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National Workforce Centre for Child Mental Health

Scoping child mental health workforce capability: Final Report

May 2024

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Table of Contents

Executive Summary

The project was undertaken to understand more about the existing workforce capability of Australian professionals to support child mental health, particularly in rural and remote areas of Australia. We first sought to understand the number and distribution of children in Australian regions and estimate the prevalence of established and emerging mental health concerns. We then considered the workforce composition of a broad range of professionals to provide child mental health support from a prevention and early intervention perspective, and their respective distribution across Australia. Next we analysed existing workforce competency drawing on Emerging Minds National Workforce Survey for Child, Parent and Family Mental Health survey data and findings from research into evidence-based core competencies that support improved child mental health outcomes. Our research and analysis was complemented by targeted stakeholder consultation with industry experts to inform report recommendations with an understanding of the contextual issues across rural and regional Australia.

The distribution of Australian children

There are 4,004,812 children aged 0-12 years in Australia's population (16% of the total population, ABS Census 2021). About 1.25% of the population is represented at each single year of age. The proportion of the population within each state or territory is similar, although children make up slightly higher proportion of the population in the Northern Territory (18.4%) compared to other jurisdictions. Conversely, children aged 0–12 years are a smaller portion of the population of Tasmania (14.2%) and South Australia (14.6%).

Of particular note, Aboriginal and Torres Strait Islander children are not distributed evenly across regions, and culturally competent service responses should be co-designed with Aboriginal and Torres Strait Islander Communities.

Prevalence of mental health conditions in children

There are numerous data sources estimating the prevalence of mental health disorders in Australian children, each with its limitations. By averaging the prevalence rates found in these various data sources, we can estimate a national prevalence rate of 13% for mental health conditions among children aged 0–12 years, equating to 520,626 children based on the 2021 population. This prevalence rate is consistent with the commonly cited Young Minds Matter prevalence rate of 13.6% overall for 4–11-year-olds from 2013 (Filia et al., 2023).

We found that regional areas had higher estimated prevalence of child mental health conditions than metropolitan areas and remote areas. Using Emerging Minds modelling, we estimated regions that are in major cities have an average prevalence of 11.9% compared to inner regional areas at 17.8% and outer regional areas at 12.7%, while remote areas showed prevalence 6.7% and very remote regions averaged 3.5% of children aged 0-12 years with a mental health condition.

Prescriptions for mental health medications and access of community mental health services among children is more common in regional areas than in major cities, appearing to follow a need that increases with remoteness. However, there is notably lower access to prescriptions and lower number of service interactions for children in remote and very remote areas.

An estimate of potential future mental health concerns can be extrapolated from the Australian Early Development Census that measures the developmental profile of children in their first year of primary school. Estimates indicate that nationally, 11.4% of Australian children starting primary school are developmentally vulnerable on two or more domains, and 22% of children are developmentally vulnerable on at least one domain, indicating an increased risk of developing a mental health condition in later childhood.

Major cities tended to show lower percentages of children developmentally vulnerable on two or more domains. As remoteness increases, the range of levels of developmentally vulnerable children increases. Remote and very remote regions show higher proportions of vulnerable children but also broader range in these proportions, demonstrating both an increased need and increased diversity of that need across different regions. Six remote or very remote regions (out of the 15 measured) had greater than 20% of children developmentally vulnerable on two or more domains.

Risk and protective factors for child mental health

Children's mental health is shaped by the systemic environment in which they live. This environment contains both risk and protective factors that influence the child's mental health and wellbeing. Within the research literature, these risk and protective factors are conceptualised, organised, described and utilised in many ways including categorisation of factors by their proximity to the child. We reviewed the literature to explore the child, family and community risk factors associated with child mental health and wellbeing, as well as to understand their impact and extent to which these factors are modifiable for children aged 0-12 years.

We used this research to estimate the prevalence of risk and protective factors for children's mental health outcomes to indicate the degree of complexity, unmet need or future service need. This data helped to create a profile of population need for children and family mental health support which can inform the design of an optimal workforce and service response.

Without knowing how many children are experiencing multiple risk factors and in what combination, our approach was to estimate the number of risks per local child population to give a general impression of the load of multiple risk across different regions of Australia. This method was limited by the data available however, meaning only selected risk factors from the 2021 Census that have region-level data were included. This analysis also assumes that risk factors have equal weight and impact on children which we know is unlikely to be true. Our analysis found a national average of 1.03 risks per child aged 0–12 years, varying widely across regions and within states, and ranging from an average of 0.4 to 1.63 risk per child.

A relationship was found between the prevalence of risk factors to child mental health and mental health presentations, with the aggregation of risk factors likely to lead to poor mental health in childhood. Risk factors to child mental health are most prevalent in regional areas of Australia, and more risk factors are present with increasing disadvantage of an area. There is a pattern of higher levels of need with increased remoteness from major cities, and although the prevalence of recorded child mental health conditions and service use appears to drop off for remote and very remote areas, the high levels of developmental vulnerability in remote and very remote regions suggest there is unmet or sub-threshold need present. Under-representation of the prevalence of child mental health problems in available data sets is potentially linked to issues such as access to obtaining diagnoses, stigma, low child mental health literacy.

The Australian workforce

In our analysis, we have identified the occupations within the Australian workforce that can play a key role in supporting infant and child mental health. As part of this, we have outlined a categorisation framework developed for this project, which defines the level of support the workforce may provide to support child mental health in their role. We then used the framework to enumerate the available workforce and its distribution across Australia, with a particular focus on regional and remote areas. Lastly, we determined the current workforce competency of the Australian workforce in supporting infant and child mental health and wellbeing through our analysis of the Emerging Minds 2023 National Workforce Survey for Child, Parent and Family Mental Health.

Specialists in mental health and specialists in infant and child mental health are low in number nationally and usually represent a small proportion of the potential child mental health workforce in a local region. These specialists who have a high level of opportunity to influence children's mental health are considerably fewer in number in Australia than other workforce groups, who have a more generalist level occupation or more generalist mental health specialists with fewer opportunities to influence children's wellbeing.

Fewer occupations are captured in this specialist group, contributing to the smaller headcount of around 150,000, which highlights the limitations of relying heavily upon a workforce with a high level of specialisation towards infant and child mental health. The broader range of occupations in the more generalist categories of professions, a cohort of around two million workers, offers a large potential pool of workforce to draw upon for increased capacity to support children and their families. These more generalist mental health or other generalist professions who connect with families regularly are more well represented across regions within Australia and are an opportunity to build capacity for the support of infant and child mental health.

Our analysis finds that the workforce is maldistributed across Australia, with low workforce availability in areas that need it most, including rural and remote areas and regions of greater disadvantage. As may have been expected, workforce numbers in the major cities across Australia were above the national average for all workforce groups, indicating that areas of the greatest population density are also the areas where the workforce is at its largest.

While we may expect to see higher numbers of specialists located within areas of high population numbers, this trend continues even when the data has been standardised to the number of children in a region. This indicates that there is an unequal distribution in the availability of specialists for areas that fall outside major cities throughout Australia. Furthermore, when exploring this relationship by remoteness, we see that the more remote the area, the fewer specialists there are and less work hours are available for infants and children to access specialist support. This indicates that infants and children have limited access to specialists in remote areas. We also see a trend in some locations, such as Western Australia and the Northern Territory, where the number of specialists is below the national average but the hours worked is above the national average. This could be an indication of increased need in these areas and workforce shortages, where existing specialists are having to work high hours to meet the needs of the community.

Low supply, high need

Our analysis indicates the highest need areas in states are most commonly in inner regional and outer regional areas, but regions within major cities can also demonstrate high levels of need. High need areas are mostly areas with high levels of disadvantage, with the exception of those

regions in ACT. Services which are culturally competent and developed with Aboriginal and Torres Strait Islander communities are essential for the regions identified in the analysis.

Our data shows that the supply of child mental health specialists that are well placed to support child mental health is low in almost all of the highest need regions. This lack of local specialists does highlight a need to investigate the proportion of other workforces who could also support infant and child mental health in their role, for example, by drawing upon the more generalist workforce to increase support for children and families. However, for the most part the identified high need regions also show a low ratio of generalist workforces compared to the national average, suggesting that a boost is required of more generalist professions that can support some aspects of infant and child mental health.

To explore the alternative starting point of workforce supply, we investigated regions in each state or territory with the lowest workforce availability based on the ratios of workforce to children and the hours of work available. Workforce headcount was not used for ranking because the regions have different sized populations and land areas which would be expected to influence the number of workers in residence. The lowest workforce availability regions are not always the same as the highest need regions, but there is some overlap.

Low workforce availability regions are a mixture of mostly major cities, inner regional and outer regional areas, and are almost all marked by very low availability of both specialist and generalist workforces. When comparing with the summary data on local population need, this analysis indicates that the lowest workforce availability regions commonly display an increased need for child mental health support that is above average or high compared to the national average.

Current workforce competency to support infant and child mental health

Overall, Australian professionals who responded to the National Workforce Survey for Child, Parent and Family Mental Health showed moderate self-rated capability, on average, across the generalist child mental health competency domains. Lower levels of workforce confidence were seen in infant mental health and in child-focused practice, which is consistent with the findings of the 2020–21 survey where infant mental health and child mental health practice were rated low among a range of workforce groups.

While family resilience approaches appear to be a sphere of some confidence for much of the workforce, workers showed low capability in working with Aboriginal and Torres Strait Islander families, and working with children and families in the context of disasters.

Across different remoteness areas, there is a pattern showing higher levels of capability in practitioners who do most of their work in major cities, which decreases with increasing remoteness, and for all competency domains there is a sharp drop off for practitioners in very remote areas. Although the survey respondents from very remote regions are very small in number, meaning the results around competency in very remote areas must be considered cautiously.

However, rural workers demonstrate skills particular to the needs of their regions that are higher than city workers. For the competency domains *Working with Aboriginal and Torres Strait Islander families* and *Contextually driven practice* (about adapting practice to suit cultural differences and service needs of rural families) – capability in these domains increases with distance away from major cities before again dropping off for very remote workforces. This reverse pattern may suggest these particular skills are grown through experience of working in communities which require more adaptive and culturally competent ways of working with families.

While experience can be gained on the job by incoming workers, this trend suggests also there is a potential gain to be made by building locally grown rural workforces which, due to their existing experience, can start from a position of being naturally more responsive to local need.

The potential impact of place and experience upon workforce competency building also appears evident in the results for the disaster competencies. Understanding the impacts of man-made and natural disasters on children's mental health and having the skills to respond is an increasingly important competency for practitioners working with children and families, especially in disaster-prone areas. However, this is an area showing some of the greatest need for improvement, with results indicating low capability amongst the workforce. A difference however is shown between practitioners who have found themselves needing to address the impacts of disasters with children and families in the past, compared to those without prior experience. The group with previous experience had quite notably higher scores, while the others scored very low on both generalist and specialist disaster competency. This suggests that merely being in a role that provides specialist care does not necessarily prepare practitioners for supporting families through a disaster. This indicates that there is a need to equip practitioners in disaster-prone areas with specific child mental health training, especially those who may have not yet lived and worked through a disaster and its immediate aftermath.

The availability of local services to refer to is considered low in all areas by survey respondents but especially in rural and remote areas. This indicates a need to develop and support those practitioners already working in rural and remote areas to increase their skills in child mental health practice.

Based on these initial results of our survey data, it's strongly evident there is a need for improved child mental health capabilities among a range of practitioners working in Australia.

Child mental health workforce competencies

To situate the population and workforce data within the context of the research literature, policy, and practitioner and lived experience evidence, we conducted a desktop literature review and stakeholder consultations to understand the core workforce competencies needed to support the development and social emotional wellbeing of Australian children. Our detailed review of the existing frameworks involved analysing common competencies across a range of sources.

Several gaps were identified in existing frameworks including limited acknowledgement of the social and cultural aspects of mental health (especially for Aboriginal and Torres Strait Islander children and families but also more generally for culturally and linguistically diverse communities); the ability to identify and address psychosocial and ecological factors impacting on mental health; supporting children based in rural and remote areas; or skills in responding to contemporary issues impacting on children's wellbeing (e.g. cyber safety). We deemed it important to include consideration of these factors explicitly when recommending competencies with potential to impact on the wellbeing of Australian children. Further, in light of the lessons learnt from implementing competency-based workforce competencies in other countries, the need to emphasise successful implementation and service delivery factors was also highlighted.

In addition to core competencies, we identified 'meta-competencies' that underpin the successful practice of all skills such as the confidence and ability to work in partnership with families and peers; the ability to share expertise and engage in reflective supervision and mentoring; and the ability to communicate across a range of settings such as telehealth, online support, group work, community consultation and face-to-face service delivery. Our consultations highlighted the value of using language that is less diagnostic in nature to make the framework more accessible to a

wider workforce audience. As a result, the framework describes the mental health care processes of ‘identify, assess, and support’ in more simple language as ‘recognise, reflect, and respond’.

A range of competencies for supporting child mental health were identified from existing frameworks, research evidence and sector consultation, which can be deployed across a range of service settings to support early intervention for improved children and family outcomes. Where similar workforce development initiatives have been evaluated (e.g., the UK CYP IAPT initiative), these evaluations support the inclusion of broader skills such as working with families and systems, working collaboratively with colleagues and families, the importance of leadership and ‘change agents’, and improving access through staff competency in a range of delivery options.

Stakeholder consultations

We engaged with strategic stakeholders who possess deep knowledge across various aspects of child mental health service delivery, including commissioning, service planning, workforce, program leadership, clinical expertise, academia, families with lived experience, and peak industry bodies. The research team prioritised engaging stakeholders with experience and perspectives from regional, rural, and remote parts of Australia, as well as those with expertise in rural and remote health, workforce barriers and enablers, those with lived experience and mental health care. The consultations provided valuable nuance and insights that offered context to the population-level data helping to identify implementation considerations and potential strategies that could be scaled or adapted from successful local initiatives. Themes for the way forward identified by stakeholders were:

- **System level stewardship** – stewardship at national, state and community levels and centralised leadership to champion more integrated, system-wide changes that consider local/context needs.
- **Strength of innovation in the bush** - services, programs and individuals displaying innovation in rural and remote settings were adept at utilising what they had (i.e. resources, funding, professionals), often collaborating across professions and working beyond funded roles and scope of practice, yet this innovation was stifled by short-term or inflexible funding.
- **Flexible and continuous funding** - funding models were cited as a key mechanism for addressing workforce shortages and other workforce issues. Funding should consider essential workforce development needs beyond direct service delivery such as training, supervision, implementation and systems improvements.
- **General practice as a place for multidisciplinary teams** - participants advocated for a re-evaluation of the Medicare Benefits Schedule (MBS) incentives for the general practice clinical workforce and consider expanding item numbers to include a wider range of professionals working in multidisciplinary general practice settings.
- **Earmark prevention and early intervention** - participants were unanimous in arguing for early intervention and prevention activities that were not bound by the capacity of the service to deliver crisis intervention and acute services, and the need for clearer stepped care roles and earmarked funding service provision for early intervention and prevention.
- **Using and supporting local professions** - more localised, flexible and multidisciplinary models of care, suggestions included greater utilisation of allied health assistants, cultural community workers, navigators and single points of access workers to reduce the burden on specialist services.
- **Need for implementation support for changes within the system** - need to better "operationalise" best practice on the ground and help organisations contextualise changes

to their local settings to reduce mismatch between standards or practice guidelines and their actual implementation.

The voice of lived and living experience was included via the Emerging Minds Family Forum members. Feedback from members identified several important types of support they would like from practitioners who might be less specialised in child mental health including the provision of low level supports for self-directed interventions or resources. The family forum made a clear rationale for a more integrated, community-based approach to supporting child mental health, with professionals who can provide practical, flexible, and empathetic care - both for the child and the family.

Recommendations

To summarise, it is estimated that the prevalence of mental health issues in children will continue to grow with considerable long term economic and social costs that are projected to increase for developed countries into the future. Currently, the demand for mental health support is growing in the context of access barriers and workforce pressures. The need to intervene early to support children's mental health is well recognised in policy. The National Children's Mental Health and Wellbeing Strategy, released in 2021, specifically recommends early preventative intervention and provision of needs-based supports.

The demand for mental health supports exceeds current workforce capacity; indicating the need to improve access to early mental health supports. The development and promotion of generalist workforce positions able to deliver a range of mental health supports is one way to address this issue. Equipping a broader workforce with the necessary skills to support children and families has the potential to play a significant role in mental health prevention and aligns with national and international policy recommendations.

Conclusions drawn from sector consultations also highlight the need for supportive funding models and to focus on early intervention and prevention. Similarly with other findings in this report there is also a call amongst stakeholders for system level responses, beyond a focus on practitioner change, that allow for adaptation for local contexts.

Here we outlined several interlinked recommendations to help improve the capability of the Australian workforce to better support infant and child mental health.

