drive and inform evidence-based services, inform the coordinated commissioning of services, and coordinated regional implementation of national priorities.

The Northern Territory Mental Health and Suicide Prevention Foundation Plan 2021 - 2022[10] is the first step in a commitment to developing a Joint Regional Mental Health and Suicide Prevention Plan for the Northern Territory (NT). The plan, developed by NT PHN, NT Health and AMSANT in collaboration with the Top End and Central Australia Health Services, Territory Families, the non-government community mental health sector, Aboriginal community-controlled sector, and those with lived experience of mental illness and suicide commits to a shared vision. This vision is to better integrate mental health services and suicide prevention responses across our health and social service system and offers five priority areas to focus efforts.

An Environment of Change

While stakeholder feedback focused on the challenges of recruiting and maintaining the mental health workforce in the current funding environment, feedback also suggested that if funding were commensurate with need, the demand for workforce would be far greater again. The execution of this sentiment can be seen in recent Federal Budgets with additional investment in mental health likely to have a significant impact on workforce planning, development, and demand.

Perhaps the most salient aspect of the current policy environment is simply the degree and rate of reform and increasing flexibility. The environment is agile, where solutions may be proposed, debunked, and reimagined with surprising speed. While this report describes the current needs,

challenges, and opportunities, these will change as new and locally designed service models, workforce diversification and substitution occur, and innovative digital solutions emerge.

NT Mental Health Demand

There is no doubt that mental illness and suicidality contribute significantly to the burden of disease in the Northern Territory [11] and that needs often remain unmet. Acute mental health services in the NT are characterised by a high demand and limited capacity (acute mental health beds)[12]. The resultant throughput suggests that a higher burden of care rests with the primary and community sectors[13] and correspondingly that a larger and more capable community and primary mental health workforce is required.

While NT primary care responses are characterised by a larger proportion of bulk funded services[6] in response to the failure of MBS in remote Indigenous context and the AMS model of service delivery, MBS remains significantly underutilised. Fixed and unpredictable funding allocations limit workforce growth in bulk funded services, whereas MBS is an 'unlimited' source of funding with growth limited only by workforce capacity and the viability of the MBS funding model.

Burden of Disease

Approximately 20% of Australians are affected by some form of mental illness every year. Mental health and substance use disorders, including suicide-related self-inflicted injuries, alcohol use disorders and depressive disorders, make up 14% of the total burden of disease in Australia, and are slightly higher in the NT.[11]

In 2018–19, one in four (25%) Indigenous Australians in the Northern Territory had high to very high levels of psychological distress (age-standardised), compared with 11% of non-Indigenous Australians.[13]

In 2019, the NT had the highest standardised death rate for suicide compared with the other states and territories at 21 deaths per 100,000 population. This is much higher than the national average of 12.9 deaths per 100,000.[14]

The NT PHN Program Needs Assessment 2019 provides a more comprehensive account of the burden of disease relevant to the NT population as a whole and to specific population cohorts. Rates of mental illness and attempted suicide-related hospitalisations are also documented for each region in the NT in NT PHN Regional Data Profiles.

Demand for Mental Health Services

Acute Services

In 2018-19 the NT had the highest public emergency department presentations by population with a principal diagnosis relating to mental health at 272 presentations per 10,000 population compared with 120 nationally. Barkly and Alice Springs were amongst the SA3 regions with the highest mental health-related emergency department presentation rate in Australia, at 715.7 and 706.9 presentations per 10,000 population, respectively (2017-18).[14]

Mental health hospitalisations are slightly higher in the NT with 46.8 separations per 10,000 population compared with 44.6 nationally. However, patient days are fewer at 587 per 10,000 population for NT compared with 674 nationally, along with the average length of stay at 12.6 for the

NT compared with 17.8 nationally[13]. While this may, in part, reflect fewer mental health beds at 17.5 per 10,000 population compared with 27.8 nationally[15] and the absence of a private or specialist psychiatric hospital, it may also suggest the NT is at the forefront of client-centred initiatives to increase care in the community and reduce inpatient care

Primary Mental Health Care Services

The complex and disparate mental health policy and funding environment creates significant challenges in accurately gauging the collective demand for and supply of primary mental health care services nationally and in the NT. Medicare data shows that in 2017-18, the NT had the lowest proportion of population (Table 1) receiving Medicare-subsidised mental health-specific services (5%), much lower than the national average (10.2%). GPs delivered the majority of these Medicare-subsidised mental health-specific services, with a small proportion provided by clinical psychologists, other psychologists, psychiatrists, and other allied health professionals.[18] The reasons for the disparate access for Territorians to MBS mental health items is unclear but may relate to a lack of access to health professionals or a lack of awareness or skills of primary care professionals in meeting the mental health needs of their patients.

While poor access to Medicare subsidised mental health services is somewhat offset by substantially higher funding for other programs ($308.31 per capita compared with $256.58 per capita nationally)[6] that support the delivery of mental health and SEWB services outside of MBS billing arrangements, improved access to MBS funded items could provide substantial community benefit.

Table 1: Medicare-subsidised GP, Allied Health, and specialist care 2018-19, services per 100 people NT vs national figures

Provider type	NT (Per 100 people)	National (Per 100 people)
Allied Health - Mental Health Care (subtotal)	6.0	23.7
Clinical Psychologist	2.1	9.7
Other Allied Mental Health	0.3	1.8
Other Psychologist	3.6	12.1
GP Mental Health	7.3	14.6
GP Focussed Psychological Strategies and Family Group Therapy	0.03	0.2

Source: AIHW, Medicare-subsidised GP, allied health, and specialist health care across local areas: 2013-14 to 2018-19.

During the Mental Health and Suicide Prevention Service Review 2017, the Northern Territory Mental Health Coalition identified service shortfall across all regions in the NT[16]. The review noted that the utilisation of non-government (community) mental health care services in the NT is much higher than the national average. This is partly due to a correspondingly lower availability and over-stretched specialised public facilities and limited private (allied health) referral options.

Clinical Mental Health Workforce supply in the NT

The NT psychology workforce is decreasing against a backdrop of national increases. Improving graduate internship offerings, including supervision, is potentially the most significant contribution to make.

The number of nurses working in mental health is decreasing and faster than that seen nationally. However, nurses working in mental health are a small proportion of a much larger workforce and therefore represent a large untapped potential workforce. Expanding opportunities for nurses to experience and develop skills in mental health while increasing the profile of mental health may encourage greater participation of nurses in the mental health workforce.

Given the relatively high supply of social workers in the Northern Territory, directing attention to attracting more social workers to mental health could be considered. Good alignment of VET pathways into tertiary education may also provide an opportunity for local and Aboriginal workforce development.

Occupational therapists working in mental health are fewer, although anecdotally this is increasing, and new local training pathways will soon see its first cohort of graduates. Given overall numbers, and the relatively small proportion currently working in mental health, occupational therapists may have a greater potential contribution to the future workforce.

Supporting mental health accreditation for social workers and BAMH endorsement for occupational therapists will increase capacity to offer MBS funded services and may lead to demand-based workforce growth.

Data and Limitations

The primary source of quantitative data available to assess the supply of psychologists, MHNs and MHOTs in the NT is derived from the National Health Workforce Dataset (NHWDS). This data is collected by the Australian Health Practitioner Regulation Agency (Aphra) through a workforce survey that health professionals complete as part of their annual National Registration and Accreditation process. Survey questions are based on the collection of information about each health professionals' circumstances in the week before they complete the survey. This method of collection results in several limitations impacting the interpretation of this data. In particular, the published data represents a headcount of the number of professionals who worked in the NT in the previous week, meaning that there is an inability to differentiate between those who are working in permanent NT-based roles, or temporary roles such as locum or FIFO roles. It also cannot gauge the degree of workforce transience between the NT and interstate in any given year.

Psychologists

Despite a significant increase in funding for mental health over recent years, the number of psychologists practising in the Northern Territory is decreasing, while disparity between the NT and national supply is widening. To be considered as a practicing clinician, psychologists are required to

be accredited by the Australian Psychology Accreditation Council and must be registered under the Australian Health Practitioner Regulation Agency.[17] In 2019, 176 psychologists reported that the NT was their main location of work in the week prior to renewing their registration with Ahpra (Table 3). This was a decrease from 193 in 2013. Based on head count, this represents 7.2 psychologists per 10,000 people in the NT, compared with 11.2 nationally (Table 4). Further, while nationally the ratio of psychologists per capita has increased (9.1 in 2013 to 11.2 in 2019), it has declined in the NT (7.8 in 2013 to 7.2 in 2019) (Table 4).[21]

The distribution of psychologists within the NT broadly represents the distribution of population, particularly within the Top End. Of the psychologists who worked in the NT in 2019, 61% worked in Darwin & Palmerston. This is relatively representative of the Top End population distribution, with 60% of the 2019 estimated NT resident population living in the greater Darwin area. Conversely 20% worked in Alice Springs while just 11% of the 2019 estimated NT resident population live in Alice Springs. The remainder worked in Katherine, East Arnhem, and the Barkly.

28% of psychologists reported working in private practice (46% nationally), 13% working in the ACCHO sector compared with 0.4% nationally and a further 17% in community-based mental health services compared with 12% nationally (Table 3). This distribution reflects greater involvement of the ACCHO and community sector and dependence on funding outside of MBS billing arrangements in the NT.[6] It also suggests that private providers funded through MBS represent an opportunity for demand driven workforce growth. Psychologists in the NT were slightly younger and less experienced than the national profile (Table 3).

Charles Darwin University provides the only NT-based tertiary psychology training pathway, including offerings in Diploma of Psychology, Bachelor of Psychological Science, Bachelor of Psychological Science Honours, Bachelor of Psychological Science Graduate Entry and Master of Psychology (Clinical). Provisional registration as a psychologist requires completion of a four-year honours degree. CDU currently offers two pathways for provisionally registered psychologists to obtain general registration, including:

- 4+2 pathway – Two-year internship (This pathway is closing, and no new applications for provisional registration to undertake the 4+2 internship program will be accepted beyond 30 June 2022).
- Higher degree pathways – Fifth- and six-years master's degree or combined Masters/PhD or Doctorate – these pathways can also lead to practice endorsement in clinical psychology.

The productivity commission noted that completion of psychology studies was not closely related to registrations as a psychologist, attributed partly to the limited availability of supervised internships and a declining number of approved supervisors [1]. Currently, approximately six to ten students graduate from CDU as fully qualified psychologists each year. This is from a starting undergraduate cohort of approximately 100 per year (53 equivalent full-time student load) in the undergraduate program of which approximately 58% are from the NT. In 2017, there were 113 provisional registrations granted in the NT, with this number dropping to only 47 in 2020 (see Table 2). This is attributed to a decision by CDU to reduce the intake of students to the program between 2016 and 2018, as well as challenges for potential students in accessing and paying for supervision. In March 2021, just 0.6% of provisional registrants and 0.6% of board approved supervisors identified their

principal place of practice as the NT despite the NT having 1% of the national population. A recent increase in CDU capacity is expected to result in larger intake into post graduate pathways in 2022, however the need to increase the number of intern positions and board approved supervisors remains.

National phasing out of the 4+2 pathway from 2024 will mean that 2021 graduates will be the last with access to this pathway. The potential impact of this is unknown and should be closely monitored, however CDU are currently developing two additional pathways as alternatives. Internships, which are generally paid positions, will be critical to these pathways and therefore to the movement of CDU psychology graduates into the mental health workforce.

Of the 47 provisional NT registrants in 2020, approximately half were undertaking the Master of Psychology (Clinical). Psychologists who have completed this higher degree pathway may undertake a registrar program of 1-2 years further supervised practice to become a clinical psychologist. A clinical psychologist is a psychologist is an expert in mental health having completed specialised training in the assessment, diagnosis, formulation, and psychological treatment of mental health, behavioural, and emotional disorders[18]. In the NT 19% of generally registered psychologists have clinical psychology endorsement compared with 30% nationally.

Territory Families currently play a significant role in the provision of employment for 35 students in CDUs graduate program, although this is a time-limited program, and a lack of qualified/available supervisors is an on-going challenge. Even more challenging is the ability of many services, particularly remote services, to provide student placements. In addition to lack of supervision, the resourcing and time required to coordinate and support student placements is considerable and often competes with front-line service delivery priorities. With COVID-19, previous requirements for face-to-face supervision have been lifted to enable remote supervision by telehealth which may move some of the burdens of support for placement away from providers. However, there remains a need to address the issue more holistically, taking account of the range of resourcing and support requirements necessary. CDU has implemented an 'in house' placement program through the CDU run Wellness Centre in response to these difficulties.

Table 1 Provisional registrants by pathway in the NT – 2013 to 2020

Pathway	2013	2014	2015	2016	2017	2019	2020
4+2 Internship	118	55	52	51	53	14	17
5+1 Internship	3	2	5	10	15	6	7
Higher Degree program	20	21	18	21	25	22	22
Transitional Program	-	19	15	15	20	1	1
	141	97	90	97	113	43	47

Source: Australian Psychology Board[19]

Mental Health Nurses

Issued by the Australian College of Mental Health Nurses (ACMHN), the Mental Health Nurse Credential "recognises the qualifications, skills, expertise and experience of nurses who are practicing as a specialist mental health nurse". [20] Of the 994 credentialed MHNs in Australia in 2020/2021, eleven are registered in the NT[21, 22] representing equitable distribution of this very small specialist

workforce relative to population. Data drawn from the NHWDS does not distinguish between nurses with or without a mental health credential. It does, however, identify nurses whose primary job role was in mental health in the week prior to their registration renewal. Based on headcount, the number of nurses who reported working in a mental health setting in the NT declined, from 217 in 2013 to 190 in 2019 (Table 3). This represents a reduction from 9 to 7.7 nurses per 10,000 people working in a mental health role or setting. Over the same period, maldistribution increased with the number of nurses working in a mental health role/setting nationally rising from 8.7 to 9.5 per 10,000 people (Table 4).