The following recommendations and proposed actions include a need to promote rural and remote health equity (Recommendation 1), provide opportunities to increase the scope and flexibility of service delivery models to enhance existing services locally, including the expansion of primary health (Recommendation 2) and build a locally grown child mental health generalist role(s) (Recommendation 3). A broader conceptualisation of the potential mental health workforce is described in Recommendation 3, encapsulating an ecological and transdiagnostic approach to child mental health that will allow for greater flexibility to expand the opportunities of the workforce to support emerging mental health issues in children and their families. Recommendation 4 recognises the need for system level coordination and stewardship of child mental health workforce development through the creation of a network of system designers who will lead multi-sector approaches informed by local contexts.


Recommendation 1 – Rural and remote equity
Expand and improve the coordination of rural and remote workforce recruitment and retention programs that are inclusive of a workforce to support child mental health, wellbeing and development.
1.1 Targeted rural and remote recruitment and retention financial incentives
1.2 Alternative models of service delivery to rural and remote communities
1.3 Recruit to Train rural scholarships
Recommendation 2 – Expanding primary care support
Expanding child mental health and wellbeing support in primary health/GP settings to facilitate enhanced early and multidisciplinary treatment in the primary care system.
2.1 Whole-of-Practice child mental health learning program
2.2 GP practice incentives
2.3 MBS items supporting multidisciplinary care teams
Recommendation 3 – Building capability for early intervention to meet mental health needs of Australian children
Grow the capacity of the generalist workforce by establishing new mental health and wellbeing early intervention roles within a tiered competency framework, informed by a task-shifting methodology.
Recommendation 4 – Embedding regional System Designer positions with centralised intermediary support
Establish a national network of System Designers to lead creation of multisector, place-based approaches to support children's mental health and wellbeing across the service spectrum, supported by an intermediary organisation and access to grant opportunities.

Chapter 1.

Recommendations & implementation guidance

1. Recommendations and implementation guidance

Chapter 1 overview

This first chapter of the report details the report recommendations and high-level implementation guidance supported by the data, evidence, and analyses outlined in the following chapters. These recommendations should be viewed as a collective, interlinked response to improving child mental health and wellbeing support, targeting change at the system level, and backed by ongoing implementation support.

The recommendations and proposed actions to improve rural and remote health equity (Recommendation 1) also sit alongside other recommendations that aim to provide opportunities to increase the scope and flexibility of service delivery models to enhance existing services locally, including the expansion of primary health (Recommendation 2) and building a locally grown child mental health generalist role(s) (Recommendation 3). A broader conceptualisation of the potential mental health workforce is described in Recommendation 3, encapsulating an ecological and transdiagnostic approach to child mental health allows for greater flexibility to expand the opportunities of the workforce to support emerging mental health issues in children and their families.

All report recommendations need to be implemented with the local service system in mind. Recommendation 4 outlines how a System Designer employed within regions can help coordinate these types of initiatives and target particular areas of need locally.

Recommendation 1 – Rural and remote equity of access

Description of recommendation:

This recommendation outlines the need to expand and improve coordination of rural and remote workforce recruitment and retention programs that are inclusive of a workforce to support child mental health, wellbeing and development. These strategies seek to leverage and expand existing government programs and evidence-based approaches to support the ongoing development of a rural and remote health workforce.

Possible enhancements to programs focus on increasing availability of practitioners or services in specific areas of low health workforce supply and/or high need (as per Emerging Minds data analyses) or broadening existing programs' remit to include incentivising practices important to delivering better child mental health care.

As demonstrated in Chapter 4 of this report, rural and remote locations have limited access to mental health support, especially from specialists who can support child mental health. Our analyses show that support decreases as remoteness increases, and this is often coupled with high needs of children and families.

The strategies outlined in this recommendation are in three parts. Each part is interlinked and focuses on increasing the number of child mental health and wellbeing professionals who provide support to rural and remote communities.

Purpose of recommendation:

To leverage existing incentive schemes targeting rural and remote health workforce supply to increase provision of child mental health and wellbeing support in low-supply regions.

Components of recommendation:

1.2 Targeting recruitment and retention financial incentives

Overview:

A range of schemes already exist within the health sector at Commonwealth and state and territory levels (e.g. Workforce Incentive Scheme[1] and the NSW Rural Health Incentive Scheme[2]) to attract and retain health workers to rural and remote regions to improve equity of access. Effective delivery of health services in rural and remote Australia depends on the availability of qualified personnel to work in those areas.

This strategy recommends enhanced targeting and expanding workforce incentives to attract and retain qualified health and human services staff in hard-to-fill positions in rural and remote areas, identified as having low supply yet a high population of child mental health needs.
Typically, a tiered system of incentives is allocated based on the Modified Monash Model (MMM) classification to incentivise and compensate for isolation and the high cost of living in rural and remote areas. Appendix 1 summarises common measures used for recruitment and retention in rural and remote regions.[3] Incentives can include a mix of relocation costs, annual salary bonuses, subsidised living expenses, access to accommodation supports, and resources for family support including employment support for partners and childcare supports for children. Alongside these, access to enhanced supervision and professional development opportunities should be provided to support the lack of opportunities for the workforce in rural and remote areas. It is important, however, to have some degree of local oversight to ensure the recruitment of key health and human services workers matches the need of local populations.

Implementation of recommendation:

The potential funding necessary to progress this recommendation depends on identifying a mix of incentives most needed to increase the workforce in particular locations and/or professional groups. Identify regions of low health workforce supply and corresponding high proportions of child mental health support need and leverage existing incentive programs to target these regions. Existing successful programs could be identified by analysing participation demographics and introducing additional grant rounds for popular schemes. Funding from programs that do not attract sufficient numbers of participants could be rolled into more successful programs. Reviewing program eligibility criteria and increasing targeted recruitment

[1] Australian Department of Health and Aged Care, Workforce Incentive Program, https://www.health.gov.au/our-work/workforce-incentive-program
[2] New South Wales Ministry of Health, Rural Health Workforce Incentive Scheme, https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2024_012.pdf
[3] Table 1b

campaigns may be needed to grow interest. Locations of high-need may also require strategies that seek to overcome specific challenges of the location (e.g. limited housing, access to supervision, cross-sector professional networks or local community of practice).

Rationale:

- Supporting relocation and living in rural areas can assist with attracting a workforce to choose to work rurally over urban areas.
- Compensation of professionals is needed for the higher costs of living and limited access to similar opportunities, compared to metropolitan and urban professionals.
- A sustainable rural health workforce needs dedicated professional development and supervision, and lifestyle support (e.g. access to affordable childcare, housing, schools, work for partners, etc.) (National Rural Health Alliance, 2023).
- Providing ongoing support to retain workers reduces costs associated with recruitment and staff vacancies while increasing continuity of care and service availability.

Evidence for recruitment and retention incentives:

- There is evidence suggesting incentives increase the workforce in rural and remote areas (Bärnighausen & Bloom, 2009), although there is also evidence to suggest that these workers are less likely to stay in the designated area longer term. However, employment of those who are local to the area or with a history of rural living are more likely to stay in the longer term (Esu et al., 2021; Russell et al., 2021; Bärnighausen & Bloom, 2009). Spending the time in assessing potential candidates for suitability for employment based on these factors is recommended.
- There remains a paucity of evidence on the effectiveness of incentives to attract and retain a workforce in rural areas longer term. More evaluation of the existing investment in workforce incentives to understand effective incentive combinations is needed.

Benefits of recruitment and retention incentives:

- Financial incentives may aid an initial boost in workforce relatively quickly, particularly in regions most in need.
- In combination with other strategies in this recommendation, these incentives could be effective at bringing specialist care and other supports to rural regions, particularly identified as high-risk.
- Current investment in rural and remote health workforce incentives could be increased quickly using pre-existing funding mechanisms and infrastructure.

Risks of recruitment and retention incentives:

- May not result in a workforce that is sustained longer-term to provide continuity of care.
- Incentives may not directly address broader issues that impact worker satisfaction and retention (e.g. lack of appropriate supervision or limited access to professional support if high vacancies in region, isolation from support network, etc.)
- Incentives may not target factors outside of the workplace that influence retention (e.g. employment opportunities for partners, access to childcare and schools, local housing unavailability, etc.).
- Incentives could draw practitioners away from other regions which may possibly create, transfer or exacerbate workforce shortages from one location to another.

1.2 Alternative models of service delivery to rural and remote communities

Overview:

Several alternative service delivery models have been trialled across Australia from Fly in Fly Out (FIFO), Drive in Drive Out (DIDO), Work in Work Out (WIWO), through to a provision of purely telehealth therapy services for rural areas. These models have been designed to fill a workforce gap, particularly in child-focused services, to address a pressing need in rural and remote locations. Implementation of these models highlights the importance of drawing upon local contexts and customising resources to the distinct requirements of rural communities.

Service planning and targeted commissioning in areas of high need is recommended to support the expansion of these approaches to supplement existing service availability. Several models are operating in Australia that use a combination of time-limited, community-intensive face-to-face delivery with multidisciplinary teletherapy, or an option to travel to a centre for further support. These programs are often delivered in partnership with local services, schools and early learning centres. The partnership enables early access to children identified within the education or family service systems, and also provides opportunities for professional development to build the capacity of local professionals to support these children in their roles.

Several gaps continue to exist in rural and remote Australia in the provision of early intervention and support for child developmental issues, learning deficits and multidisciplinary concerns. Initiatives such as those delivered by Outback Futures and Royal Far West have been developed to focus on the mental health and allied health needs of children in rural and remote regions of Australia, mainly in Queensland and New South Wales. These flexible working arrangements – using a combination of face-to-face and telehealth service delivery, can remove the barrier of the need for workers to relocate to rural areas permanently, and help the workforce to maintain their important connections to their existing social support and family networks. Through improving access to a workforce located in urban areas, there is improved equity of access for children in rural locations impacted by a paucity of workforce availability.

Commonalities of existing alternative models operating in parts of rural Australia to support the developmental concerns of children include:

1. Community engagement to co-design the approach to meet local needs.
2. Partnerships with local service providers and education settings and a focus on building relationships across the community.
3. Work in, work out (WIWO) – short term emersion in local community and face-to-face assessments and provision of mental health and allied health services.
    a. Multi-disciplinary teams (Psychology, counselling, Occupational Therapy, Speech and Language Pathology and Learning and Literacy) offer assessments, family triage and case management plans (e.g. five-day on-site clinics in community)
4. On-going telehealth therapy delivering a multidisciplinary and developmental approach.
5. Treatment centres established within urban locations for rural families to travel for therapy supports (e.g. Country Kids in Manly).

More recently, other components have been added to these models. For example, Royal Far West implemented a telecare psychiatry assessment clinic within a rural child and family service as a pilot to serve this group of children. The initiative also offers assessment and management recommendations to support the local paediatrician and other relevant care providers, for the child and their family.

Purpose of recommendation:

Incentivise development of alternative models of care that support children's mental health and wellbeing in resource-constrained rural and remote settings.

Implementation of recommendation:

At present, pilots of alternative service delivery models are underpinned by multiple funding streams including the Commonwealth Department of Health and Aged Care, the Commonwealth Department of Education, state and local governments (health and social services departments) and philanthropic organisations. Some services for complex developmental needs are also funded under the National Disability Insurance Scheme (NDIS).

It is proposed in this recommendation that additional innovation grant funding rounds are made available to develop these models more broadly across Australia with a particular focus on child mental health and wellbeing support. These grant rounds could target specific communities of high need and boost connections with existing rural primary health or education centres (drawing on the evidence identified above).

Rationale:

- Securing a localised workforce to support children's mental health and wellbeing at full complement may, even in the longer term, continue to challenge remote areas of Australia. The ability of regions to develop an alternative, innovative service delivery model that achieves safe, high-quality, and effective care should be facilitated through local planning and government commissioning cycles.
- The examples discussed above have increased service availability of child mental health and wellbeing support to high-need areas and demonstrate the need for key evidence-based characteristics such as the use of multidisciplinary teams, flexible delivery modes, integration with local services (including early education and schools), and the application of a child development lens.
- Alternative model pilots are already funded through government programs (e.g. Innovative Models of Care Program, Emerging Priorities Program) demonstrating the effectiveness of this type of approach to incentivising health sector innovation.
- Supporting the expansion of these models could be coupled with activities to clarify pathways to enable scaling of effective models and transitioning to longer-term, stable funding sources.

Evidence regarding alternative service models:

- At present, there is a lack of robust evaluation evidence on the impact of these various workforce models in rural and remote Australia.
- However, tele-mental health interventions show some promise in effectively addressing mental health needs and are generally accepted among stakeholders (Barnett et al., 2020).
- The current literature also suggests (Hussain et al., 2015) that FIFO and DIDO healthcare services operate best where local primary healthcare services are adequately resourced and staffed. The advantages of FIFO and DIDO services are that they offer services that would otherwise be unavailable, avoiding the need for patients to travel large distances to receive health care. In most instances, it is not just the patient who is greatly inconvenienced but also their families, since a designated carer has to accompany the patient, causing considerable disruption to family caring arrangements.

- However, FIFO and DIDO services 'should be seen not as a replacement for local health care, but as a necessary compromise between the tyranny of distance and equity of access to health services' (Hussain et al., 2015).
- Implementation needs to consider the role of these programs in providing generalist care, as this can lead to an erosion of local services and infrastructure. Implementation of these models would need to couple with workforce development of local professionals, for example, FIFO being supported to participate in case conferencing to capacity build other professionals and improve collaboration.
- To make FIFO and DIDO services work well, continued support for local primary healthcare services is essential and a new funding model is necessary. Options include:
    - Greater flexibility on the part of employers to sustain a team of FIFO health professionals in rural regions on a longer-term job-share basis, so that they and their colleagues feel part of the local healthcare system and communities.
    - In the longer term, the creation of a robust rural generalist pathway for clinical practice, with appropriate remuneration benefits.
- A report prepared for the National Rural Health Alliance recognises the opportunity to tackle gaps in rural health service availability through a comprehensive strategy that combines on-site resources, mobile services, and telehealth solutions (National Rural Health Alliance, 2023).

Benefits of alternative service models:

- Flexible working arrangements can make rural opportunities more enticing to workers and support rural health settings to be more competitive in attracting staff.
- Improvement to equity of access to specialist and multidisciplinary support from metropolitan and urban areas.
- Innovation grants have facilitated funding for several models of effective ways to deliver primary health care to people who live outside of major centres, addressing distance and access issues, as well as workforce shortages.
- Models that integrate with early education and schools also build the capacity of local educators in supporting prevention and early intervention and can act as a pathway to enhanced support when required.

Risks of alternative service models:

- Potential that these approaches may stretch an already limited workforce.
- Requires access to temporary accommodation, local infrastructure, supervision support, and linkages to a functioning local primary health system.
- Requires community engagement and uptake of the services provided (and possibly a need to address local barriers to help-seeking and sometimes low mental health literacy).
- May lead to reduced continuity of care for families located rurally depending on how the model is designed.
- May erode existing service infrastructure to build a locally grown workforce.

1.3 Recruit to Train rural scholarships

Overview:

Utilising the existing rural and remote health training infrastructure, increase the number of students participating in courses related to children's mental health and wellbeing (through

scholarships) and develop a curriculum for delivery that aligns to the core competencies necessary to provide this care (as outlined in Recommendation 3).

The existing Commonwealth funded Rural Health Multidisciplinary Training (RHMT) program offers health students the opportunity to train in rural and remote communities via a network of facilities, including University Departments of Rural Health (UDRHs). It aims to improve the recruitment and retention of medical, nursing, dental and allied health professionals in rural and remote Australia. This existing initiative could be expanded to support the role of a generalist Child Wellbeing Practitioner (see Recommendation 3) or multidisciplinary team/rural generalist specialising in child mental health.

Evidence shows that undergraduate students who complete training in a rural area (Morrell et al., 2014; Wolfgang et al, 2019; O'Sullivan & McGrail, 2020), and those from a rural background (Russell et al., 2021), are more likely to take up rural practice upon graduation. While the evidence primarily relates to the medical profession, these factors are likely to be influential in the rural retention of other health graduates, including allied health professionals.

The RHMT program could be expanded to include rural training and placement support dedicated to a child mental health workforce model, which includes primary health and allied health professionals. The workforce may include a combination of primary health professionals such as medical practitioners, practice nurses, midwives and allied health professionals covering psychology, social work, occupational therapy, speech pathology, pharmacy, counselling, and art therapy.

Purpose of recommendation:

To provide financial incentives for current and future health professionals to complete education and training related to supporting children's mental health and wellbeing in rural and remote locations.

Implementation of recommendation:

The expanded RHMT program will target and build rural practice in addressing child development concerns and child mental health and wellbeing issues, particularly in managing complex developmental presentations in low resource settings and through culturally appropriate practice. A competency-based training program could be developed by Emerging Minds to improve core skills in child mental health practice to support these professionals to upskill (see Recommendation 3). This training program could then be supported by face-to-face supplementary clinical training, rural placement support and competency-based assessments through additional academic and clinical staffing in UDRHs.