While the number of nurses working in mental health per 10,000 people in the NT is significantly lower than that experienced nationally, the total number of total nurses per 10,000 population is significantly higher than the national rate (Table 4). While this reflects a combination of burden of disease and model of primary care service delivery in the NT, and there is no denying the shortage of nurses in many areas of the NT, this data represents an opportunity to attract more of the existing broader nursing workforce into the mental health sector.

Of the NT nurses whose main role was in mental health in 2019, 60% worked in Darwin & Palmerston. This percentage reflects the top end population distribution, with 60% of the NT 2019 estimated resident population also living in the greater Darwin area. Conversely, 30% worked in Alice Springs, while just 11% of the 2019 estimated resident population live in Alice Springs (Table 3).

The majority (59%) of nurses whose main role was in mental health worked in a hospital setting, followed by community-based mental health services (26%). While the proportion working in ACCHOs and private practice were comparatively small, they were notably higher than seen nationally, again reflecting the different funding and model of care in the NT (Table 3).

The age profile of the mental health nursing workforce presents both as a threat and an opportunity. It has been projected nationally that by 2030, the mental health nursing workforce will have a shortfall of 19,000 due to low numbers of new entrants, ageing of the workforce and high exit rates[23]. The age of nurses working in mental health in the NT suggests that as many as two-thirds of NT mental health nurses could retire in the next 10-15 years. An experienced mental health nurse noted that many of her colleagues are starting to retire and added that "*I don't know if there's many young people coming up to replace them*". On the other hand, the current level of experience is conducive to providing a high level of support and mentoring for new nurses moving into this area of specialisation.

Accredited Social Workers

Currently, social workers are not registered under the National Registration and Accreditation Scheme for which Ahpra is the registration body, so therefore do not participate in the Ahpra survey. Only limited data is readily available on this group. AASW report 13,104 members [24] over 270[25] of whom are registered in the NT (including social workers and students). These figures indicate a significantly greater per capita rate of supply in the Northern Territory with 9.9 Social Workers per 10,000 population compared with 5.2 nationally. It should also be noted that there are a number of social workers who are not members of this professional representative body, with ABS estimating that there were approximately 23,166 professional social workers in 2016. [26]

Outside of a strong regulatory framework for the social work profession, the Australian Association of Social Workers (AASW) has introduced a legally protected Collective Trademark scheme to set benchmarks for social workers' professional development and practice standards. Trademarks can be used by social workers who meet the relevant standards to distinguish themselves as professionals with legitimate credentials. Trademarks include[27]:

- Social Worker Trademark – identifies "professionally qualified Social Workers who are accountable to the AAWS Code of Ethics
- Accredited Social Worker (ASW) - includes "professionally qualified Social Workers who are accountable to the AASW Code of Ethics and who have committed to, and completed a minimum amount of on-going, annual, continuing professional development".
- Accredited Mental Health Social Workers (AMHSW) – in addition to the above AMHSW's have "been assessed by the AASW, on behalf of the Commonwealth Government, as having specialist expertise in the field of mental health". This level of accreditation is required to become a Medicare Provider.

Despite a significantly larger per capita supply of social workers, the NT has proportionately fewer accredited mental health social workers. Nationally, 2,200 (14%) social workers registered with AASW are AMHSWs[28] while 14 (6%) of those registered in the NT are AMHSWs[29]. A search of the AASW's publicly available "Find a Social Worker" database (March 2021) produced results indicating that there are at least 13 social workers in private practice in the NT (10 in Darwin and 3 in Alice Springs). Of these 6 are identified as Medicare providers (4 in Darwin and 2 in Alice Springs)[29].

CDU offers a Bachelor of Social Work and Master of Social Work (Qualifying) in Darwin and online. In 2020 there were approximately 300 enrolments, with 45% of these students based in the Northern Territory. Charles Darwin University reports good employment outcomes with anecdotally more vacancies than graduates.

There are also numerous Vocational Education and Training (VET) pathways into tertiary education in social work, including:

- Certificate IV in Mental Health > Diploma of Social Care > Bachelor of Social Work
- Certificate IV Alcohol and other Drugs > Diploma of Social Care > Bachelor of Social Work
- Diploma of Mental health > Diploma of Social Care > Bachelor of Social Work
- Diploma Alcohol and other Drugs > Diploma of Social Care > Bachelor of Social Work

These align closely with a number of non-clinical roles in the NT and therefore suggest a very credible pathway for development of a local Aboriginal workforce.

Occupational Therapists

Occupational Therapists (OT's) can work across the spectrum of mental illness, providing services to people with mild, moderate, and severe mental health conditions. OTs require a BAMH Endorsement from Occupational Therapy Australia (OTA) to become a Medicare Provider under Better Access to Mental Health program. This requires a minimum of two years full time (or equivalent) supervised post-graduate experience working in mental health and meeting all the domains of competency set by the Ahpra Occupational Therapy Board of Australia.[27] According to the OTA website search

function, there are no BAMH endorsed OTs available in the NT. Once again, there appears to be an opportunity for future demand-driven workforce development by encouraging BAMH endorsement.

The NHWDS does not distinguish between OTs who do or do not have an OTA Mental Health Endorsement. It does, however, identify OTs for whom mental health was their main scope of practice in the week prior to registration renewal. Of the 163 OTs who worked in the NT in 2019, only 10 (Table 3) identified their main scope of practice as mental health (6%, compared to 12% nationally). OTs whose primary role was in Mental Health were on average older than the national profile and located in Darwin or Alice Springs. Due to the small numbers, conclusions from this data are limited.

CDU offers a Bachelor of Health Science/Master of Occupational Therapy tertiary pathway to become a qualified OT. This is a new course, commencing in 2020. CDU are currently seeking accreditation with the Occupational Therapy Council of Australia Ltd and approval by the Occupational Therapy Board of Australia. There are approximately 160 students currently enrolled across the first three years of the Bachelor of Heath Science/ Master of Occupational Therapy (student registration can only occur once the program has been accredited). One-third of the course enrolments for 2020 were based in the Northern Territory with four students enrolled living in Alice Springs and 38 living in Darwin and its surrounds. Intensives to be run from Darwin Campus in most semesters will introduce interstate students to the Northern Territory with the objective to attract some of these students to apply for positions here. The first cohort of graduates is expected at the end of 2021. The graduate cohort and need for undergraduate placement providing an opportunity to attract this cohort into mental health.