This program may also expand the current incentives and training supports for the rural health generalist position, with an extension to support child mental health practice. It is expected that this level of training is required to support a postgraduate qualification for the rural Child Wellbeing Practitioner described in Recommendation 3.

Rationale:

Providing postgraduate rural training programs has been recognised as central for successful recruitment and retention of the medical workforce. Significant government investment has

already been made, including the Commonwealth funded RHMT program that supports the UDRHs.

Rural generalism, or rural generalist medicine, has emerged in many jurisdictions as one approach to training and providing care for rural communities. Educational and training programs usually include developing appropriate skills in primary care, in-patient care, emergency medicine, public health, and one or more extended skills, emphasising meeting community needs.

It is generally understood that simply placing professionals in rural environments is considered insufficient to make them capable of safely and competently serving these communities. Located far from health-resourced urban centres, these professionals often work with socially and economically disadvantaged communities and populations. A generalist approach provides health professionals with the skills to operate in uncertainty and treat diverse conditions in patients over their lifespan, combined with an understanding of the disease prevalence and context in which the patient is situated to guide diagnosis and management (Saito et al., 2022).

A greater awareness and training in supporting child mental health could be built into this existing program to help support early intervention and treatment of emerging child mental health issues.

Evidence:

The evidence suggests that students who attended a rural clinical school were 1.5 times more likely to be in rural practice, regardless of rural background (McGirr et al., 2019). However, students from rural backgrounds and/or who train rurally, are even more likely to work in rural and remote locations (Esu et al., 2021; Russell et al., 2021; Bärnighausen & Bloom, 2009).

An independent evaluation of the RHMT program published in 2020 found the program contributed to improving workforce outcomes in many regions (KBC Australia, 2020).

Benefits:

- Utilises existing infrastructure alongside the development of competency-based training to upskill rural practitioners to better support child mental health needs.
- Develops a local workforce capable of supporting child mental health and providing early intervention support, reducing the burden on specialist child mental health services.
- Helps establish continuity of care with the recruitment and sustainment of a local workforce.
- Offers meaningful career pathways for rural and remote-based communities with entry through subsidised higher education learning opportunities.

Risks:

- Lack of support for the significantly higher costs of living regionally can be a disincentive to trainees pursuing rural clinical training – these costs are currently not always considered in funding models.
- Inadequate support for additional costs including relocation, lack of accommodation, visiting family and travelling for mandatory education could also be a disincentive.

- Often the rural workforce is working longer hours with the professional pressure of not having easy access to specialists, and working with minimal access to peers, and personal and mental health support services available in cities[4].

[4] Australian College of Rural and Remote Medicine. Grow the Rural Generalist Workforce as a Rural Healthcare Solution, https://www.acrrm.org.au/docs/default-source/all-files/acrrm-policy-priorities-grow-workforce.pdf?220608

Recommendation 2 – Expanding primary care support

Description of recommendation:

Expanding child mental health and wellbeing support in primary health/GP settings to facilitate better early and multidisciplinary treatment in the primary care system. This requires upskilling and incentivising the primary health sector to deliver brief psychological and multidisciplinary care to infants and children, including care delivered by GPs, nursing or allied health workforce (e.g. psychologists, occupational therapists, speech pathology, social workers, Aboriginal and Torres Strait Islander health workers) in primary health settings.

Better integration of behavioural and child mental health support in primary care settings facilitates earlier identification of emerging child mental health, wellbeing and developmental needs and risk factors. This enables holistic care as primary health providers can expand on early engagement activities and low intensity support to reduce the likelihood of children escalating to higher levels of mental health care.

This recommendation capitalises on the skillset of primary health and allied health practitioners working in GP settings to provide comprehensive children's mental health support, including responding to the challenge of case coordination and treatment management for children with complex developmental issues and/or access constraints (e.g. located in rural or remote location).

Purpose of the recommendation:

To embed a multidisciplinary, prevention and early intervention approach into general practice settings to enable better access to child mental health and wellbeing support.

Implementation of recommendation:

This recommendation consists of three inter-related components:

2.1 *Whole-of-practice child mental health learning program* - upskilling primary health staff in identification, assessment and brief intervention support for child mental health through incentivising training completion by GP practices.

Whole-of-practice learning programs could be implemented as a training package developed by Emerging Minds through the National Workforce Centre for Child Mental Health (NWC), in partnership with PHNs across Australia. A similar incentive-based training program for GP practices has been completed in the North Western Melbourne PHN catchment with 25 GP practices completing child mental health assessment training (see NWC 2023 Evaluation Report). This program could be expanded to all PHNs with additional support from Emerging Minds.

2.2 *GP practice incentives* - incentivise GP practices to hire allied health and nursing professionals to support child development and mental health concerns, including funding provisions for collaborative care management for complex developmental concerns.

GP practice incentives could be implemented through a grant-based scheme (similar to the Innovative Models of Care (IMOC) Program) which could be expanded to fund salaries of the necessary staff within a GP practice or to fund payment of external partnering services, with

five-year funding cycles to determine the impact aligned with future child mental health service delivery targets.

2.3 *MBS items supporting multidisciplinary care teams* - expand MBS-item funding for multidisciplinary care from a range of GPs, nursing and allied health staff within GP practices to provide evidence-based child mental health support and complex case management.

MBS items for multidisciplinary care teams could be implemented by expanding existing MBS items for child mental health support and care coordination, with additional loading for rural health settings.

Rationale:

- Increasing the ability of the primary health system to provide holistic, collaborative care will help address service fragmentation and improve equity of access to mental health support, as well as locating mental health services within a non-stigmatising setting.
- Consistent with actions in the Strengthening Medicare Taskforce Report (Department of Health and Aged Care, 2022), expanding access to primary care and considering flexible funding arrangements to enable multidisciplinary care.
- Consistent with key actions in the Primary Health Care 10 Year Plan 2022-2032 (Department of Health, 2022), to focus on scaling innovative approaches that support comprehensive primary care teams in general practice, particularly for local community-developed models supporting rural and remote areas.
- Recommendation is supported by key findings throughout this report including the need for holistic service delivery that responds early to child mental health and wellbeing risk factors and a workforce that can work collaboratively across a stepped care model.
- Consistent with the longer-term goal of transforming the child mental health and wellbeing system to embed low intensity support in settings accessed by children and families.

Evidence:

- Some evidence of collaborative care grant schemes already shows the uptake of a community-based primary health codesign approach that utilises a collaborative planning framework to develop a workforce model that meets the unique needs of rural communities.
- Growing evidence base showing provider and patient satisfaction and improved outcomes for models that integrate mental health support into primary care settings (Hunter et al., 2018; Isaacs & Mitchell, 2024).
- Stakeholder consultation feedback advocated for incentives to support a general practice clinical workforce that can better support children's mental health. Interviewees felt this was necessary to move beyond the transactional, high-turnover model currently in place that makes it difficult to spend more time with children and families in need.

Benefits:

- Opportunity to improve equity of access to specialist and multidisciplinary care that is essential for child mental health support needs.
- Helps reduce the burden on specialist child and adolescent mental health services.
- Generates momentum for service integration and collaboration by incentivising greater linkages between primary care providers focused on delivering child- and family-focused support.

- Provides funding to support general practices to develop new ways of working that are consistent with research evidence and prevailing government policy.

Risks:

- Existing shortages of key professions in many regions may make recruitment and retention of the target workforce challenging, particularly for limited-time pilots.
- Low knowledge or acceptance of the potential benefits of this approach to child mental health amongst target service providers may influence take up.
- Scheme potentially competes with existing quality improvement activities underway within general practices (e.g. against other target populations or health conditions).
- Skills required to develop the model may not be available within a general practice or limited within a region.

Recommendation 3 – Building capability for early intervention to meet the mental health needs of Australian children

Description of recommendation:

Grow the capacity of the generalist workforce by establishing new mental health and wellbeing early intervention roles to address persistent gaps in multidisciplinary workforce distribution for infant and child mental health. This recommendation calls for the development of new transdisciplinary child mental health roles within a tiered competency framework, informed by a task-shifting methodology.

This recommendation contextualises international evidence into Australian health and human services settings. It identifies core competencies that aid more effective engagement of a low-intensity support workforce with children who have emerging mental health needs and their families. The recommendation outlines implementation of the competencies through new service delivery roles which will help manage demand for future child mental health support needs and build resilience at the individual, family, and community levels.

Purpose of recommendation:

To increase the opportunity for children and families to receive earlier support, this initiative aims to train a new workforce for infant and child mental health called Child Wellbeing Practitioners. These roles are expected to complement the work of existing CAMHS practitioners by building links with communities and offering rapid access to brief treatment interventions for infants and children presenting with either risk factors or with mild to moderate mental health difficulties, as part of a stepped care model of service delivery.

With training, it is expected that these roles will operate with:

- fundamental skills to assess cases using appropriate and effective assessment tools and engage infants, children, parents, and families.
- knowledge and skills in effective brief (low-intensity) interventions for infants, children and family systems, based on the most up-to-date evidence.
- knowledge of a range of interventions (including written and computerised interventions) and knowledge of services available to infants, children and their families in their region.

Overview of Child Wellbeing Practitioner roles:

The new Child Wellbeing Practitioner roles are designed within two levels of care – Level 1 and Level 2 roles – who collaborate in partnership to provide early engagement and support to children and families experiencing mental health and wellbeing concerns (Table 1). The roles will help families navigate the service system, acting in a triage-type capacity to guide children and families into support relevant to their presenting concerns. Support will be provided appropriate to the skills and qualifications of the Child Wellbeing Practitioners' level, with a strong focus on service navigation; building child mental health, wellbeing and development literacy; providing care coordination, and offering brief therapeutic interventions.

Table 1 :Definition of proposed Level 1 and Level 2 Child Wellbeing Practitioner roles

Level 1 roles:	Family engagement and early screening of child mental health and social determinants of health, education on child development and parenting,

	linkage to self-guided and online resources, assistance with service navigation and consultation, enhancing the village of support for families/children, co-facilitation of group programs (i.e. parenting, playgroup).
Workforce roles: vocational education and training (VET) qualified, peer/lived experience and parent peer/carer workforce, cultural advisors/SEWN workforce.	

Level 2 roles:	Initial assessment and referral, supported engagement in guided self-help, family intervention and wellbeing support, brief psychological therapy, working with complexity/care co-ordination, co-facilitate groups with Level 1 roles. Delivering a transdisciplinary approach, according to the competencies outlined below and in the previous briefing.
Workforce roles: Postgraduate certificate (similar to Child Wellbeing Practitioners in the United Kingdom (UK)), targeted child mental health rural generalist, allied health/nursing professional.	

This recommendation is modelled on implementation of UK National Health Service (NHS) model of Child and Young People's Improving Access to Psychological Therapies (CYP IAPT), embedded in salaried, government services. In the UK CYP IAPT program, a competency-based curriculum was developed to transform existing services for children and young people.[5] The curriculum adopted those elements of the IAPT programme that help improve outcomes for children and young people, including cognitive behavioural therapy, parenting training, interpersonal psychotherapy and systemic family practice. Training of staff across CAMHS, education and voluntary and social care services were targeted first in its implementation in the UK.

As part of the implementation, the CYP IAPT program created a new workforce called Child Wellbeing Practitioners who are trained to offer brief, focused, evidence-based treatment in the form of low-intensity support and guided self-help to children and young people who demonstrated mild/moderate anxiety, low mood and common behavioural difficulties. Early evaluations have been promising and show these roles have delivered a range of interventions including psychoeducation; cognitive restructuring; behavioural analysis; worry management; graded exposure; and relapse prevention (Turnbull et al., 2023; CYP IAPT Midlands Collaborative, 2018).

In the UK, Child Wellbeing Practitioners work in a variety of different settings including CAMHS, Local Authority and voluntary sector organisations. The work of Child Wellbeing Practitioners is highly varied as each service will be tailored to local need and provision but can include assessments, face-to-face sessions, telephone work, workshops, groups and service user involvement activities.

The evaluation indicated that 60% of referrals were received from school and education, but the vast majority of children and young people seen were not receiving support elsewhere. 75% of discharges occurred within eight appointments, which were usually face-to-face. On average, the data indicated a 50% recovery rate, with calculated cost savings recorded as a return on investment of £2.90 for every £1 spent (CYP IAPT Midlands Collaborative, 2018).

[5] See Appendix 1, Table 1a for detail of the competency frameworks reviewed, including CYP IAPT.

Like the UK model, the recommended Child Wellbeing Practitioner roles are designed to be low intensity and to sit within the existing child mental health system, enhancing the stepped care model of support for children and their families.

Implementation of Child Wellbeing Practitioner roles:

These new roles could be implemented within the development of the Head to Health Kids Hubs model roll-out, with Level 1 practitioners placed as an initial engagement role with families, followed by an initial screening and assessment role that also offers low intensity psychological and family support by Level 2 practitioners.

A postgraduate qualification connected to a university system has typically been utilised in the UK to develop the Child Wellbeing Practitioner roles, and this would be most applicable to this recommended Level 2 practitioner who will be trained in evidence-based low intensity interventions with strong supervision support. Entry into the postgraduate qualification is usually dependent on completion of a relevant undergraduate degree. Ideally those professionals already working in some capacity with children and young people could be sponsored to attend this course as part of their work. Enhanced rural scholarships and placement support could be used to incentivise a workforce to be established in areas of high need.

Level 1 roles are akin to carer and lived experience peer roles and cultural advisors that can be VET qualified through sponsorship to support the development of their competency in this specific role. Again, strong supervision support models will also need to be in place for these roles and there may be a need to support the development of managers or leadership in supporting the integration of both these roles within the workplace.

To carefully integrate these roles to sit in between the primary health system and education settings that might identify children in need of support and more specialised integrated multidisciplinary (Head to Health Kids Hubs) or psychiatric support (CAMHS), a System Designer role could be beneficial (see Recommendation 4). The Child Wellbeing Practitioners might complement or receive referrals from GPs, practice nurses, midwives, maternal and child health nurses, or school mental health and wellbeing professionals.

Rationale:

Persistent universal shortages exist in access to early intervention support for child mental health concerns. This includes a lack of access to specialist child mental health professionals and services, and a limited ability to access early intervention support for emerging challenges. Targeted service delivery is required for child mental health and development across different levels of need, with incentives for prevention and early intervention support. Prioritisation of acute and tertiary responses continues, and demand is expected to increase for infant, child and adolescent mental health presentations.

Mental health conditions are developmental in children. Due to the developmental processes occurring in childhood, presentations that are consistent with diagnosis are less common. Evidence indicates that infant and child mental health presentations are more likely and often co-occurring/interacting with other developmental delays and challenges in developmental environments (home, education/care, community and digital social environments).

Workforce expansion initiatives should leverage incentives that aim to improve workforce distribution in areas of unmet need. Targeting SA3 regions with high unmet need by cultivating locally grown workforces could reduce workforce maldistribution and improve health outcomes. The introduction of Child Wellbeing Practitioners could help address inequitable workforce supply by training and employing a new clinical workforce to deliver low-intensity psychological and family-based interventions within a stepped-care model framework for the treatment of emerging mental health difficulties in children. Recent evidence shows that a number of neurodevelopmental (Autism, ADHD) and psychological disorders (anxiety, phobia, separation anxiety, personality disorders) show a peak onset of below six years of age (Solmi et al., 2022). The location of these Child Wellbeing Practitioner roles need to be suited to the regional context however, and may reside in Head to Health Kids Hubs, CAMHS or outside of the health sector and in community services.

Evidence:

Evidence suggests a lack of early intervention and brief intensity support for those at-risk and experiencing emerging child mental health concerns (Catania et al., 2011). Our stakeholder consultation indicates a problem exists for early intervention support with current workforces not equipped or funded to provide prevention and early intervention support. Challenges also exist in current services not being equipped to navigate and mitigate the impacts of risks to child developmental processes, increasing the risk of future mental health difficulties in children.

These low intensity roles have been shown to lead to significant improvements of mental health outcomes of children and young people who engaged with a Child Wellbeing Practitioners in the UK (Turnbull et al., 2023). There is also evidence to suggest that children who access these services are generally not receiving mental health support elsewhere, filling an existing gap in service delivery.

Proposed description of generalist Child Wellbeing Practitioner competencies:

In developing competencies suitable to child mental health and wellbeing roles, Emerging Minds has reviewed existing child mental health workforce competencies as described in international literature (see Chapter 5 of this report). Competencies identified have been further elaborated on based on feedback and consultation with sector representatives and internal consultation within Emerging Minds. The proposed competencies have been specifically targeted to two broad types of workforce settings. These settings are more than likely to be areas of opportunity for developing child mental health support given the existing workforce composition found in rural areas (outlined in Chapter 4):

1) Workforces in settings that are not traditionally seen as providing mental health support to children but that have the opportunity to intervene in response to the early signs of emerging difficulties.
2) Workforces in settings that can provide low to medium intensity interventions and supports to children and families to prevent the escalation of more serious mental health issues.