Table 3 Mental Health Practitioners Working in the NT

		Psychologists	Nurses and Midwives - Mental Health	Occupational Therapists - Mental Health	AMSWs
NO. PRACTITIONERS	2019	176	190	10	14
	2013	193	217	9	
FTE (Total)	2019	171.6	193.1	10.0	
	2013	197.0	229.9	8.1	
FTE (Clinical)	2019	120.4	178.6	8.7	
	2013	138.0	206.4	8.1	
LOCATION	Darwin & Palmerston	61%	60%	70%*	
	Alice Springs	20%	30%*	30%*	
	Rest of NT	18%	10%*	30%*	
AGED <35 yrs.	NT	24%	23%	30%	
	National	21%	25%	47%	
Country of Qualifications - Overseas	NT	10%	0	0	
	National	7%	0	8%	
SELECTED PRACTICE SETTINGS[b]	Hospital/Outpatients NT	6%	58.9	<3	
	Australia	7%	67%	39%	
	ACCHO NT	13%	4%	0	
	Australia	0.4%	0.2%	0.2%	
	Community NT	17%	26%	<3	
	Australia	12%	20%	34%	
	Private Practice NT	28%	2%	0	
	Australia	46%	1%	9%	
	Other NT	37%	10%	<3	
	Australia	35%	11%	18%	
TIME IN WORKFORCE	≤ 5 Years NT	25%	25%	<3	
	Australia	19%	25%	28%	
	≥ 11 Years National	47%	45%	<3	
	Australia	57%	50%	44%	

Table 4 - Mental Health Practitioners by 10,000 population, 2013 and 2019

	2013		2019	
	NT	Australia	NT	Australia
	Rate per 10,000		Rate per 10,000	
Psychologist	8.0	10.0	7.2	11.2
Mental Health Nurse	9.0	8.7	7.7	9.5
Nurses and Midwives	134.2	112.8	158.3	124.4
Social Worker*			9.9**	5.2**
Occupational Therapist (MH)	0.4	0.7	0.4	0.9
Occupational Therapist	4.3	5.1	6.6	7.0
General Practitioner	12.8	11.3	14.6	12.6
Aboriginal Health Practitioner	7.9	0.1	6.5	0.2
Psychiatrist	0.7	1.3	1.2	1.5
Total	38.7	32.1	37.6	35.9

Source: National Health Workforce Data Set, derived from APHRA registration data 2019
**Source: Australian Association of Social Workers Annual Report 2019-2020*
*** Calculation based on 2019 Estimated Resident Population*

National Mental Health Services Planning Framework

The National Mental Health Services Planning Framework (NMHSPF) tool uses national averages to calculate the optimal level of investment in mental health services, including workforce, for a given jurisdiction. Ideally, this would provide a useful comparison between current and desired staffing levels. However, the NMHSPF has several key limitations, including a decrease in robustness in populations of less than 250,000 people and no way to adjust for the unique needs of remote populations or populations with a high proportion of Indigenous peoples. While additional modules due to be released in late 2021 will allow better predictive outcomes for remote and Indigenous populations, the small population size in the NT will remain an issue. NT PHN will review the feasibility of undertaking the complex work to understand current sector staffing levels against the NMHSPF standards once the new content is available.[30]

NT Mental Health Future Workforce: Strategic Considerations and Needs

A number of strategic considerations impact on what is required of a mental health and suicide prevention workforce in the Northern Territory. A model of care driven by individual needs of consumers and the remoteness and unique needs of Aboriginal people that characterise the NT point to cultural competence and trauma-informed approaches as crucial. This also highlights the importance of an Aboriginal workforce and the significant roles that non-clinical and lived experience workers will play in successful workforce models, particularly in optimising the value of clinical roles. Community-based training utilising VET pathways is needed both to grow the non-clinical and lived experience workforce and as a pathway to increasing our own clinical workforce. Exposure of students to, and capacity to support early careers health professionals in remote practice, is proven to improve remote workforce outcomes. However, in traditional approaches, the small size, workload and/or experience of the remote workforce can limit capacity to provide the required mentoring and supervision.

Retaining our existing rural and remote workforce will continue to involve addressing professional loneliness, providing access to professional development, managing workloads, workplace safety and vicarious trauma. Increasing the capacity of the broader health sector to support mental health needs of their clients will mitigate the impact of the undersupply of mental health workforce in the NT. Equally, continuing innovation in adapting workforce models to meet community needs, address workforce shortages and maximise emerging opportunities will ensure the most is made of the workforce we have.

As mentioned previously, this report focuses on issues more specific to the mental health workforce while those affecting the Allied Health workforce as a whole are addressed in previous reports[31].

Implementation of the Stepped Care Model

Under the 5th Plan, the implementation of the stepped care model across the Australian health system is a driver of future workforce development. Broadly "stepped care involves providing person-centred care, targeted at the individual needs of consumers for mental health services. It involves moving from a provider-driven approach to a service system genuinely designed with, and for, consumers and carers"[32]. Determining specific workforce models and requirements to implement stepped care in the NT is contingent on mapping needs and service gaps. This work is being undertaken as part of the NT Regional Mental Health and Suicide Prevention Plan development. While a stepped care workforce will comprise a full range of clinical and non-clinical professions, many stakeholders noted the lived experience workforce as a vital consideration in the development of a stepped care model.

Cultural Competence and Safety

Spirituality, ancestry, and connection to country are key elements of Aboriginal and Torres Strait Islander culture[33]. The general workforce is not always well equipped with the knowledge, experience, or tools to effectively deliver mental health supports within the Aboriginal and Torres Strait Islander cultural context, and this may adversely impact the trust and cultural safety experienced

by Aboriginal and Torres Strait Islander consumers and co-workers. This frequently results in Aboriginal people disengaging from the service, leading to unmanaged mental health conditions, late diagnosis and misdiagnosis when presenting to acute settings. [33]

Molloy et al. (2020) revealed that mandatory training in Indigenous health has not necessarily reached a degree of maturity or depth to enable effective delivery of mental health care to Aboriginal and Torres Strait Islander people.[34] All key informants identified cultural competence and training as being integral to both staff development and workforce models. One key informant noted the responsibility held by the service to support a staff member who had come to the NT from Sydney with no prior rural or remote experience and/or experience working with Aboriginal and Torres Strait Islander people.

"And we have a responsibility to make sure that she doesn't really harm. It's not about her clinical skill set, but how to make sure that she doesn't do or say the wrong thing, or even ask a question that can be, without her knowing, offensive. That's the biggest concern and the critical stuff she can learn".

Another stakeholder highlighted the efficacy of a 'both ways' approach to learning where there is a sharing of cultural, clinical and non-clinical knowledge amongst Aboriginal and non-Aboriginal staff respective of their different knowledge and skill sets. This approach is more likely to promote a balance of power through which different types of knowledge are equally valued, and sustainable change is supported.

Key strategies to build a culturally competent workforce include: [35-37]

- Incorporating Aboriginal and Torres Strait Islander leadership in workforce programs
- Increasing Aboriginal and Torres Strait Islander employment in social and emotional wellbeing programs
- Developing place-based workforces and creating pathways for Aboriginal education and training, targeting current and emerging professionals
- Training all staff in Aboriginal and Torres Strait Islander concepts of social and emotional wellbeing and mental health
- Appropriate clinical supervision of mental health and social and emotional wellbeing practitioners.
- Recognition of traditional healers, Elders, and other cultural healers as an integral component of the social and emotional wellbeing workforce.

Trauma-Informed Care

Several stakeholders highlighted the critical need to ensure that the mental health workforce, and the health workforce more broadly, is equipped to provide care in trauma-informed ways. This requires a comprehensive understanding of the impact that trauma can have on individuals, families, and communities. While both Indigenous and non-Indigenous people may experience various traumas throughout their lives, for Aboriginal people, these life traumas are often compounded by intergenerational trauma stemming from colonisation, ongoing displacement and dislocation from country, culture and family[38].

The mental health workforce is at the frontline of supporting and caring for people who live with the legacies of these traumas. Therefore, it is salient to ensure that both Indigenous and non-Indigenous mental health professionals are cognizant of the challenges and the necessary knowledge and skills

required to work in this specialised area of mental health. Stakeholder feedback noted that people living with the impact of trauma are often misdiagnosed and receive inadequate forms of treatment, highlighting the need for practice and programs to be robustly trauma-informed and equipped to work in this complex, and at times challenging.

Further, it is important to ensure that the mental health workforce, and in particular Aboriginal health workers, are appropriately supported in recognition of the potential triggering effect that working in this area can have. The mental health workforce should also be well supported in managing the risk related to vicarious trauma.

Aboriginal Workforce

The principles underpinning the National Strategic Framework for Aboriginal and Torres Strait Islander People's Mental Health and Social and Emotional Wellbeing 2017-2023 highlight the significance of Aboriginal culture, kinship and connection to the environment to the social and emotional wellbeing of Aboriginal people.[3] In this context, it is recognised that "culture is… critically important in the delivery of health services" [3]. A well trained, supported, and resourced Aboriginal social and emotional wellbeing workforce is critical to the delivery of equitable and culturally safe services. Expanding this workforce requires investment in opportunities for higher education, recognising existing skills, successful transfer of tacit cultural knowledge and effectively working with education providers, families and community leaders.[35]

The downward trend in the number of Aboriginal Health Practitioners (AHP) is of particular concern. Promoting training pathways and leveraging from other opportunities such as the development of the new Health Coaching VET qualification, led by Katherine West Health Board, will be critical to developing the scale of the Aboriginal health and social and emotional wellbeing workforce in the NT over the coming years.

Strategies that are specific to the current and future Aboriginal workforce are critical. The challenges and barriers faced by Aboriginal people, particularly those living in remote communities, are significant, and there is ongoing tension between 'mainstream' clinical methods and traditional healing approaches. The integration of mainstream and traditional approaches crosscuts the overarching need for integration of clinical and non-clinical practice. This cultural layer adds a degree of complexity and depth to the set of issues surrounding the capacity of multi-disciplinary workforce teams to deliver holistic and person/family/community-centred care for Aboriginal people.

Community-based VET pathways are widely considered more accessible and appropriate for Aboriginal people, particularly if delivered on community. There is a wide range of barriers that exist for Aboriginal people in accessing VET and tertiary pathways. While stakeholders and literature widely cite these barriers, a commitment to solutions at the NT level will require close engagement with education providers, relevant peaks, service providers and, most importantly, Aboriginal communities.

Clinical and non-clinical workforce

Stakeholders emphasised the significance of the non-clinical workforce to the sustainability of the mental health and social and emotional wellbeing workforce in the NT. This is particularly relevant to the remote Aboriginal community-based workforce where cultural knowledge and expertise are

crucial to the meaningful and effective provision of social and emotional wellbeing services (or, indeed, any service) to families and communities.

Stakeholders considered the interface between clinical and non-clinical practice at various levels: the broad interface between clinical and community-based services; service models within organisations delivering Comprehensive Primary Health Care; and the specific requirements for clinicians to work more effectively with non-clinical counterparts. While educational pathways for Aboriginal people employed in social and emotional wellbeing support roles are frequently a key area of focus, key informants noted that this, in isolation, will achieve little benefit if the clinical mental health workforce is not sufficiently trained and supported to work with, understand and respect the roles of their non-clinical colleagues.

The development of a lived experience workforce was raised by numerous stakeholders as a critical consideration for the future stability and sustainability of an NT-based mental health workforce, a sentiment strongly supported in policy and literature[1, 36]. Mental Health Association of Central Australia is currently leading *Promoting Peer Work in the NT – 2020*[i][1]. This is an NT-wide project funded by the National Disability Insurance Scheme to create economic opportunities for lived experience workers in the Northern Territory. The project has two key aspects: training for peer workers and an organisational readiness program to encourage employment opportunities. Importantly, the organisational readiness component of this project addresses how to integrate a lived experience workforce into existing clinical and non-clinical structures and, conversely, how to build structures that would appropriately support peer workers with the tools to use their lived experience in meaningful and supported ways. Building the capacity of the clinical mental health workforce to understand the role(s) of peer workers and provide the necessary clinical supports for this group is a key consideration for future workforce planning and development.

Here, non-clinical refers to a range of occupations such as mental health support workers, Aboriginal liaison officers, community-based workers, care coordinators and lived experience workers. Stakeholder feedback described a lack of understanding of how organisational interfaces and structures can incorporate the clinical and non-clinical workforce and how non-clinical roles can be best supported to apply their lived experience in a safe and culturally appropriate manner.

Training and Development Pathways

There is growing evidence that a locally trained mental health workforce is easier to recruit and heralds better retention outcomes in remote areas.[7] 'Growing our own' was a key theme identified by stakeholders in the 2018/2019 Allied Health Needs Assessment and has been reinforced by key informants through this needs assessment process.[31]

'Growing our own' is a key strategy to ensure that the NT has a strong and sustainable workforce into the future. However, a lack of training pathways and access to supervision, particularly among remote services where health professionals are often sole providers, busy and sometimes junior, remain barriers.

Community-based pathways

Training pathways on country is a key priority. Stakeholders widely recognise that 'employ-first-then-train' models are preferable for Aboriginal people and more likely to lead to successful outcomes.

Training opportunities 'close to home' are more likely to attract people living remotely into health careers. There are significant costs associated with the provision of training in remote areas, and these are not met through standard VET funding arrangements. Stakeholders also highlighted the complexity of the VET system, difficulties identifying RTOs that have qualifications on scope, and challenges accessing funding to support the training of their community-based workforce. Stakeholders also noted the importance of tailoring training to meet the learner's needs initially, who can then be supported to grow towards the organisation's goals and priorities. However, while this is an ideal scenario, employers must manage the tensions between learner needs, resourcing, and organisational priorities.

In addition to limited exposure to higher education, there are other barriers to entry into and successful completion of tertiary studies for Aboriginal people living remotely in the NT. These are linked to cultural connections and obligations, family responsibilities, language barriers and a range of other factors.

NT PHN has recently commissioned AMSANT to commence a project that will provide training on country for AHPs in East Arnhem in partnership with Miwatj Health Aboriginal Corporation. This is an important step in the development of training models that can be delivered locally.