More detail about these settings is provided in Box 2 below.

Value of a competency approach:

It is envisaged that investment in workforce development focused on Level 1 and Level 2 Child Wellbeing Practitioner competencies will:

- Broaden the potential workforces available for early intervention to include those with naturalistic opportunities to support children in their environment in non-stigmatising ways.
- Strengthen the skills of a wide range of child and family support practitioners across disability, social services, and family services.
- Provide a wider workforce with a set of 'common language' and transferable skills, offering a buffer against high levels of workforce 'turnover' and cross sector mobility that exists in a range of support, education, and social service workforces.
- Enable a wider workforce to respond to children's developmental and wellbeing needs both early in their life and early in the life of the problem for those children and families that do not yet meet criteria for clinical services.
- Broaden the skill base for mental health workers, trained in evidence-based, discipline specific skills. This includes working with family-based, systemic and ecological factors, and in delivering interventions in a range of ways that may be more inclusive and better suited to a variety of settings, such as rural and remote or other resource-limited settings.
- Provide a set of skills that are broadly aligned with those services provided by levels 1-3 of the proposed *Initial Assessment and Referral guidance and decision support tool – Child criteria* (Department of Health, 2021).

The opportunity to embed the proposed Level 1 and 2 roles within the system is explained in more detail below in Box 1.

Box 1: Generalist child wellbeing workforce skills

Child wellbeing skills for Level 1 settings

Level 1 core curriculum skills are designed to meet the need of workforces that have naturalistic opportunities to impact on children's wellbeing in non-stigmatising ways. A lay and paraprofessional workforce with Level 1 competencies in supporting child wellbeing will have the skills to contribute to children's wellbeing:

- directly via resilience building interventions, lifestyle supports, and positive relationships; and
- indirectly via psychoeducation, provision of practical resources and skills, and warm referral to more intensive services where needed. Training and support for this workforce will provide them with the confidence and ability to recognise and respond to early behavioural indicators of child, parent and family stress, and the skills to respond in supportive ways within the context of existing relationships and communities (possibly through the VET system).

This level of 'competency' will enable a range of lay and paraprofessional workforces, across settings such as home, school, community, and health service settings to support children's mental health and wellbeing. This set of competencies is broadly aligned to the Level 1 and Level 2 service responses as outlined in the proposed *Initial Assessment and Referral guidance and decision support tool – Child criteria* (Department of Health, 2021).

Participants who can apply these skills to enhance child wellbeing could include: school support officers, community services workers, family peer members, general population,

first responders, peer workers or educators, cultural advisors, childcare workers, disability support workers, or allied health assistants.

Child wellbeing skills for Level 2 settings

Level 2 core curriculum skills are designed to meet the need of workforces that have regular contact with children, families, and adults in a service capacity, these may or may not be solely child-focused services. This workforce can support children's wellbeing:

- directly through provision of low intensity and evidence-based supports for children, parents and families; and
- indirectly through the provision and facilitation of a range of parallel supports such as guided self-help, online resources, telehealth, liaison with consulting specialists, assisted referrals, and advocacy for practical resources to support families.

This level of 'competency' will enable a range of (diploma and graduate) professional workforces across diverse disciplines and settings such as school, community, health service and counselling settings to support children's mental health and wellbeing . This set of competencies is broadly aligned to the Level 2 and Level 3 services responses as outlined in the proposed *Initial Assessment and Referral guidance and decision support tool – Child criteria* (Department of Health, 2021).

Participants who can apply these skills to enhance child wellbeing include: allied health professionals, nurses, midwives, family support services, adult support services, school wellbeing officers/mental health, teachers, early educators, GPs, PHN workforce, disability support coordinators, Head to Health teams.

Proposed Child Wellbeing Practitioner core competency framework:

The core competencies outlined in the framework fall within four broad areas of practice. Our internal consultations highlighted the value of using language that is less diagnostic in nature to make the framework more accessible to a wider workforce audience. As a result, the framework describes the mental health care processes of 'identify, assess, and support' in more simple and inclusive language as 'recognise, reflect, and respond'. These domains are defined in Figure 1 below.

Figure 1 : Generalist child mental health competency domains

Recognise Generalist training in supporting children's mental health will enable a wider workforce to better recognise indicators of child, parent and family risk in encounters with children and families.	**Metacompetencies = Collaborate, Communicate, Coach** Generalist training in metacompetencies will enable a wider workforce to provide flexible, joined up services via a range of methodologies to accommodate the diverse needs of a variety of service models and settings, and to be responsive to the
Reflect	

Generalist training in supporting children's mental health will enable a wider workforce to consider a child's current needs in the context of existing strengths and vulnerabilities and existing supports and reflect on what they can do to contribute to a child's wellbeing.	needs of local communities, including rural and remote settings. Competencies in collaboration, communication and coaching will enable a broader workforce to support children in more effective ways.
Respond Generalist training in supporting children's mental health will enable a wider workforce to consider and prioritise responses that will support a child's social emotional wellbeing through community and ecological supports through to low intensity evidence-based interventions directed at children, parents and families.	

Table 2 below describes the generalist competencies with example behaviours that would be expected of a Level 1 and Level Child Wellbeing Practitioner.

Table 2: **Example behaviours by core competency for Level 1 and Level 2 Child Wellbeing Practitioners**

RECOGNISE	
*Level 1^*	*Level 2^*
Able to ask children about mental health and wellbeing	
Supports wellbeing by opening or directing conversation with the child regarding wellbeing or current concerns in daily life.	Can support wellbeing by asking the child about home and school stressors; assessing the nature and duration of stressors, including with the use of screeners or diagnostic tools as needed.
Able to ask parents about mental health and wellbeing	
Supports wellbeing by opening or directing conversation with the parent regarding their own wellbeing and current stressors in daily life.	Can support child's wellbeing by asking the parent about their own wellbeing and impact on parenting; assessing the nature and duration of distress, including with the use of screeners or diagnostic tools as needed.
Able to recognise (transdiagnostic) indicators of emerging and established mental health concerns in children *	
Can support wellbeing by noticing difficulty in transdiagnostic risk factors such as irritability, impulse control, sleep and emotional regulation in naturalistic settings such as home or school.	Can support wellbeing by detecting, highlighting and assessing underlying transdiagnostic indicators of risk; assessing the nature and duration of risk, including with the use of observation, screening or diagnostic tools.
Able to recognise neurodevelopmental difference in children *	

Can support wellbeing by noticing indicators of neurodiversity that may increase risk including factors such as attention difficulties, emotional dysregulation, sensory issues and learning difficulties.	Can support wellbeing by detecting, highlighting and assessing indicators of neurodiversity; pervasiveness and duration, including with the use of observation, screening or diagnostic tools as needed.
Able to recognise children's developmental needs	
Can support child wellbeing through the ability to recognise when the child is not meeting typical developmental milestones or developmental transitions.	Can support wellbeing by detecting, highlighting and assessing indicators of developmental delay and the extent of developmental risk, including with the use of observation, screening or diagnostic tools as needed.
Able to recognise the role of families in children's wellbeing	
Can support child wellbeing by identifying positive aspects of family functioning and impact on the child.	Can support child wellbeing by identifying positive protective relationships within the family and extended family and identify supporting relationships and opportunities within the child's family of origin or identified family; including with the use of semi-structured and evidence-informed assessment tools that sample protective factors and parenting styles as needed.
Able to recognise when families need support / are not travelling well	
Can identify indicators of family stress, unhelpful family routines and behaviours that likely impact on child across home and school settings.	Can identify indicators of family stress, unhelpful family routines and behaviours that likely impact on child across home and school settings; including duration and impact of distress; including with the use of semi-structures and evidence-informed tools that sample risk and protective factors as needed.
Able to recognise the impact of big events on children (e.g. trauma, moves, divorce, bereavement)	
Can support child wellbeing by recognising and asking about significant events in a child's life; and recognising the potential impact on a child's sense of safety, emotional regulation and behaviour (e.g. school attendance).	Can support child wellbeing by recognising and asking about significant events in a child's life; and recognising the likely impact on school attendance, sleep, sense of safety, parent–child relationships, friendships and learning; including with the use of parent interviews, screening tools, play and observations.
Able to recognise when a child is at risk of harm (e.g. suicidal thoughts, self-harm, drug use)	
Can support child wellbeing by recognising and asking about stressors in a child's life; can identify indicators of depression, suicidal ideation and self-harm. Is confident to ask specific questions that can assist child to disclose risk.	Can support child wellbeing by recognising and assessing extent, intensity and duration of high-risk behaviours and ideation; including intention and unintentional self-harm; using structured risk tools as needed.
Metacompetencies	

As indicated by setting and child's support need:

Collaborate: Assist recognition of emerging concerns through the ability to consider information and views of family members and workers across different settings, agencies, and organisations based on the child or family's presenting needs across different settings. Ability to refer and collaborate with specialist input as indicated.

Communicate: Assist recognition of emerging concerns through the ability to engage with families via a range of means; including face-to-face, information sessions, group settings, informal support groups, telehealth, and online forums.

Coach: Assist recognition of emerging concerns through the ability to access relevant information and supervision as appropriate, and to encourage skill development and integrity of therapeutic interventions in peers.

REFLECT	
Level 1	*Level 2*
Able to consider a child's developmental and mental health support needs	
Can support children by identifying possible developmental risks within the home or school environment and consider opportunities to address these needs.	Can support children by identifying and prioritising developmental and mental health risks for children; reflect on and formulate a plan to address these needs; with consideration of specialist support as needed.
Able to consider a child's strengths / privileging strengths	
Can support children by identifying protective factors in child's world and reflect on opportunities to build these.	Can reflect on identified protective factors and how these can be built on in conjunction with the child and family; create a plan to build on children's strengths.
Able to consider a family's support needs	
Can support children by identifying family support needs and reflect on opportunities to help families address these, including consideration of practical strategies and resources.	Can support children by identifying family support needs, communication style, conflict resolution, and practical support needs and reflect on priorities in conjunction with family; with consideration of joint goal setting and considering mandated requirements.
Able to privilege a family's strengths	
Can support children by identifying and privileging the strengths of a family and creating more opportunity for family members to experience these strengths; with consideration of naturalistic opportunities and practical resources that can create opportunity to build on these strengths.	Can support children by identifying and privileging the strengths of family members and leveraging these strengths and experiences to strengthen these abilities and apply them to other challenges in family's lives.
Able to consider the impact on parent-child relationship	
Can support children by highlighting and reflecting on the impact of family circumstances and the behaviour of family	Can support children by considering and reflecting on how to strengthen parent-child relationships; with consideration of safety,

members on children's wellbeing and considering practical ways to build positive parent-child experiences; considering broad practical strategies such as lifestyle and family routines and celebrations.	harm minimisation and broad practical strategies such as lifestyle, family routines and rituals, and parenting factors known to impact on children's wellbeing.
Able to consider the child's connection to family and community	
Can support children by considering the behavioural presentation of children and families with reference to the values and aspirations of a child's cultural community, with consideration of workers' own assumptions.	Can support children by considering the behavioural presentation and issues raised by children and families with reference to the values of a child's cultural community and parenting practices; with consideration of a workers' implicit assumptions regarding a range of issues such as school attendance, achievements, parenting practices, routines and safety, and how a workers' behaviours and assumptions may impact on families and children.
Able to consider a child's diversity	
Can support children by considering how diversity may impact on a child's wellbeing in environments such as the child's school, sporting clubs, and family environment.	Can support children by considering how diversity may be experienced by children in relation to their ability to participate in the family, social and community environment; with consideration of how interactions with the child may be adapted to better suits their needs.
Metacompetencies As indicated by the setting and the child's support need: **Collaborate:** Ability to reflect on the whole child in their family, social and cultural context, through working with the parents and child to identify strengths and important relationships. **Communicate:** Ability to reflect on the whole child in their family, social and cultural context; ability to communicate a shared understanding through a variety of methods of communication (information sheets, resources, telehealth, face-to-face, digital supports). **Coach:** Ability to reflect on the whole child and their family, social and cultural context, through consideration of effective skill development for parents and children; appropriate reflective supervision or communities of practice learning approaches. Ability to support skills of reflective practice, strength-based focus, biopsychosocial framing, seeking reflective supervision.	
RESPOND	
Level 1	*Level 2*
Able to form partnerships and engage with children's families – work with families as partners	
Can support children by creating opportunities to involve their family members in community activities and	Can support children by creating opportunities to collaborate with parents and other family members; with consideration of strength-based strategies,

events; create opportunities to involve family members within scope of role.	joint goal setting and strategies to engage and motivate parents.
Able to support parents to talk about children's mental health and support needs	
Can support children by creating opportunities for parents to reflect on their children's wellbeing and to discuss concerns.	Can support children by creating opportunities for parents to reflect on their children's support needs and collaborate on a plan to address any support needs; with consideration of strategies to engage and motivate parents.
Able to encourage and support parenting 'capacity' building and the use of positive parenting 'strategies'	
Can support children by creating opportunities for parents to learn practical principles of effective parenting; with consideration of psychoeducation, effective instructions, logical consequences, routines and rituals, family 'rules' and values.	Can support children by working with parents to assist them to learn and rehearse effective strategies for supporting prosocial behaviours, deliver effective instructions, support emotional regulation, and effectively resolve conflict; with consideration of family values, safety, need for additional specialist support and mandatory notification obligations.
Able to support diverse families (e.g., families with low literacy, parents and children with neurodiversity, cultural and linguistic diversity (CALD) & Aboriginal and Torres Strait families)	
Can support children by identifying and accessing practical adaptions such as visual supports and additional resources tailored to the needs of diversity in parents and families.	Can support children by adapting and implementing evidence-based strategies for parent and family support across diverse needs.
Able to support children of parents with additional considerations (CALD, COPMI, AOD, ID, other)	
Can support children by identifying additional support needs in parents and provide practical information about support services and harm minimisation.	Can support children by identifying additional support needs in parents and adapting psychoeducation and parenting support to better meet the additional needs of parents; with consideration of mandatory notification obligations.
Able to support parent-child relationships	
Can support children by identifying opportunities for parents and children to experience positive relationships; consideration of strategies for building positive relationships (e.g., floor time) and techniques for effective discipline.	Can support children by encouraging parenting strengths, structuring play opportunities and supporting parents with effective communication, routines and discipline; with consideration of mandatory notification obligations.
Able to support sibling relationships	
Can support child wellbeing by identifying opportunities to support safe sibling play; can provide practical ideas for reducing sibling conflict.	Can support child wellbeing by identifying strategies for supporting safe sibling play and reducing sibling conflict; with consideration of the additional needs of families of children with additional support needs

Able to develop strategies with family members to support their children's mental health and development	
Can support child wellbeing by providing practical responses to build on children's strengths and positive connections in collaboration with parents; with consideration to additional services and assessments as needed.	Can support child wellbeing by recommending strength-based activities and remedial supports where needed in collaboration with parents; with consideration of low intensity evidence-based interventions for children and parents as required.
Able to facilitate and support families to incorporate play and joint activities in children's lives	
Can support child wellbeing by identifying opportunities to support play and floor time; can provide practical education regarding child development and play based activities to support development.	Can support child wellbeing by working with parents to find opportunities to encourage play based development activities; with consideration of facilitating specialist input as needed.
Able to develop strategies to minimise the impact of parental issues on children's wellbeing and mental health	
Can support child wellbeing by identifying practical harm minimisation strategies for parents; with consideration of strategies to promote parental mental health and wellbeing.	Can support child wellbeing by co-development of harm minimisation approaches with parents; with consideration of additional online supports, adult focused services and mandatory notification obligations.
Able to support parents and families in family transitions - perinatal period, adolescents, separation, loss	
Can support child wellbeing by parental education regarding developmental needs of children at key developmental transitions; with knowledge of referral pathways for additional support as needed.	Can support child wellbeing by providing children and parents with psychoeducation regarding key developmental transitions; ability to respond to difficulty with life transitions; ability to identify and respond to risk arising from transitions and loss.
Able to work with principles derived from Cognitive Behaviour Therapy (CBT) for fostering social emotional wellbeing (connection between thoughts, emotions and behaviours)	
Can support child wellbeing through provision to parent/child of information regarding resilience building strategies including responding to cognitive distortions, behavioural activation and stress inoculation approaches; with consideration of available online supports and guided self-help.	Can support child wellbeing through provision of information regarding principles of CBT and Acceptance and Commitment Therapy (ACaT) as developmentally appropriate; including parental stress inoculation and behavioural activation as required
Able to support children with developmental delays (language, self-regulation, attention)	
Can support child wellbeing by providing practical information regarding resources to support and respond to developmental difficulties, with consideration of guided self-help and parent support groups.	Can support child wellbeing by providing psychoeducation regarding developmental milestones, brain development; and provide practical strategies for responding to these differences in children and for supporting child development.

Able to adapt evidence-based interventions according to a child's needs (e.g., developmental age and stage, current functioning)	
Can support child wellbeing by providing accessible and plain language communication to parents and children.	Can support child wellbeing by scaffolding communications and adapting language level according to child's developmental age and communication level; with consideration to visual aids and visual supports.
Able to support children with (neuro) diversity (SLD, ID, gender identity, higher body weight)	
Can support child wellbeing by accommodating additional support needs and applying principles of scaffolded learning, creating opportunities to experience success, and intrinsic rewards.	Can support child wellbeing by demonstrating knowledge and understanding of the child's experience of diversity to parents and the child; applying strength-based approach to creating opportunity to experience (child identified) success and intrinsic reward; with consideration of the unique needs of children with a range of diversity.
Able to address contemporary issues impacting on heath and wellbeing (sleep hygiene/ cyber safety/ vaping)	
Can support child wellbeing by providing parents or children with credible information about how a presenting issue impacts on mental health and wellbeing; support harm minimisation/health promotion approach with consideration of additional support as needed.	Can support child wellbeing through psychoeducation; highlighting the underlying driver of behaviours and facilitating alternative evidence-based coping mechanisms.

Metacompetencies

As indicated by the setting and the child's support needs:

Collaborate: Ability to respond to child and family needs through connecting families to services, partnering with other agencies or referral for additional supports as needed. Partnering with children and families through guided learning approaches and the development of shared therapy goals. Knowledge of community consultation skills suited to vulnerable groups (as indicated by role e.g., lived experience, place-based program development). Ability to consult with peers; ability to form support networks around the child; Ability to refer and collaborate with peers and with specialist input as indicated. Ability to engage with other agencies on behalf of the child; engage in reflective practice and seek advice from specialists as indicated.

Communicate: Ability to respond to child and family needs through delivery of information, support, didactic skill development and therapy via a range of forums including group work, online delivery, guided self-help, telehealth, face-to-face support.

Coach: Ability to respond to child and family needs through provision of effective instruction and information, including use of visual prompts, infographics, criterion-based instruction, and adaptive instruction. Ability to engage in supervision and skill development and source additional learning. Ability to demonstrate knowledge of relevant legislation and mandates. Ability to provide oversight of guided self-learning approaches.

Benefits of introducing Child Wellbeing Practitioner roles:

- Improve access to evidence-based early intervention approaches including psychological therapies for children with emerging and mild mental health issues.
- Improve access to developmentally appropriate selective prevention and early intervention, reducing the need for more intensive mental health treatment.
- Improve the child and family user experience as the roles fill an existing gap in stepped care and can provide support (or even eliminate the need) during the current extensive waiting times for specialist support.
- Opportunity to develop a locally grown low intensity workforce building on existing skills (undergraduate training for Level 2 or lived experience Level 1) with targeted training in transdisciplinary skills and low intensity interventions through either the VET system (Level 1) or postgraduate training (Level 2). This could be delivered through UDRH infrastructure in conjunction with Emerging Minds.

Risks of introducing Child Wellbeing Practitioner roles:

- A low intensity, short term treatment approach may not be suitable for all presentations and would still require an ease of access to multidisciplinary care or CAMHS support.
- May increase referrals to higher intensity support (i.e. CAMHS or Paediatricians) because of the increased access for children and families.
- Requires strong, local supervision structures and on-going professional development to ensure a level of competency that meets local needs.
- Implementation of IAPT in the UK also has required engagement with an organisation's management and leadership to ensure the role is fully understood and supported within the organisation.

Conclusion:

On balance, given the barriers and challenges experienced by the children's mental health and wellbeing system in Australia, the implementation of Child Wellbeing Practitioners could be a catalyst for transitioning the system to a more effective early intervention and prevention model of care. As outlined in the available evidence, these roles are considered to be successful by contributing to improved mental health outcomes for children, improved access to care for children not currently accessing any and strong return on investment results. However, the success of these roles is conditional on the ability to integrate them effectively into local service systems, particularly with key potential referring partners such as GP practices and educators.

Recommendation 4 – Embedding regional System Designer positions with centralised intermediary support

Description of recommendation:

Establish a national network of System Designers to lead the creation of multisector, place-based approaches to support children's mental health and wellbeing across the service spectrum. System Designers may require support from an intermediary organisation and access to grant opportunities (existing or new) to deliver local changes aligned with identified needs of the population.

System Designers are to be placed in locations across Australia (proposed as the 31 PHN regions) to act as regional leads in developing holistic and stepped models of care based on local needs, workforce composition and infrastructure. The models are to involve cross-sector collaboration and service integration between organisations and programs providing children's mental health and wellbeing support across the mental health continuum. This is expected to result in the development of place-based, integrated, multisector service systems that can adapt to children's mental and health wellbeing needs into the future.

Purpose of recommendation:

To provide dedicated, systems change and implementation support within regions to achieve a localised approach to supporting children's mental health and wellbeing.

Components of recommendation:

A. System Designer role:

Proposed activities of the System Designer role are:

- Work with PHN health data analysts to accurately articulate child mental health and wellbeing service gaps and overlaps within the local PHN catchment.
- Build strong relationships with stakeholders, including service users, community representatives and service providers to identify local barriers to access and service delivery.
- Work with stakeholders to map priority areas for partnerships, capacity building and service delivery and integrate into mental health planning,
- Assess and identify models of care/interventions appropriate for the local context, in partnership with stakeholders.
- Support the integration of models of care/interventions into practice settings through a variety of methods (i.e. training, supervision, mentoring).
- Ensure commissioning activities are evidenced-informed, aligned to identified community needs and undertaken collaboratively with internal and external partners.
- Monitor and support referral pathways as part of a stepped care, continuum of mental health approach.
- Contribute to strategies to support service integration and collaboration across the mental health stepped care continuum.
- Contribute to the development of mental health and suicide prevention needs assessments and planning, ensuring opportunities for meaningful participation from people with lived experience and community members.

- Review and provide advice and guidance in relation to child mental health on the design, implementation, delivery and performance of mental health and suicide prevention services and initiatives funded by the PHN.
- Support the local implementation of key government policies, primarily the National Children's Mental Health and Wellbeing Strategy.

The knowledge, skills, experience and qualifications for this role include:

Essential:
- Relevant degree and post graduate qualifications in health/mental health combined with a minimum three years' experience in a management or strategic planning role.
- Demonstrated understanding of capacity building and understanding of system change and implementation.
- Considerable demonstrated experience of successfully managing multi-stakeholder projects or programs.
- Highly developed ability to provide professional leadership and engage in strategic planning for issues relating to children, mental health and families.
- Significant experience in health service planning, health project delivery or health policy review and improvement.
- Significant experience in high level strategic thinking and planning skills; and ability to transition between the strategic to the operational.
- Proven track record in organisational capability building.
- Excellent interpersonal and communication skills with the ability to motivate, influence and gain commitment and express concepts clearly and effectively.
- Ability to develop, influence and lead strategy in a collaborative manner.
- Successful track record in management of significant budgets, business and project management plans.
- Strong conceptual, analytical and problem-solving skills.
- Ability to be agile and flexible in approach to work with a continuous improvement mindset.

Desirable:
- Significant clinical interest and demonstrated experience in working in mental health and with children, youth and families.
- Understanding of the Australian primary health care system, including understanding of patient care approaches such as stepped care mental health service delivery.
- Understanding of the role of Primary Health Networks as commissioners for the delivery of primary health care.
- Sound knowledge of the relevant legislation, strategic documents and recovery-oriented practice pertaining to working in mental health and with children, youth and families.
- Ability to build and maintain strong collaborative business relationships for the benefit of the organisation.

Key outputs of the Systems Designer role will include:
- Child Mental Health and Wellbeing Needs Analysis (reviewed as per the existing PHN needs analysis guidelines)
- Formation or enhancement of local collaborative networks
- Community engagement
- Grant submission/s

- Training and Implementation Plan/s
- Evaluation and Monitoring reports.

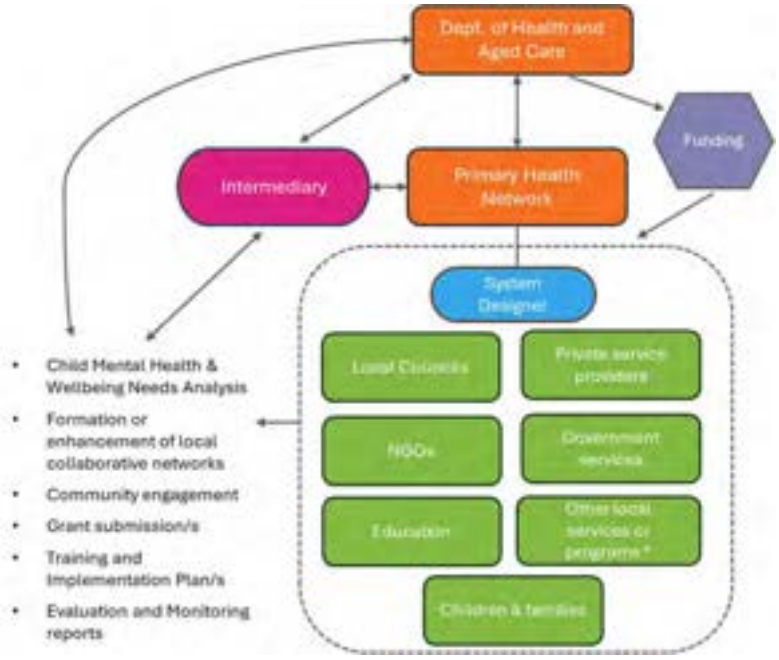
B. Intermediary support:

An intermediary organisation can help build the capacity and capability of the network of System Designers through a structured program of support related to the functions of the new roles. The network could have a coordinated Community of Practice aligned to deliverables and building skills central to the performance of the role. Resources and tools could be developed relevant to the phases of work of System Designers and in response to challenges and opportunities identified as the roles are embedded within each region. Supporting a consistent and high-quality approach across all regions, the intermediary will provide specific advice to Designers and the Department of Health and Aged Care regarding the preparation of Child Mental Health and Wellbeing Needs Analysis, evaluation reports and other deliverables and activities as part of the approvals and review processes. This intermediary role could be supported within the Commonwealth funded National Workforce Centre for Child Mental Health.

C. Funding:

Systems Designers will lead or support other local organisations to access grant and funding schemes (existing or new funding pool) for financial assistance to help with implementation of changes or initiatives identified as part of the regions Child Mental Health and Wellbeing Needs Analysis. Figure *2* below shows the interaction between the components of the recommendation.

Figure 2: Schematic of the System Designer function



Implementation of recommendation:

- Systems Designers are a newly funded role. Examples of similarly funded roles in the service system include Regional Suicide Prevention Coordinators (PHNs), Families where a Parent has a Mental Illness (FAPMI) Coordinators (Victoria, Adult Mental Health), Backbone teams supporting Collective Impact programs.
- Several potential ways to implement the System Designers role include: embed within PHNs or alternatively within the Emerging Minds structure with the roles physically located within each region under both approaches. These options leverage existing structures and extensive regional relationships.
- The intermediary function could be provided by Emerging Minds under either implementation approach – delivered through a Community of Practice approach where System Designers are embedded within PHNs or additionally funded as an internal team positioned within Emerging Minds.
- It is expected System Designers would require additional support such as a Project Officer and access to communications and marketing, data and analysis, and evaluation services.
- This role will collaborate closely with ACCHOs and Aboriginal and Torres Strait Islander programs.
- As these are new roles, the expected trajectory of embedding their presence locally and building relationships will likely progress through phases of work:
    - Short term: establish local readiness for change
        - build relationships and networks
        - develop deep understanding of local service landscape
        - deliver needs analysis.
    - Medium term: oversee placed-based grants
        - Support assessment and selection of suitable strategies to integrate multidisciplinary, multisector system
        - Contribute to submission of grants applications
        - Lead preparation and execution of implementation plans as required.
    - Long term: oversee monitoring and continuous improvement/new initiatives
        - Ensure monitoring and evaluation activities are able to provide learnings to improve service delivery and continue to evolve to meet the regions needs.
- The roles could be implemented over time, focusing on recruitment into locations where a Head to Health Kids Hub has been designated. This role could help hubs ensure they align with the National Children's Mental Health and Wellbeing Strategy.

Rationale:

- Provides a central function solely focused on supporting system development and integration without the often-competing requirement to contribute to service delivery KPIs within a client-facing organisation.
- Targeted to address known system issues impacting mental health and wellbeing outcomes (e.g. fragmented services; siloed approaches; service overlap and gaps; variable workforce capabilities; etc.).
- Focused on mitigating service delivery issues at the systems level and linking with other sectors that interact with children and families (e.g. education).

- Role purpose and proposed functions are designed to support the implementation of key government policies related to child mental health (e.g. National Children's Mental Health and Wellbeing Strategy, Primary Health Care 10 Year Plan, National Mental Health Workforce Strategy, etc.).

Evidence:

The use of System Designer function in Australia and internationally

Foundational to supporting systemic shifts is strong leadership who can play a strategic role in identifying systemic barriers and leverage points, engaging stakeholders and facilitating collaborations (Cheuy et al., 2022; Grady et al., 2018). The King et al. (2022) evaluation of community participation in PHN's national suicide prevention trial noted the importance of the role of the regional coordinator in facilitating engagement with stakeholders, providing direction and momentum to collaborations and supporting integration of otherwise fragmented services. Such roles can also be important to enable the tailoring of multicomponent programs to fit localised needs and services, supporting their effectiveness (Skinner et al., 2021) and to facilitate a coordinated approach to measuring outcomes (Goodyear et al., 2018).

Embedding a System Designer role into each PHN or at the intermediary organisation would enable a coordinated implementation of the National Child Mental Health and Wellbeing Strategy with a consistent national approach while also having the ability to tailor a local response based on the readiness, progress or existing capability of a region. This would support a child mental health and wellbeing lens to be applied to regional data collection and service planning, promoting a prevention and early intervention perspective. Working as a clear point of reference, independent of service delivery agencies, the position has the potential to draw together the multiple threads influencing child mental health and wellbeing that cross governmental departments and sectors. Working as a change catalyst, the role would leverage existing workforces, services and infrastructure to build community capacity to identify and co-create responses to system issues and barriers that meet the changing needs of children and families over time.

Enduring change is dependent on understanding the local needs in order to collaboratively design service systems to fit the context (Metz et al., 2022). This approach emphasises relationship building to develop trust to enable cocreation. While foundational to cultivating ownership, establishing good working relationships is complex and project planning timelines need to account substantial time for this (King et al., 2022). Accordingly, foundational for the success of the role will be recruiting System Designers with highly skilled communication and relationship building abilities (King et al., 2022; Touzin, 2023). Other factors important to the success of the initiative is an authorising environment to support the intergovernmental and sector engagement, buy-in from local services and organisations (many of which may reside in non-health sector) plus communities and families. System change is a slow process requiring long-term investment for sustainability while acknowledging the delay in seeing measurable changes in service responses for children and families or increase in specialist workforce.

Role of an intermediary in supporting success

Within the Australian health and mental health context, examples exist of programs that have the goal of enhancing practice and/or implementing integrated care models which also include a dedicated implementation support component. A review of the statewide coordination function (i.e. implementation support) of the Victorian Families where a Parent has a Mental Illness

(FaPMI) program[6] highlighted the importance of this centralised coordination function in linking service-based Coordinators together to help achieve consistent service delivery and enabling statewide monitoring, evaluation and research (The Nucleus Group, 2018).

Likewise, the Victorian Dual Diagnosis Initiative (VDDI)[7] is responsible for supporting Clinical Mental Health Services (Adult and Youth), Mental Health Community Support Services (MHCSS), Alcohol and other Drug Services (AOD) and the youth homelessness sector across Victoria in delivering of a model of care that embraces comorbidity in all interventions for consumers and their families/carers experiencing mental health and alcohol and drug problems. The VDDI provides expertise in the implementation of evidenced-based tools, approaches, and models of care within practice environments to support high-quality service delivery.

Research discussed by Metz et al. (2021) indicates that involving professionals who offer implementation support is an effective strategy for successful implementation. The proposed functions of a System Designer incorporate evidence-based position competencies examined by Metz such as relationship building skills, facilitation and leadership.