The Indigenous Allied Health Australia (IAHA) National Aboriginal and Torres Strait Islander Health Academy model aims to address barriers by working collaboratively across disciplines and organisational structures (health, education, training, and employment) to increase Aboriginal and Torres Strait Islander high school student engagement, retention, and successful completion of Year 12 with a Certificate III in Allied Health Assistance. The Academy works with high school students from years 7-12, starting with health literacy and progressing to leadership and career planning. In years 11 and 12, students transition into the Health Academy through a fully supported school-based traineeship that involves on the job training and wrap-around supports for an individual learning program.

A community controlled Regional University Centre in Wuyagiba (East Arnhem Land), set up by the traditional owners and delivered in partnership with Macquarie University provides facilities, administrative and academic support services and pastoral support to local Aboriginal students studying two-way pre-Uni preparation courses. Future plans include providing accredited Uni courses on country delivered by distance from any Australian Universities[39].

Pathways into remote practice

Prioritising students from remote areas for university entry is a well-cited means to promote the growth and development of the remote health workforce [40]. One key informant stated that they only take students studying in the area because they are more likely to give back to that area. However, it is also broadly recognised that many people living in remote areas may have had limited opportunities for higher education, and wrap-around supports are required, such as bridging courses, financial, pedagogical, and pastoral support.[40]

Evidence demonstrates that health professionals are more likely to work in a rural location if they have had exposure to such a setting during their undergraduate period, with the intention to work in a rural location increasing with the length of rural exposure.[33] [41] This theme was reinforced by key informants who frequently cited the importance of student exposure in supporting pathways to remote practice. In a discussion regarding psychology students, one provider identified that

supporting psychology (Masters) students had brought people to the region". Notably, 70-80% of students undertaking Master of Social Work studies at CDU are mature age and complete their studies on a part-time basis. Approximately 50% of these students have completed their undergraduate studies interstate and a small portion overseas. This suggests that these students have made a specific decision to experience the NT, and it is reported that the majority would like to secure employment in the NT upon completing their studies. This includes a willingness to work remotely.

However, the capacity to provide supervision support for student and early career placements in remote health services represents a significant barrier to growing an NT based health workforce.

"…. we can't take social workers or psychologists or anything because we don't have supervision and we don't have anyone that can do that".

"We only accept students that are with CDU that are actually working at the Katherine Hospital because we're such a scant team [and] students take a lot of effort and a lot of work".

While CDU has been successful in attracting a cohort of clinical psychology and social work students willing to undertake remote placements, the lack of supervision capacity in remote services frequently results in a reliance on Darwin-based services to accommodate placements. Difficulties in accessing placements are exacerbated for those training with online or interstate RTOs where relationships between RTOs and providers are limited.

As a result of the COVID-19 response, the requirement for face-to-face supervision arrangements has been relaxed to enable tele-supervision. If these arrangements continue, this presents an opportunity to facilitate more remote placements in services where supervision capacity is limited. However, this does not consider the overall demand on services when supporting placements such as local orientation and training, direct supervision of clinical learning, access to clinical infrastructure and accommodation requirements.

Pathways into the mental health sector

Encouraging people into mental health careers will require a multi-faceted approach. Mental Health careers should be promoted to both those considering a health career and as an area of specialisation for existing health professionals. This promotion must be supported by activities that provide positive messaging and improve the appeal of the sector as a career[1].

Data (Table 4) indicates that opportunities may exist to attract nurses and social workers in particular, to transition from other health sectors into mental health as there is a healthier relative supply of these professions in the NT. Equally, the small proportion of occupational therapists and nurses currently working in mental health and the expected increase in occupational therapists through CDU identify these groups as a potential untapped workforce. Efforts to provide opportunities for undergraduate and postgraduate students and career health professionals working in other sectors to increase their knowledge of and exposure to mental health would encourage this transition.

Career Development Pathways

Stakeholders suggest that a lack of clearly visible career pathways within the NT mental health sector may contribute to new graduates choosing to work interstate. This may be, in part, due to many organisations having small-discipline specific cohorts unable to distinctly articulate and

support pathways from graduate to senior clinical roles within the organisation. Stakeholders suggested that an opportunity exists to encourage larger employers to more clearly articulate internal pathways as well as identifying and articulating career paths spanning employers and sectors.

Supporting our existing workforce

Professional loneliness can have a significant impact on the retention of rural and remote mental health professionals[1]. Attraction and retention of health professionals in the primary mental health sector can be improved through peer support and access to professional networks[36]. Stakeholders reported that mental health professionals may work as sole practitioners in their discipline within small remote non-government or Aboriginal Community Controlled Organisations. Line managers may be from a different discipline, often nurses or non-clinical managers and the lack of professional practice support can result in poor retention.

Stakeholders also note that professional development is particularly important in the NT context, given the broad scope of practice required in remote locations, including the shift towards rural generalist workforces and the population's unique needs. However, access to these supports is particularly difficult given the challenges of distance, access to locum/relief support and critical mass in the Northern Territory.

Job satisfaction, workload and vicarious trauma also have a significant impact on the retention of mental health professionals. Leadership and supportive work environments are critical in managing these variables[1]. Previous needs assessments undertaken identify a range of factors affecting recruitment and retention of allied health professionals, and these should also be considered here [31].

Broader Health Sector Capability

GPs have been identified as the "frontline of the mental health workforce[36]" and a "relatively accessible gateway to mental healthcare" [1] and therefore it is particularly important that they are "equipped to detect, diagnose and respond to mental health problems"[36]. In remote and Indigenous health settings, this role is often taken by the Aboriginal Health Practitioner and/or the Remote Area Nurse.

The productivity commission report[1] notes that GPs provide more mental health treatment than psychologists and psychiatrists combined, even more so in rural areas. This is somewhat attributed to the role of the GP as the instigator of Mental Health Treatment Plans. However, data shows that Northern Territory GP's claims for mental health MBS items are at half the national rate (Table 1). While this report focuses on the clinical workforce needs of the primary mental health sector, a recurring theme in consultations was the need to improve the capacity of the whole of the health and social care sector to support the mental health needs of their clients. Stakeholders noted that in doing so, demand on the specialised mental health workforce would be better managed, and the impact of the 'undersupply' of mental health professionals/services will be less pronounced.

Workforce Models

One stakeholder identified that they have two mental health positions to cover a region that encompassed 336,674 km^2, three shire zones and 18,646 people. Other stakeholders noted that due to the small size of their communities, they were often funded for service types or programs at a portion of an FTE while the capacity to recruit to part-time positions in rural and remote locations is severely limited. With numerous small and geographically dispersed populations, economies of scale can be difficult to achieve. Add to this the unique cultural complexities and difficulty in recruiting and retaining a workforce. This highlights the need for workforce models and approaches that address the unique challenges of our regions.