The rationale for a place-based, local approach to improving child mental health

- Emerging Minds defines place-based approaches as *local solutions to local problems* (Centre for Community Child Health, 2017), where the collective needs of families and communities are considered holistically and there is a focus on building community resilience. These types of approaches support addressing entrenched challenges and are a long-term solution to improving outcomes for children and families (Moore & Fry., 2011).
- An example of the application of a long-term place-based approach is the *Stronger Places Stronger People* (SPSP) strategy,[8] which has established 10 Collective Impacts around Australia and is currently scoping the creation of a National Centre for Place-Based Collaboration (Nexus Centre) to support best practice inclusive, evidence-based, place-based approaches.[9]
- Data analyses for this project show that each region has its own profile based on population need and workforce supply which requires a tailored response. Enhancing support will require the use of a range of services (along a stepped care continuum) including access to universal services or deployment of specific evidence-based interventions.
- During the project consultation, stakeholders strongly advocated for any response to improve child mental health and wellbeing to take into account the local context, particularly for rural and remote communities.
- The National Children's Mental Health and Wellbeing Strategy promotes the use of place-based approaches and describes characteristics of successful approaches (National Mental Health Commission, 2021; Centre for Community Child Health, 2017; Moore & Fry, 2011).
- A collection of Australian rural and remote health organisations recently outlined key strategies for better outcomes in the Orange Declaration on Rural and Remote Mental Health (Perkins et al., 2019) which argues for using approaches such as tailoring service models to

[6] https://emergingminds.com.au/resources/families-parent-mental-illness-fapmi-information-professionals-victoria/
[7] https://www.svhm.org.au/ArticleDocuments/2140/VDDI-Role-Contacts-Policy-Context-May-2021.pdf.aspx?embed=y
[8] Department of Social Services Australian Government, https://www.dss.gov.au/families-and-children-programs-services/stronger-places-stronger-people
[9] Department of Social Services, Australian Government, https://www.dss.gov.au/place-based-collaboration

local contexts; co-designed, bottom-up processes; and whole-of-community approaches, amongst others.

Benefits of the System Designer role:

- Funded implementation capacity to support long-term, sustainable system change in a region (funding implementation is a key driver of success); evidence-base for the value of this role.
- Supports the implementation of the National Children's Mental Health and Wellbeing Strategy.
- Centres the consideration of children's mental health and wellbeing under a single role (currently this sits across levels of government and departments).
- Ensures a child mental health and wellbeing lens is applied to needs analysis and service planning, particularly from a prevention and early intervention perspective.
- Independent role outside of any single service delivery agency.
- Responds to the core system issues and barriers identified (fragmented system, service overlaps and gaps, siloed system/s, significant workforce shortages, variable workforce capability in core child mental health and wellbeing competencies, limited system focus on prevention and early intervention).
- Leverages existing infrastructure (through PHNs or intermediary organisation).
- Allows for a coordinated, consistent, tailored approach across Australia with the flexibility to respond locally based on the readiness, progress or existing capability of a region.
- Builds long term capacity of local communities, services and structures to respond to the changing needs of children and families over time.
- Interlinked with other recommendations, which when implemented collectively, will help build the capacity and capability of a generalist workforce to better support prevention and early intervention activities, while simultaneously building a larger, more skilled workforce.

Risks of the System Designer role:

- If not implemented carefully, these roles may be viewed as temporary, and thus may need to be defined differently to support a long-term function e.g. liaison officer.
- Does not immediately (upon implementation) increase the number of specialists available to support children and families.
- Requires an authorising environment and buy-in from local services and organisations to be successful (many of which may reside in non-health sector) plus communities and families.
- child mental health and wellbeing cuts across many levels of government and departments so may be challenging to achieve structural change.
- Role holds a wide-ranging remit which may take time to build local understanding and acceptance of the role.
- Requires permanent, on-going funding to prevent disruption to change process.
- Success of the role dependent on the recruitment of highly skilled, values-based System Designers.

Implementation guidance

Progressing report recommendations

The report recommendations have been developed with the objective of creating long term, sustainable, systems-level change to enhance child mental health and wellbeing support for Australia's children. This level of system transformation inevitably means that some recommendations require a more intensive and extended implementation period. However, several proposed actions, largely related to financial incentives for recruitment and retention activities or funding for pilot initiatives, are proposed specifically for the purpose of rapid deployment. Where possible, these recommendations are linked to existing programs, schemes, or infrastructure to enable this.

It is important to view the report recommendations as a collective response, with actions interlinked to address pressing issues such as service gaps in specific regions, while simultaneously working towards longer-term change targeting pervasive system deficits.

Report recommendations suitable for rapid deployment include:

- Recommendation 1.1 – Targeting recruitment and retention financial incentives
- Recommendation 1.2 – Alternative models of service to rural and remote communities
- Recommendation 1.3 – Recruit to Train scholarships
- Recommendation 2A – Whole-of-practice child mental health skill building program

All recommendations require additional funding, ranging from support for direct service delivery or practitioner incentives through to enabling a dedicated focus on the *process* of change. Allocation of sufficient funding to provide effective implementation support and build the capacity of the system to continue to evolve is critical for realising better outcomes for children and families in the future.

Detailed implementation plans for the recommendations are not within scope of this project. These plans rely on decisions regarding acceptance of the approaches outlined within each recommendation which impact factors such as resource requirements, timeframes, and costs. Emerging Minds will work with Department of Health and Aged Care to develop comprehensive plans if required or provide more detailed information for any recommendations as part of the governments' consideration of this report. Further advice can also be supplied regarding monitoring and evaluation of the implementation of project recommendations.

Considerations for sustainable implementation

The report recommendations support broad change across complex systems. Successful change of this scale requires ongoing stewardship and oversight by government and systems leaders. Drawing on the combined approaches of implementation science and systems thinking offer the opportunity to employ evidence-based strategies to support change efforts over a prolonged period. Systems thinking helps us view the challenges of the broader child mental health and wellbeing system as interconnected, influenced by multiple factors within larger contexts and emphasises understanding relationships and feedback loops which require holistic solutions. Implementation science seeks to bridge the gap between research and evidence-based practice by providing frameworks, methods, and strategies to address barriers and facilitate successful implementation across the various system levels. (Fixsen et al., 2019; Whelan et al., 2023; Harrison & Janes, 2023). These approaches have steered the development of the report

recommendations and can offer guidance on vital activities and conditions favourable for sustainable change.

To support improvements to the child mental health and wellbeing service system, a state of ‘readiness for change’ must be developed, nurtured and maintained across the breadth of services and organisations identified as having an opportunity to support better outcomes (Fixsen et al., 2019). The complication of carrying out the report recommendations across these complex systems reinforces the value of dedicated implementation resources and planning. In part, this need to support change is built into Recommendation 4 through the deployment of a network of System Designers who could act as a conduit between national consistency of pursuing systemic change and application of recommendations in local contexts. System Designer functions are seen as potential valuable resource to support all report recommendations.

Chapter 2.

Project overview

2. Project Overview

Purpose and problem definition

Emerging Minds was contracted by the Australian Government Department of Health and Aged Care to undertake the 'Scoping child mental health workforce capability' project (the project). The project was undertaken to understand more about the existing workforce capability of Australian professionals to support child mental health, particularly in rural and remote areas of Australia where workforce supply is scarce. In the recent National Children's Mental Health and Wellbeing Strategy (National Mental Health Commission, 2021), it was identified that professionals working across primary health, public mental health and other sectors have variable skills and abilities in child mental health, with many professionals lacking the skills or competency to specifically support children's mental health and wellbeing.

This project completed a workforce scoping process to consider opportunities to increase the skills of professionals working with children and families, particularly in rural areas.

Through this project researchers sought to understand child mental health workforce needs and consider opportunities for workforce development in the following areas:

- current workforce capabilities
- service and population demand for these capabilities (unmet needs)
- ideal workforce competencies to respond to service needs
- level of need and capability within specific geographic and demographic workforce groups; and
- models of workforce development and competency building programs that government could commit to.

Our recommendations for policy development outlined in this report are expected to result in better equity of access to early intervention and treatment support for child mental health needs leading to improvements in the mental health and wellbeing of Australian children.

Research questions

To aid the project in reaching its aims, a set of questions were developed to guide the project. As reflected in the structure of the questions, there were three core yet interlinked project workstreams – population demand for child mental health support, workforce supply to provide child mental health and wellbeing services, and workforce competency (present and future) to deliver services that meet population need. Table 3 outlines the project research questions.

Table 3: Scoping child mental health workforce capability project research questions

RQ1	What is the distribution of children aged 0-12 in different locations in Australia?	**Chapter 3**
RQ2	What is the prevalence of mental health difficulties among children aged 0-12, in different locations in Australia?	
RQ3	What is the existing service use by children aged 0-12 for mental health support, in different locations in Australia?	

RQ4	What workforce is available to provide infant and child mental health and wellbeing support?	**Chapter 4**
RQ5	What is the distribution of these workforces across Australia?	
RQ6	What is the current competency and skill levels of these workforces to support child mental health?	
RQ7	What competency drivers exist to support workforce development in child mental health support?	**Chapters 5 and 6**
RQ8	What are the core workforce competencies needed to enhance child and family mental health outcomes?	
RQ9	What workforce development strategies are needed to enhance the scope and skill level of the current workforce, according to location?	**Chapter 1**

Method

Project activities can be broadly captured under four main areas – data collection and analysis; evidence review; stakeholder consultation; and developing recommendations. Table 4 below describes the high-level project activities, timelines, and deliverables.

Table 4: Scoping child mental health workforce capability project activities, timeline and deliverables

Jan 2023 to Mar 2024	Data collection and analysis – Identification and access of public and government held data sources – Human research ethics application and approval through Monash University Human Research Ethics Committee – Determination of appropriate variables and indicators of interest to help answer the research questions – Access to and analysis of relevant data sets using source platform environments and statistical packages (as required) – Presentation and visualisation of data analysis	**Progress Update Sep 2023** **Interim Report Dec 2023**
Feb 2023 to Mar 2024	Evidence review – Desktop research of grey and peer reviewed publications (including citations and secondary sources) using broad search strategy – Identification and analysis of international workforce models for relevance to Australian context and the project research questions – Development of identified workforce competencies and consideration of implementation approach (e.g. tiers of competency, generalist v specialist)	
Nov 2023 to Mar 2024	Stakeholder consultation – Stakeholder mapping and analysis to identify key national and state level contacts covering the target sectors and workforces of interest	**Presentation to DOHAC Feb 2024**

	– Preparation of stakeholder consultation materials (reach out emails, interview guides, interview summary templates, etc.)^ – External stakeholder contact and interviews/focus groups – Written post-interview/focus group summaries	
Jul 2023 to May 2024	Developing recommendations – Review and analysis of government policies and strategies in relation to children's mental health and workforce development – Analysis of findings and implications from data, literature review and stakeholder consultation – Scoping, development and refinement of competency framework and broader system recommendations – Preparation of final report	**Presentation to DOHAC Mar 2024** **Final Report May 2024**

^ *The Monash University Human Research Ethics approval included approval of activities completed in relation to data access and use and stakeholder consultation.*

Key methodology decisions

Key decisions were made early in the project about the quality and reliability of various data sources that have guided Emerging Minds analysis and presentation of findings. These considerations are outlined below.

Use of population level data

The key data sources for this project are the Australian Census of Population and Housing (Census) and Australian Early Development Census (AEDC) due to their coverage of the population and recency of completion (2021). They allow for exploration of broad demographic and sociodemographic data points and are part of the Commonwealth Government's data integration program and provide a consistent data source for considering both population need and workforce supply. Limitations of available data sources are discussed further in the relevant chapters of this report.

Geography standard

The ultimate purpose of this project is to provide government with policy recommendations to enhance workforce competency in supporting children's mental health, with a particular focus on addressing the needs of rural and remote communities. The project team has been attentive to the need to protect the confidentiality of children and families residing in small locations while also presenting data at a sufficiently granular level to support policy responses relevant to a region. Therefore, following discussions with the Australian Bureau of Statistics (ABS), the project will apply the Australian Statistical Geography Standard (ASGS), with data presented in Statistical Areas Level 3 (SA3) (by state or territory) and Remoteness Areas (RAs).

Chapter 3.

The mental health and wellbeing of Australia's children

3. The mental health and wellbeing of Australian children

Chapter 3 overview

In this section we explore the number and distribution of children in Australian regions and the prevalence of established and emerging mental health concerns. We also present prevalence of risk and protective factors for children's mental health outcomes, at a regional level, to indicate the degree of complexity, unmet need or future service need. Through presenting these layers of data, we attempt to create a profile of population need for children and family mental health support which can inform the design of an optimal workforce and service response.

Children represent a significant consumer group within the overall population and across regions. Workforce responses need to adapt to the unique local needs and take account of the supports needed for Aboriginal and Torres Strait Islander and culturally and linguistically diverse children. Here we show, that while data sources vary, a notable proportion (approximately 13%) of the child population are experiencing mental health conditions. In addition to this, children are at an increased risk due to developmental vulnerability or child, family or community level characteristics and could be experiencing sub-threshold mental health concerns. The need for child mental health support is greater overall in rural regions, but also much more variable with not all rural regions being the same.

Understanding child mental health need

Understanding need in child mental health is complex. Child mental health exists on a continuum which includes no disorder or concerns; risks and adversities that may increase likelihood of mental health deteriorating; emerging emotional, behavioural or developmental challenges; through to established mental health concerns which may be diagnosed and ongoing. Conceptualising children's mental health as a function of children's development within the context of the child's ecology, their family circumstances, and their community environment allows for the focus to widen more broadly than diagnosable conditions and corresponding interventions towards a population health approach that incorporates a continuum of mental health and wellbeing.

Clinical staging research indicates that due to the developmental changes in children, it is more likely that those emerging or established challenges will present with multiple and co-occurring emotional, behavioural and developmental challenges. In response, it is recommended that the child mental health workforce incorporate:

- a developmental perspective of child mental health that requires broadening the concept of child mental health to understand the interplay of persistent development experiences (strengths and adversities) on the child's daily experiences. This approach provides expanded opportunities for prevention, particularly selective prevention for children living with persistent adversity and maltreatment.
- a transdiagnostic approach – reflecting the likelihood of those emerging or established challenges present with multiple and co-occurring emotional, behavioural and

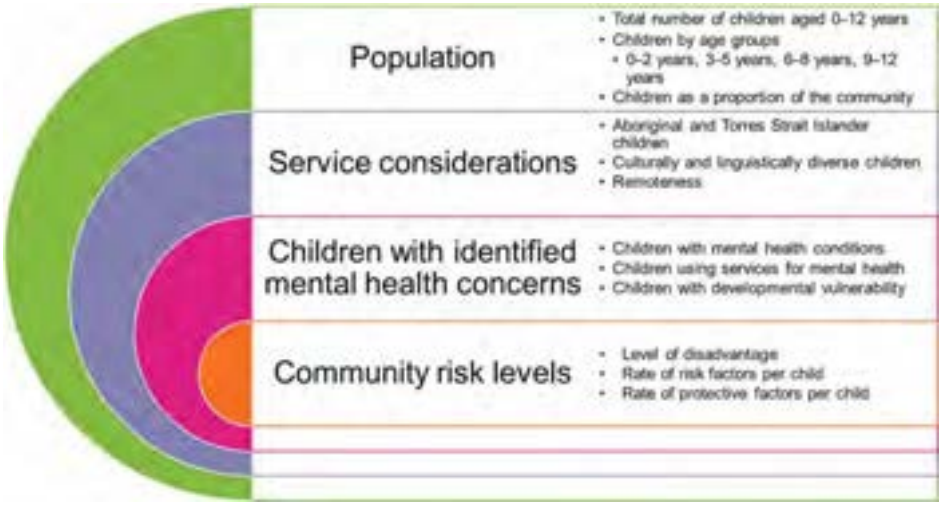
developmental challenges in response to adverse experiences. These transdiagnostic approaches are intervention approaches designed to address the broad array of symptoms using core strategies informed by Cognitive Behavioural Therapy and other evidence-based interventions (Solmi et al., 2022; Cross & Hickie, 2017; Furber et al., 2015; Sawrikar et al., 2022; Barlow et al., 2017; Weisz et al., 2012).

This spectrum of the child mental health continuum means that understanding the mental health service need of children is a complex and multi-pronged approach, and one which varies in case mix and response at the regional level across different parts of Australia. Therefore, we have concentrated on regional level data describing the mental health needs of children as a resource to help determine workforce requirements at a local regional level.

Method for examining population need

We sought to describe the population need for child mental health support at a regional level by obtaining data for indicators of each of the components of need shown in Figure 3. This involves understanding both the absolute numbers of children affected as well as prevalence data indicating the proportional impact of factors in different locations.

Figure 3: Components of population need for child mental health support



Geographical method

The ultimate purpose of this project is to provide Government with policy recommendations to enhance workforce competency in supporting children's mental health, with a particular focus on the needs of rural and remote communities. In the analysis of population level data, we have been attentive to the need to protect the confidentiality of children and families residing in small locations while also presenting data at a sufficiently granular level to support policy responses relevant to a region. Therefore, following discussions with the ABS, data is collated using the Australian Statistical Geography Standard (ASGS) Statistical Areas Level 3 (SA3).

SA3s are geographical areas determined by the ABS which are formed by aggregated smaller geographical units (SA2s) of similar regional characteristics, and which also aggregate to form larger geographical units (SA4s). In total, there are 359 SA3s covering the whole of Australia without gaps or overlap (ABS 2021). Generally, SA3s represent areas containing regional towns, cities or clusters of related suburbs and usually have populations between 30,000 and 130,000 people. This means that more densely populated areas can have a smaller geographical footprint and less densely populated regions can be spread over physically larger areas of land. This is a consideration when resourcing local service responses.

Where data summaries are required, we also present data by State or territory and Remoteness Areas (RAs)[10]. SA3 regions can also be described by their allocation to a Remoteness Area category, however we note these two geographies do not neatly map together and therefore note that the remoteness described for a given SA3 region is an approximation.

The SEIFA Index of Relative Socioeconomic Disadvantage (IRSD) is also used as a general indicator of disadvantage and to be able to compare the level of disadvantage across regions within Australia. The ABS publishes the SEIFA scores and percentiles for small-sized geographic areas (e.g. SA2s and local government areas). We contracted the ABS to calculate the SEIFA IRSD for SA3s because of the significant influence of poverty and neighbourhood disadvantage on children's mental health and its importance in understanding the risk profile of a community.

Data sources

As mentioned above, the initial phase of this project involved scoping and identifying potential data sources to answer the research questions, were publicly or readily available, and could provide data to in the geographical units required for the project. This scoping occurred simultaneously with a literature review that identified the risk and protective factors predictive of child mental health outcomes. We then sought the use of large nationally representative datasets in order to create regional profiles of population and need based on mental health diagnoses, as well as risk and protective factors.

The data scoping and collation period for both the population need and workforce supply data included identifying national datasets from government and other custodians, and assessing the recency of collection, the capacity of datasets to answer the research questions, the accessibility of the data, and the geographical breakdowns it could support.

This period also included the development, dissemination and data collection for Emerging Minds' National Workforce Survey for Child, Parent and Family Mental Health (see Chapter 4 of this report).

The most suitable readily available population need data sources for the project were:

- 2021 Australian Census of Population and Housing (Census)
- 2021 Australian Early Development Census (AEDC)
- 2021-22 Mental health services data via Australian Institute of Health and Welfare (AIHW)

Our primary source of information for understanding child mental health conditions, as well as family and community risk factors at a regional level, was the Australian Census of Population and Housing (Census) conducted most recently by the Australian Bureau of Statistics (ABS) in

[10] Remoteness Areas (RA) divide Australia into five classes of remoteness which are characterised by a measure of relative geographic access to services – major cities, inner regional outer regional, remote and very remote. Remoteness Areas | Australian Bureau of Statistics (abs.gov.au)

2021. The benefits of the Census are that it captures information about almost every person in Australia on Census night and is therefore considered to be the most representative data source.

The AEDC data forms an important part of the mental health need of children in a region, as it provides indicators of development and vulnerability as a snapshot of the key transitional point of the first year of school. While this data refers then only to children who are approximately 5–-6 years old, research has shown the predictive capability of AEDC profiles in the first year of school to forecast mental health outcomes in the proceeding years of middle childhood and early adolescence (Green et al., 2019). Therefore, as a community measure, the level of developmental vulnerability in the AEDC measures tells us about the likely future profiles of mental health need of children.

Data access and limitations

Census data was accessed through the ABS TableBuilder Pro platform. TableBuilder allows registered users to freely query the data and create bespoke tables to download, without providing access to unit record files. This platform is very useful with population data from the Census, however is more limited for survey data such as the ABS National Health Survey where not all variables and sub-groups are available for analysis.

The AEDC data and AIHW mental health service use data were available from their respective websites as downloadable data files that provided the indicators by SA3 regions. We also reviewed other potentially appropriate data sources but found that access or usefulness was limited by restrictions to access (e.g. National Mental Health Service Planning Framework (Diminic et al., 2021)), were part of a privately-owned tool with associated costs to use (e.g. HealthWork allied health workforce planning tool), were a combination of sources which could not provide all indicators for SA3 regions (e.g. The Australian Child and Youth Wellbeing Atlas) or did not readily make data available broken down by SA3 regions (e.g. NAPLAN, PHIDU Social Health Atlas). There are also promising population surveys which are some years away from being available for request by researchers (e.g. Australian Child Maltreatment Study, the next The Child and Adolescent Mental Health and Wellbeing Study, also called Young Minds Matter).

The ABS DataLab was identified as another platform which could potentially provide data not otherwise available at a granular level through access to the Person Level Integrated Data Asset (PLIDA). The PLIDA can support sophisticated linking and analysis of datasets to create a more detailed picture of population characteristics which can be examined at smaller geographical levels, to better understand region-specific service needs. Access to selected data sources within PLIDA was granted in January 2024 and access to service use data granted later in mid-February 2024. We are still awaiting access to other data sources. Unfortunately, the lengthy application process, the limitation on analysis software and stringent approval processes for extracting data from PLIDA has meant there has not been time to make the most of this platform for this report. However, this remains a tool that we will continue to use and explore in the future.

Child population in Australia

In the 2021 Census, 4,004,812 people in Australia's population were aged 0-12 years (16% of the total population). In the Census data, the age '0 years' refers to infants who are aged less than one year. About 1.25% of the population is represented at each single year of age. The proportion of the population within each state or territory is similar, although children make up slightly higher proportion of the population in the Northern Territory (18.4%) compared to other

jurisdictions. Conversely, children aged 0–12 years are a smaller portion of the population of Tasmania (14.2%) and South Australia (14.6%).

Across each age group among children aged 0–12 years, approximately 73% of children live in major cities in Australia, approximately 18% live in inner regional areas, and around 10% live in outer regional, remote or very remote areas. While a very small proportion of children aged 0–12 years live in remote and very remote areas, this still represents over 85,000 individuals. Table 5 below summarises the distribution of children at each age from birth to aged 12 years, by state and remoteness. The population of children in a given region is an indicator for universal need as well as denominators for additional indicators of mental ill-health and risk that illustrate a need for targeted services and workforce supply. To inform the need for local level service requirements, the population of children by SA3 regions by developmentally informed age groups and the proportion of their community that they represent are shown in Appendix 2 Population tables.

Table 5: Number of children in Australia aged 0–12 years by single year of age, by state/territory and remoteness of usual residence, 2021

State/territory	0	1	2	3	4	5	6	7	8	9	10	11	12	TOTAL GEO AREA
NSW														
Major cities	71,132	71,801	72,120	72,060	73,845	75,756	75,148	76,099	76,861	76,991	75,415	75,789	74,346	**967,362**
Inner regional	16,059	16,683	16,959	16,958	17,527	18,403	18,371	18,651	19,211	19,600	19,691	20,076	20,361	**238,555**
Outer regional	3,845	4,149	3,979	4,069	4,232	4,448	4,347	4,587	4,757	4,873	4,764	5,059	4,900	**57,999**
Remote	314	406	356	350	331	367	361	356	378	348	368	375	341	**4,648**
Very remote	74	102	82	86	74	90	104	89	103	93	95	94	70	**1,156**
TOTAL NSW	91,509	93,238	93,583	93,627	96,089	99,138	98,424	99,869	101,396	101,990	100,410	101,468	100,073	**1,270,820**
Vic														
Major cities	57,910	59,097	59,072	59,755	61,386	63,082	62,564	62,520	63,232	61,820	59,862	60,765	59,117	**790,180**
Inner regional	12,637	12,552	13,074	13,524	13,495	14,517	14,453	14,817	15,145	15,119	15,097	15,460	15,591	**185,474**
Outer regional	2,415	2,543	2,599	2,580	2,724	2,893	2,768	2,832	2,787	3,038	2,953	3,049	3,105	**36,295**
Remote	25	20	26	30	22	34	31	42	33	38	42	34	41	**417**
Very remote	-	-	-	-	-	-	-	-	-	-	-	-	-	-
TOTAL Vic	73,078	74,289	74,874	75,963	77,699	80,605	79,890	80,286	81,297	80,094	78,020	79,384	77,920	**1,013,394**
Qld														
Major cities	37,240	37,965	38,835	38,886	40,210	42,064	41,985	43,145	43,486	43,443	43,249	44,107	43,929	**538,544**
Inner regional	9,825	10,373	10,302	10,652	11,005	11,658	11,823	12,313	12,702	12,763	13,148	13,322	13,986	**153,868**
Outer regional	7,150	7,566	7,556	7,890	7,864	8,473	8,733	8,834	8,838	9,339	9,212	9,459	9,434	**110,347**
Remote	931	979	969	981	947	985	1,088	972	1,022	952	970	992	917	**12,719**
Very remote	670	830	770	781	772	845	822	861	832	830	858	840	672	**10,369**
TOTAL Qld	55,887	57,822	58,538	59,308	60,898	64,136	64,560	66,216	66,979	67,420	67,540	68,815	69,031	**827,142**
SA														
Major cities	14,260	14,401	14,321	14,637	14,895	15,609	15,557	15,754	15,897	16,031	15,600	15,796	15,680	**198,443**
Inner regional	1,558	1,503	1,647	1,696	1,743	1,867	1,818	1,945	2,006	2,081	2,048	2,086	2,153	**24,145**
Outer regional	1,987	1,955	2,045	2,062	2,090	2,201	2,184	2,289	2,325	2,423	2,310	2,499	2,465	**28,827**
Remote	473	489	511	513	507	521	537	578	533	552	567	548	566	**6,891**
Very remote	123	165	164	186	166	198	170	187	171	176	177	172	186	**2,245**
TOTAL SA	18,435	18,533	18,711	19,108	19,437	20,435	20,284	20,781	20,957	21,300	20,734	21,118	21,075	**260,908**
WA														
Major cities	24,654	25,195	25,538	26,050	26,777	27,414	26,803	26,778	27,077	26,699	26,875	26,699	26,343	**342,883**
Inner regional	2,271	2,385	2,483	2,539	2,626	2,830	2,961	2,942	2,937	3,107	3,031	3,291	3,131	**36,538**
Outer regional	1,948	2,043	2,091	2,075	2,202	2,312	2,258	2,350	2,419	2,397	2,398	2,450	2,425	**29,367**
Remote	1,163	1,291	1,292	1,350	1,362	1,364	1,377	1,448	1,362	1,344	1,371	1,225	1,189	**17,134**
Very remote	755	870	809	867	828	880	859	906	814	774	801	802	682	**10,635**
TOTAL WA	30,846	31,834	32,290	32,934	33,849	34,850	34,300	34,478	34,659	34,363	34,541	34,513	33,793	**437,252**
Tas														

State/territory	0	1	2	3	4	5	6	7	8	9	10	11	12	TOTAL GEO AREA
Major cities	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Inner regional	3,586	3,678	3,552	3,560	3,702	3,979	3,857	4,024	4,021	3,914	4,143	4,019	4,237	**50,271**
Outer regional	1,820	1,844	1,998	1,960	2,032	2,042	2,139	2,156	2,219	2,227	2,301	2,311	2,476	**27,528**
Remote	70	82	71	73	78	84	75	78	73	81	77	58	79	**979**
Very remote	16	28	24	27	28	28	22	29	22	39	30	28	24	**346**
TOTAL Tas	5,487	5,651	5,659	5,626	5,852	6,136	6,104	6,292	6,345	6,270	6,568	6,422	6,821	**79,233**
NT														
Major cities	-	-	-	-	-	-	-	-	-	-	-	-	-	**-**
Inner regional	-	-	-	-	-	-	-	-	-	-	-	-	-	**-**
Outer regional	1,926	1,890	1,918	1,868	1,941	1,918	1,960	1,955	1,946	1,945	1,809	1,853	1,764	**24,711**
Remote	619	664	657	652	648	698	706	629	632	703	671	694	663	**8,637**
Very remote	485	744	623	676	732	702	788	681	690	710	784	705	688	**9,011**
TOTAL NT	3,055	3,339	3,236	3,244	3,344	3,362	3,485	3,301	3,291	3,398	3,292	3,286	3,139	**42,779**
ACT														
Major cities	5,105	5,301	5,307	5,245	5,651	5,810	5,878	5,855	5,876	5,679	5,622	5,709	5,356	**72,390**
Inner regional	9	9	11	15	11	12	14	6	15	12	6	14	10	**138**
Outer regional	-	-	-	-	-	-	-	-	-	-	-	-	-	**-**
Remote	-	-	-	-	-	-	-	-	-	-	-	-	-	**-**
Very remote	-	-	-	-	-	-	-	-	-	-	-	-	-	**-**
TOTAL ACT	5,121	5,306	5,322	5,262	5,664	5,824	5,894	5,869	5,888	5,686	5,635	5,724	5,364	**72,568**
Other Australian Territories														
Other Aust Territories	43	38	54	50	51	59	59	71	50	65	62	56	66	**713**
AUSTRALIA														
Major cities	210,295	213,761	215,195	216,629	222,749	229,736	227,933	230,152	232,420	230,660	226,623	228,871	224,759	**2,909,794**
Inner regional	45,951	47,177	48,038	48,932	50,118	53,265	53,295	54,702	56,041	56,611	57,176	58,261	59,472	**689,035**
Outer regional	21,084	21,992	22,187	22,515	23,092	24,290	24,383	25,003	25,292	26,233	25,744	26,685	26,562	**315,066**
Remote	3,596	3,928	3,882	3,958	3,893	4,049	4,171	4,104	4,029	4,020	4,070	3,928	3,796	**51,426**
Very remote	2,161	2,780	2,522	2,677	2,643	2,791	2,822	2,818	2,669	2,680	2,799	2,685	2,380	**34,414**
TOTAL AUS	**283,457**	**290,064**	**292,272**	**295,139**	**302,888**	**314,542**	**312,998**	**317,156**	**320,861**	**320,584**	**316,798**	**320,782**	**317,281**	**4,004,812**

Data Source: ABS Census of Population and Housing, 2021

Note: Sum of cells may not match state totals due to rounding and because approximately 5,000 children listed with no usual address are not shown in this table.

Service considerations by region in Australia

In the 2021 Census, 229,149 children aged 0–12 years were identified as being Aboriginal and/or Torres Strait Islander. This accounted for 5.7% of children overall (Table 6). **Aboriginal children are overrepresented in rural and remote areas** (Table 7), therefore it is important that workforce and service responses for rural and remote areas recognise the unique needs of Aboriginal and Torres Strait Islander people, and include Aboriginal and Torres Strait Islander people and the community in the design and delivery of high quality services. Any model of care for Aboriginal and Torres Strait Islander children and families must be contextualised, developed and implemented within the context of self-determination of Aboriginal and Torres Strait Islander peoples (Office of the National Rural Health Commissioner, 2023).

Speaking an Indigenous language has been found to be protective factor for the mental health of Indigenous children (McIvor et al., 2009). The Census reports that 18,728 Aboriginal and Torres Strait Islander children speak an Indigenous language at home, which equates to 8.7% overall, although this varies widely among SA3 regions, from very small in most SA3 regions (for example: Limestone Coast, SA 1.1%, Serpentine – Jarrahdale, WA 1.8%, Tamworth-Gunnadah, NSW 3.1%) to very high proportion of Aboriginal and Torres Strait Islander children speaking their language in areas such as Alice Springs (64.1%), Katherine (68.2%), Daly-Tiwi-West Arnhem (85.8%) and East Arnhem (95.5%) all in Northern Territory and Far North Queensland (94.1%).

Table 6: Aboriginal and Torres Strait Islander children aged 0-12 by state/territory and remoteness area

	0–2 years		3–5 years		6–8 years		9–12 years		TOTAL[a]	
	N	%[b]	N	%	N	%	N	%	N	%
NSW	18,279	6.6%	18,101	6.3%	18,591	6.2%	25,032	6.2%	**80,006**	**6.3%**
VIC	4,262	1.9%	4181	1.8%	4,311	1.8%	5,463	1.7%	**18,220**	**1.8%**
QLD	15,504	9.0%	15,535	8.4%	15,981	8.1%	22,031	8.1%	**69,055**	**8.3%**
SA	2,670	4.8%	2,810	4.8%	2,786	4.5%	3,778	4.5%	**12,045**	**4.6%**
WA	5,422	5.7%	5,796	5.7%	5,725	5.5%	7,622	5.6%	**24,565**	**5.6%**
TAS	1,698	10.1%	1,777	10.1%	1,884	10.1%	2,685	10.3%	**8,040**	**10.1%**
NT	3,096	32.2%	3,415	34.3%	3,476	34.5%	4,838	36.9%	**14,827**	**34.7%**
ACT	524	3.3%	549	3.3%	587	3.3%	702	3.1%	**2,355**	**3.2%**
OT	5	3.7%	3	1.9%	5	2.9%	16	6.5%	**37**	**5.2%**
TOTAL	51,474	5.9%	52164	5.7%	53,354	5.6%	72,163	5.7%	**229,149**	**5.7%**

Data source: Australian Bureau of Statistics Australian Census of Population and Housing, 2021, Via TableBuilder

a) Total includes those residing at no usual address or migratory-offshore-shipping locations. Total may not equal sum due to rounding of small numbers by ABS

b) Aboriginal and Torres Strait Islander children as a proportion of all children in Australia in the same age group and state.