Stakeholder consultation showed that providers are both intuitively and deliberately adapting mental health service and workforce models. Examples included changing the mix of resident and visiting services, clinical and non-clinical roles (vertical substitution), integrating service types with synergistic goals and substituting health professions (horizontal substitution). Action 16.1 of the Productivity Commission Report notes that "workforce planning should factor in the potential for substitution between occupations and consider new ways of meeting consumer needs"[1]. However, while cost savings measures drive the productivity commission concept of substitution, adaptations reported by providers, were prompted by a combination of workforce shortages, sustainability and resilience imperatives and consumer needs. Examples described more diverse roles implemented to complement and supplement traditional roles, including positions designed to better meet cultural needs or locally based paraprofessionals to complement fly-in-fly-out professionals. While stakeholders embraced opportunities to consider different workforce models, they suggested caution in clearly defining and understanding each model's scope of practice and supervision needs. Stakeholders also suggested that substitution can also have a negative impact on recruitment outcomes. Roles advertised using the practice of 'broadbanding', where providers may, for example, advertise roles as requiring qualifications in "psychology, social work or occupational therapy", can be perceived by health professionals as not recognising, valuing, or having the capacity to develop their particular skill set.

Stakeholders have also reported an increase in the use of telehealth over recent years, propagated by COVID-19. However, providers noted this as evident in some cohorts and service types more than others, and while being 'pleasantly surprised' by consumer take-up during COVID-19, it is unclear as to whether this endured once the Northern Territory restrictions relaxed. Stakeholders and literature reflected barriers including consumer digital literacy, access to, and comfort with, this medium and the need for facilitation at the consumer end. The use of telehealth and other forms of virtual care is consistently supported in the literature as "a potential alternative approach to combating issues of distance and service delivery" [36] while professional bodies consistently call for caution seeing telehealth as complimentary and offering alternatives to, rather than a replacement for, face to face delivery[1].

While stakeholders noted that NDIS has created greater competition for a limited workforce pool, there was also acknowledgment of the potential that cross-sectoral coordination could produce economies of scale by bringing together demands from aged care, disability, primary care, and other sectors to create viable roles at a local community level.

Current Mental Health Workforce Initiatives:

Both nationally and within the NT, there is much activity in this space; coordination and integration of this activity will be critical, supporting and building on the activity already underway.

Mental Health Workforce Strategy

The development of a National Mental Health Workforce Strategy is currently under way. The strategy will "consider the quality, supply, distribution and structure of the mental health workforce" and will look at approaches that can be taken to improve the attraction and retention of a mental health workforce.

2021/22 Federal Budget

The 2021/22 Federal Budget outlined a range of initiatives to strengthen workforce and governance arrangements. These included initiatives to grow the mental health workforce, including through scholarships and clinical placement supports. Workforces specifically targeted included psychiatry, those working with children and families and the Aboriginal and Torres Strait Islander mental health workforce. Measures were also announced to improve mental health training for GPs and the aged care workers, promote mental health as a preferred career option and reduce mental health stigma among health practitioners.

CDU-NTG Health Collaboration Committee: Mental Health Workforce Working Group

A mental health workforce working group has been convened through a collaboration between Charles Darwin University and the Northern Territory Government. The Working Group will provide advice on the development of a mental health workforce to match current models of care, the Northern Territory context, and future aspirations. In particular, the group will consider the training needs for both the current and future mental health workforce and how interdisciplinary and collaborative training and education can be best provided across CDU and NT Government. Membership includes representatives of NT Health, CDU, NT Department of Education, NT PHN and the NT Mental Health Coalition[42].

AMSANT

AMSANT's AOD and Mental Health Support Program provides information and training sessions to health services and clinical staff across the NT, building the primary health care workforce skills and capability in coping with trauma. The program provides ongoing support, mentoring and clinical supervision support through Aboriginal professionals with extensive experience in trauma and Social and Emotional Wellbeing. This enables mental health care workers to feel strong and confident in their roles. The Damulgurra support team provide Culture Response Trauma Inform Care (CRTIC) training which has been developed in consultation with Aboriginal communities and elders in the NT. The training focuses on local experiences and knowledge of trauma and healing that is demonstrated from a local cultural context. The Workforce Development Support unit has undertaken a Needs

Analysis to establish a comprehensive picture of workforce training and support needs across the sector[43].

Regional Planning

The Fifth Plan and the Northern Territory Mental Health Strategic Plan 2019-2025 [2, 4] are aligned in prioritising the coordination of care through regional planning[9]. In the NT mental health system, care is provided by primary health clinics, Aboriginal Community Controlled Health Services, Specialist Tertiary Mental Health Services, Top End Mental Health Services, Central Australian Mental Health Services, and non-government community managed mental health services. NT PHN is funded by the Australian Government to facilitate the development of an evidence-based Joint Regional Mental Health and Suicide Prevention Plan to support the integrated delivery of mental health and suicide prevention services. The Plan will identify needs and gaps, reduce duplication, remove inefficiencies, and encourage innovation. A regional planning approach that includes workforce planning provides a significant opportunity for RWA NT and a key foundation for mental health service integration in the NT.

Emerging Opportunities

Needs assessments in previous years have led to the development of four RWA NT priority areas, including:

1. Develop the Aboriginal workforce – clinical and non-clinical.
2. Develop pathways into and through health careers.
3. Attract, maintain, and retrain workforce in the NT.
4. Develop locally responsive sustainable models of care.

This section provides an overview of key findings concerning each priority area and suggests how we may consider these findings with respect to future solutions. This is intended as a stimulus for further discussion and planning with stakeholders, including the HWSG and through the NT PHN led Regional Mental Health Planning process.

Findings	Opportunities	Relevant Priority Area
Funding is fragmented, with roles and responsibilities spread across numerous government and non-government agencies and the private sector. The result is a fragmentation of the workforce along with poorly coordinated and inefficient training and development initiatives to support them. While the Northern Territory Government has introduced five-year funding cycles for mental health and suicide prevention, short-term Commonwealth funding cycles continue to have a negative impact on workforce retention.	Advocate for Commonwealth to implement longer-term funding cycles.	Priority Area 4: Develop locally responsive, sustainable models of care
	Support, encourage and advocate for activity that coordinates and integrates mental health (and other related) policy initiatives and funding cycles to support workforce models that facilitate services close to home, are resilient, flexible, and sustainable.	Priority Area 4: Develop locally responsive, sustainable models of care
	Work within mental health regional planning process to identify and support opportunities to develop integrated workforce models and training approaches that increase capacity to deliver resilient, flexible, and sustainable services close to home.	Priority Area 4: Develop locally responsive, sustainable models of care
Workforce growth to meet community need is limited in bulk funded services by fixed and unpredictable funding allocations, whereas MBS is an 'unlimited' source of funding with growth limited	Consider initiatives that investigate how MBS can be maximised to attract and sustain workforce.	Priority Area 4: Develop locally responsive, sustainable models of care

Findings	Opportunities	Relevant Priority Area
only by workforce capacity and the viability of the MBS funding model.		
The number of psychologists working in mental health in the NT is decreasing, per capita supply is significantly lower compared with national ratios and this disparity continues to increase. However social workers as a whole, however, are more prevalent in the Northern Territory with greater numbers per capita than found nationally.	Consider workforce models that maximise potential role of social workers. Encourage social workers working in other fields to consider specialisation and/or employment in mental health	Priority Area 4: Develop locally responsive, sustainable models of care
The proportion of the total occupational therapy workforce working in mental health is small. Along with the potential increase in supply resulting from the new training pathway through CDU, this discipline represents a potential future mental health workforce.	Consider workforce models that maximise potential role of occupational therapists. Encourage occupational therapy students and occupational therapists working in other fields to consider specialisation and/or employment in mental health	Priority Area 3: Attract, maintain, and retain workforce within the Northern Territory
Nursing is the largest discipline of mental health workforce. Given overall numbers and the relatively small proportion currently working in the mental health space, there is potential to attract more nurses to mental health as an area of specialisation.	Consider workforce models that maximise potential role of occupational therapists. Encourage nurses working in other fields to consider specialisation and/or employment in mental health	Priority Area 3: Attract, maintain, and retain workforce within the Northern Territory
A model of care driven by individual needs of consumers, remoteness and the unique needs of Aboriginal people point to cultural competence, safety, the ability to work in trauma informed ways and increased Aboriginal participation in the workforce is essential.	Increase opportunities for mental health professionals to improve proficiency in trauma informed and culturally appropriate care. Support the development of an Aboriginal mental health and suicide prevention workforce	Priority Area 3: Attract, maintain, and retain workforce within the Northern Territory
Stakeholders highlighted the importance of considering the interface between clinical and non-clinical roles and the need to build the capacity of	Support the capacity of service models and mental health professionals to deliver multi-disciplinary care integrating non-clinical roles.	Priority Area 1: Develop the Aboriginal and Torres Strait

Findings	Opportunities	Relevant Priority Area
the clinical mental health workforce to work effectively with the non-clinical workforce such as disability support workers, Aboriginal community-based workers, and the emerging peer workforce.	Support the development of lived experience and other non-clinical workforce.	Islander Workforce – Clinical and Non-clinical
Training and development pathways that support 'growing our own' clinical mental health workforce was considered crucial to the development and retention of a sustainable workforce in the NT.	Support activities that increase opportunities for appropriately supported student placement and early years employment	Priority Area 2: Develop pathways into and through health careers

Conclusion

This Health Workforce Needs Assessment (HWNA) is an activity under the Rural Health Workforce Support Activity funded by the Australian Government Department of Health and managed by Northern Territory PHN (NT PHN).

The needs assessment will be used to inform activities that contribute to the following overarching objectives:

- Access: improving access and continuity of access to essential primary health care.
- Quality of access: building health workforce capability; and
- Future planning: growing the sustainability of the health workforce.

NT PHN, in collaboration with the Health Workforce Stakeholder Group and other key stakeholders, will use the findings identified in this report to inform the 2021/2022 Activity Work Plan.

Opportunities identified in the report provide a basis for this work which will take place in the coming months.

NT PHN would like to thank all stakeholders who contributed their time, knowledge, and expertise in assisting us to understand the needs of the mental health and social and emotional wellbeing workforce in the NT.

Appendix A

National Health Workforce Dataset

The National Health Workforce Dataset (NHWDS) was used as the primary data source for sourcing workforce data. The NHWDS is compiled from health professional registration and survey data collected by the Australian Health Practitioner Regulation Agency (AHPRA), – the agency responsible for the national registration of 15 professions. [20]

In general, the definitions and filters used for extracting data aligns with those used by the Australian Institute of Health and Welfare (AIHW) to report on health workforce statistics. As presented, these figures include practitioners who are employed in areas other than clinical practice – e.g., teaching and research. The filters and definitions described below are used throughout this report unless otherwise stated (Table 1).

Table 1: Filters used for extracting data.

Universal Filters:			
Variable	***Filters applied***		***Notes***
Employment	Workforce Status:	Employed in Australia working in registered profession	
Geography	Primary Health Network 2017:	Northern Territory	PHN region where main job was located in the previous week
Specific Filters:			
Profession	***Filters applied***		***Notes***
Mental Health Nurses	Professions:	Nurses and Midwives	For the purposes of this data set, a nurse is a Mental Health Nurse if they have identified their Job Area as 'Mental Health'
	Job Area as a Nurse:	Mental Health	
General Practitioners	Professions:	Medical Practitioners	GPs are a critical part of the mental health workforce, although most are not specifically qualified in this area
	Job Area:	General Practitioner (GP)	
Psychologists	Professions:	Psychologists	The NHWDS does not differentiate between clinical psychologists and others
Psychiatrists	Professions:	Medical Practitioners	
	Primary Speciality:	Psychiatry	
Occupational Therapists	Professions:	Occupational Therapists	
	Scope of Practice:	Mental Health	
Aboriginal Health Practitioners	Professions:	ATSI Health Practitioners	AHP is a generalist role which often has a significant mental health support component. Only AHPRA registered AHPs are included in these statistics

Australian Association of Social Worker Registrations

The Australian Association of Social Workers verbally provided the data cited in this report. This was considered more valid for the purpose of needs assessment than other data available from the Australian Bureau of Statistics. The reasons for this are two-fold: First ABS data reports the qualification type (social work), but this is not a confirmation of accreditation. Second, it is possible that social workers may identify their occupation differently.[22]

Medicare Data

Australian Government Department of Health MBS online website [23] and Australian Institute of Health & Welfare websites [24] were used to obtain Medicare data.

Australian Institute of Health & Welfare (AIHW) Data Tables

AIHW data tables [26] and published reports were used where data was not available from the National Health Workforce Dataset.

NT PHN Recruitment Data

NT PHN recruitment data was sourced from the organisation's internal JobscienceTM (will be stated as Jobscience hereafter) database. This data is limited to recruitment activities that NT PHN undertakes on behalf of primary health care services upon request and is limited to university qualified mental health professions.

Quantitative Data Limitations and Interpretive Considerations

There are several limitations and interpretive considerations stemming from the quantitative data presented in this report. These include:

- Practitioner Numbers: The practitioner numbers extracted from the NHWDS will vary depending on the filters applied to the data set and the randomisation applied to small numbers to protect confidentiality. Therefore, the numbers in this report may differ from those reported in other sources.
- Mental Health Nurses (MHNs): Data inadequacies for this group were specifically noted as a limitation due to the lack of differentiation between mental health nurses and the broader nursing workforce providing mental health care.
- Aboriginal Health Practitioners (AHPs): Aboriginal Health Practitioners cannot be distinguished from specialised Aboriginal Mental Health Practitioner workforce in data extracted from the NHWDS.
- Mental Health Occupational Therapists (MHOTs): Occupational Therapists cannot be specifically distinguished from MHOTs.
- General Practitioners (GPs) and Psychiatrists: National data includes locum doctor headcounts which do not translate to FTE positions. It must be acknowledged that NT is a unique environment in which locums form a key component of the workforce.
- Social Workers: NT PHN relied on verbal information provided by the Australian Association of Social Workers.
- Other professions: There are other professions that may work within the mental health field, but there is not sufficient data available in the NHWDS or other sources to support the identification of mental health-aligned practitioners.

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Version History

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