Table 7: Aboriginal and Torres Strait Islander children aged 0-12 by state/territory and remoteness area

	Major cities		Inner regional		Outer regional		Remote		Very remote		TOTAL[a]	
	N	%	N	%	N	%	N	%	N	%	N	%
NSW	38,161	3.9%	30,002	12.6%	9,931	17.1%	1194	25.7%	483	41.8%	**80,006**	**34.9%**
VIC	8,773	1.1%	7,055	3.8%	2,310	6.4%	13	3.1%	-	-	**18,220**	**8.0%**
QLD	26,210	4.9%	16,632	10.8%	16,922	15.3%	3,570	28.1%	5,510	53.1%	**69,055**	**30.1%**
SA	6,658	3.4%	1,098	4.5%	2,754	9.6%	516	7.5%	957	42.6%	**12,045**	**5.3%**
WA	12,054	3.5%	2,042	5.6%	2,945	10.0%	2,895	16.9%	4,485	42.2%	**24,565**	**10.7%**
TAS	-	-	4,036	8.0%	3,840	13.9%	116	11.8%	41	11.8%	**8,040**	**3.5%**
NT	-	-	-	-	3,851	15.6%	3,517	40.7%	7,291	80.9%	**14,827**	**6.5%**
ACT	2,340	3.2%	5	3.6%	-	-	-	-	-		**2,355**	**1.0%**
OT	-	-	35	63.6%	-	-	-	-	5	0.8%	**37**	**0.02%**

TOTAL	94,196	41.1%	60,905	26.6%	42,553	18.6%	11,821	5.2%	18,772	8.2%	**229,149**	**100%**

Data source: Australian Bureau of Statistics Australian Census of Population and Housing, 2021, Via TableBuilder

a) Total includes those residing at no usual address or migratory-offshore-shipping locations. Total may not equal sum due to rounding of small numbers by ABS

A culturally responsive workforce response should also recognise the needs of culturally and linguistically diverse children and families. Culturally and linguistically diverse (CALD) background families can refer to a multitude of definitions and this includes a diversity of populations, including the various migration experiences and cultural, ethnic and religious backgrounds of families. Families of CALD backgrounds may experience significant barriers to receiving mental health support, and culture can play a role in the ways in which families seek and receive support (Mental Health in Multicultural Australia [MHiMA], 2014, 2014a). Young people who speak a language other than English at home can experience increased educational, employment and financial exclusion (Filia et al., 2023). A first step in ensuring a culturally responsive workforce response is to understand the distribution of CALD children and families in Australia.

Given the breadth of experience of culturally and linguistically diverse communities, a suite of variables is needed to understand the number and distribution of children from CALD backgrounds. In 2021, among children aged 0–12 years in Australia, 6.1% were not citizens of Australia (n=24,6230) and 43% had one or both parents born overseas (n=172,3021). **A quarter of children aged 0–12 years use a language other than English at home** (25.7%, n=1,027,531) and a small proportion of these children do not speak English well, or at all (3.9%, n= 158,044).

The distribution of children of culturally and linguistically diverse backgrounds and Aboriginal and Torres Strait Islander children is presented for each SA3 region in Appendix 3 Service Considerations.

Estimating prevalence of child mental health disorders among Australian children

A first step in understanding the mental health services need for children is to enumerate the proportion of children aged 0–12 with a known mental health disorder, which we can attempt to glean from various data sources. Gaps and limitations in data that is readily available have been a regular challenge of this project, as they have with other similar pieces of work (Child Development Council, South Australia, 2022). In attempting to measure prevalence of mental health conditions among children aged 0-12 years, we found a dearth of nationally consistent data, as well as data that is available at the regional level.

In 2021, a new item was added to the Census identifying mental health conditions (asking respondents if they had been told by a health professional of a long-term health conditions which included an option for mental health conditions). This question was asked of all respondents including children, meaning we could enumerate children by age (birth to 12 years), who reported a mental health condition, and could sort the data by different geographical boundaries including the SA3 geography level selected for this project. However, as seen below in Table 8 the data appears to be significantly underestimating the prevalence of mental health conditions compared to other estimates.

Table 8 shows various estimates of prevalence of mental health conditions among children from different readily available data sources, each with their own strengths and limitations. A child mental health disorder may be recorded when children have a recorded diagnosis, they or their families consider there is a condition present based on what they have been told by a professional, or are assessed as meeting a threshold for a potential diagnosis as part of the data collection or interview process. Data sources which focus on diagnosed or diagnosable mental health disorders are also subject to limitations such as access to diagnoses, mental health literacy, and reliability of self-report. There are also limitations of data sources based on a sample to be able to provide estimates which are applicable to a given region. With that in mind, in averaging the prevalence rates found in various data sources below in Table 8, **we can estimate a national prevalence rate of 13% for mental health conditions among children aged 0–12 years.** This equates to 520,626 children in the 2021 Census.

Young Minds Matter (also called the Australian Child and Adolescent Survey of Mental Health and Wellbeing) is a nationally representative population survey that was collected in 2013 and examined the emotional and behavioural development of children and young people aged 4–17 years. This research produced national estimate of prevalence of any (Table 8) as well as particular mental health conditions, although as a sample it was unable to be broken down to smaller regions. Young Minds Matter has been the go-to data source for understanding the need for children's mental health services in Australia, however this data is now a decade old and was collected before more recent cultural events known to impact children's mental health such as the expansion of social media, the COVID-19 pandemic and increased costs of living. The Australian Child and Adolescent Survey of Mental Health and Wellbeing is being run again to update the information from Young Minds Matter and is entering design phase during 2024. It will likely be a few years before the data from this survey is available to researchers and workforce planners but it will be an important source to understand current estimates of prevalence.

Table 8: Estimates of prevalence of child mental health disorders in Australia, selected data sources

Data source	Year	Estimated national prevalence	Sample	Geographical breakdown available (or applicable)	Limitations of this measure
Census	2021	**1.6%** of children aged 0-12 years	Total population	National, state territory, range of ABS and non-ABS geographical structures.	Long term conditions questions. Expected to be under reporting, relies on meeting a threshold for diagnosis, having access to a diagnosis and understanding communications about it from health professionals, as well as the respondent being willing to share this information on a government form.
LSAC[11]	2018 publication based on six waves of longitudinal data	**5.3%-7.6%** of children in age groups between 0-1 and 12-13 years	10,000 children across two cohorts aged 4-5 years and 0-1 years at commencement.	National	LSAC collects Age-based assessments of psychological distress and adversities. This study Application of rates of very high distress in combination with multiple adversities captured within a longitudinal study sample and applied to South Australian population.
National Health Survey[12]	2022–2023	**13%** of children aged 0-14 years	13,100 households across Australia	National	Breakdown of mental health conditions among children by SA3 regions is not available freely in Tablebuilder. Further interrogation of this data source in DataLab may be possible however regional breakdown could be hindered by small numbers.
National Mental Health Survey 2020-2022	2020–2022	**38.8%** of 16-24 year olds reported 12 month mental health condition	15,893 households across two cohorts	National	No children under 16 years are included in this survey. The group of 16–24-year-olds as the next closest age group for young people can be used as a loose indicator of child mental health given that many young adult mental health concerns commence during adolescence.
NSW Child development study[13]	2023 publication of longitudinal data	**2.5%** of children recorded at least one mental health disorder by age 12 years	90,269 children born between 2002 and 2005	NSW only	Data linkage over time drew upon recorded diagnoses recorded in linked health records. This relies upon access to services and diagnoses. The data is from only NSW children meaning it difficult to generalise to other states and territories, however given the large sample regional breakdown for NSW may be plausible via data request.
SA Population Health Survey[14]	2022	**18.8%** of children aged 5-15 years	2,027 SA children aged 0-17 years were included in the 2022 survey	SA only	This was broken down to 10.5% of 5–9-year-olds, 24.6% of 10–15-year-olds. The 2022 study showed similar rates to previous recent years of the survey. Only South Australia and a sample means it is not nationally representative. No geographical breakdown for the mental health data was readily available. An additional indicator of need is that 15.7% of children 5–17 years reported using a mental health service in the past 12 months.

[11] (Segal et al., 2018)
[12] (ABS, 2022c)
[13] (Watkeys, 2023)
[14] (Wellbeing SA, 2022)

Mission Australia Survey[15]	2023	**17.4%** young people aged 15–19 years identified as a person with a mental health condition.	19,501 young people aged 15 to 19 years	National, state and territory	Children aged under 15 years were not included in the survey. This question related to the self-reported demographics of respondents, however within the sections of the survey questions, 38% reported their mental health and wellbeing as fair or poor, and 25% had high psychological distress.
Young Minds Matter (Telethon Kids Institute)[16]	2013	**13.6%** overall for 4–11-year-olds	6,310 parents and carers of children aged 4–17, as well as 2,969 young people aged 11–17 years also completing a self-report questionnaire.	National	This figure is for children aged 4–11 years, while the survey also captured data for children aged 12–17. Anxiety and ADHD account in for the largest proportion of disorders. Data is a decade old from a time before children were as highly impact by social media, COVID-19 pandemic, escalated health inequities. It also doesn't take account of mental health among children aged 0–3.
Global Burden of disease study[17]	2019	**13.85%** of children aged 0–14 years in Australia.	Australia is one of 204 countries worldwide the study captured health outcome data from.	National	Considers both the prevalence and the burden of disease for different mental health presentations. For example while GBD estimates 3.3% of Australian children aged 0-14 years have ADHD, the burden of disease DALYs is rated at 1%. And while conduct disorder affects fewer children 1%, the burden of disease is listed at 3%. Prevalence of different mental health presentations ranges with an estimated 1% for depressive disorders and 7% with ADHD. Overall prevalence of any mental health conditions contributing to death or disability among 0-14 year olds is 13.85%

[15] (Filia et al., 2023)
[16] (Lawrence, 2015)
[17] (IHME, 2020)

Utilising data available to estimate regional prevalence

The team from the Young Minds Matter survey have recently (May 2023) released modelling which produces synthetic estimates of more current prevalence of mental disorders in children and adolescents across Australia (Lawrence et al., 2023). The original survey data was used to model the relationship between prevalence of the disorder and socio-demographic characteristics in areas. These relationships are then applied to 2021 Census data tables at smaller geographical area levels to estimate prevalence of mental health disorders in that area (Lawrence et al., 2023). The modelling has allowed the researchers to provide estimates of child and adolescent mental disorders at various levels including PHN, Commonwealth Electoral District, SA4 and SA3[18].

Synthetic estimates are based on assumptions about the consistency of the relationship between socio-demographics and prevalence of mental health disorders, which do not account for potential differences in this relationship in particular regions, e.g. if there is a particularly effective local program or another mediating factor.

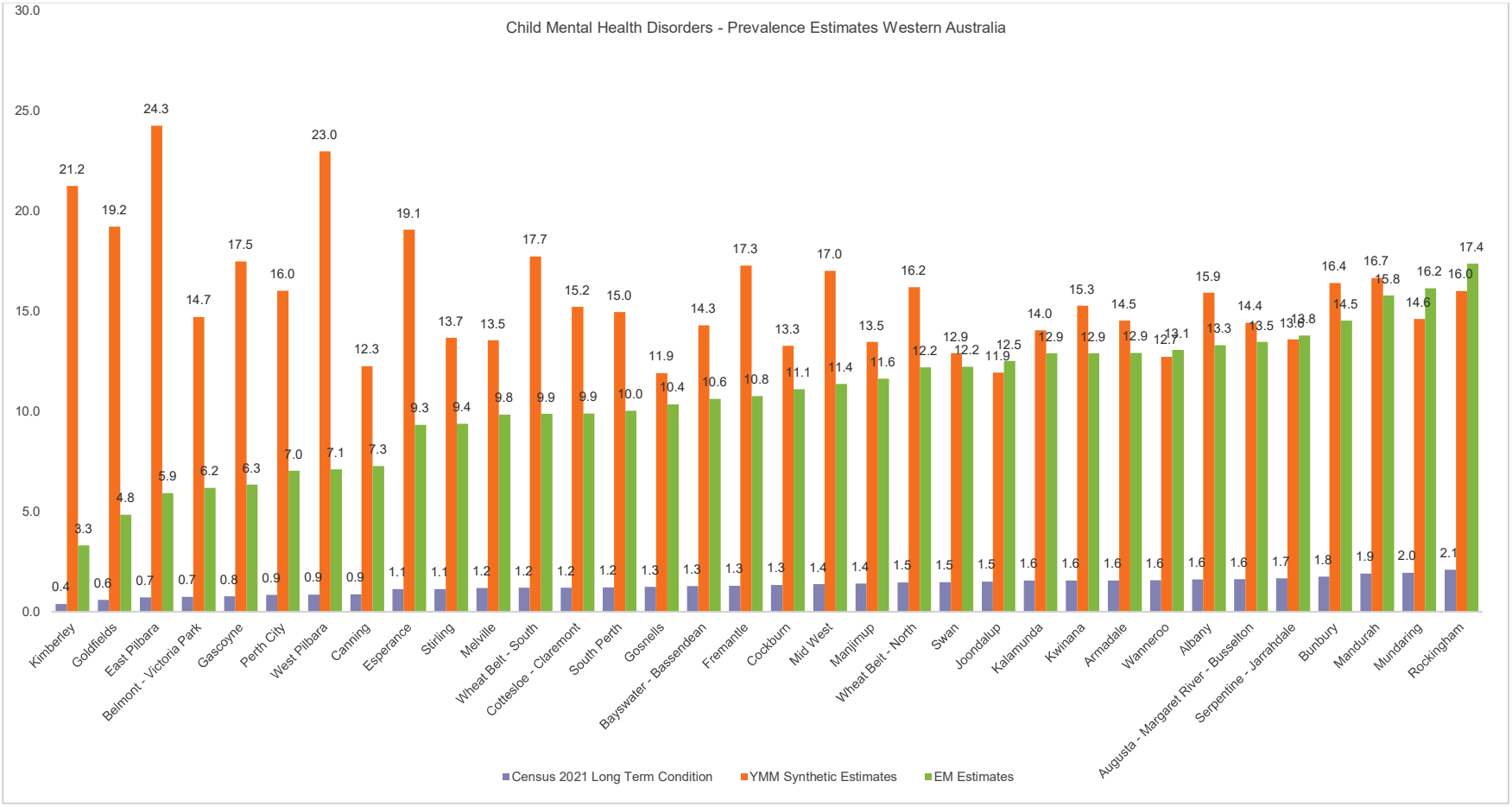
As an alternative, we also drew upon the relative differences in child mental health disorders found between regions in the 2021 Census as a basis for modelling more realistic estimates of child mental health disorders at a regional level. Using the range of prevalence rates found in various data sources (Table 8), we applied a multiplier to Census prevalence rates for SA3s to bring them in proportion to an estimated national prevalence rate of 13%. This method is also subject to false assumptions. Namely that the amount of underestimation of the Census long term conditions question is uniform across all SA3s and that bringing the same distribution up to align with a national average will provide a reliable local estimate. An example of the distribution of prevalence estimates for Western Australian SA3 regions is shown below in Figure 4.

We found that these two models of estimated regional prevalence do not necessarily agree with each other, and each have some indications of inaccuracy. For example, the Young Minds Matter synthetic modelling, relying upon distribution of selected socio-demographic indicators, predicts higher rates of child mental health disorders in some affluent regions such as Darebin, Victoria and expects low prevalence in areas of high disadvantage such as Salisbury, South Australia. Conversely, our estimate based on relative rates in the Census shows the underestimation of the Census, likely linked to factors such as isolation, service access, health literacy and hesitation to report, is compounded in areas where we might expect higher prevalence (based on socio demographic risk factors) such as Alice Springs, Northern Territory where the modelling shows a low prevalence.

However, using the Emerging Minds modelling, we found that **regional areas had higher estimated prevalence of child mental health conditions than metropolitan areas and remote areas.** SA3 regions that were in major cities showed an average prevalence of 11.9% compared to inner regional areas at 17.8% on average and outer regional areas at 12.7%, while remote areas showed prevalence 6.7% and very remote regions averaged 3.5% of children aged 0-12 with a mental health condition (Figure 5). Comparisons of the Young Minds Matter synthetic estimates, the Emerging Minds Census model estimates, and the Census health conditions data for SA3 regions in each state are presented in Appendix 4 Prevalence estimates – child mental health conditions. While it is clear our modelled estimates are not infallible, the proximity of this data to actual children throughout Australia via the Census and the directness of the mental health conditions question (compared to the socio-demographic profile approach of the synthetic estimates) makes it our preferred method of those available, at this stage.

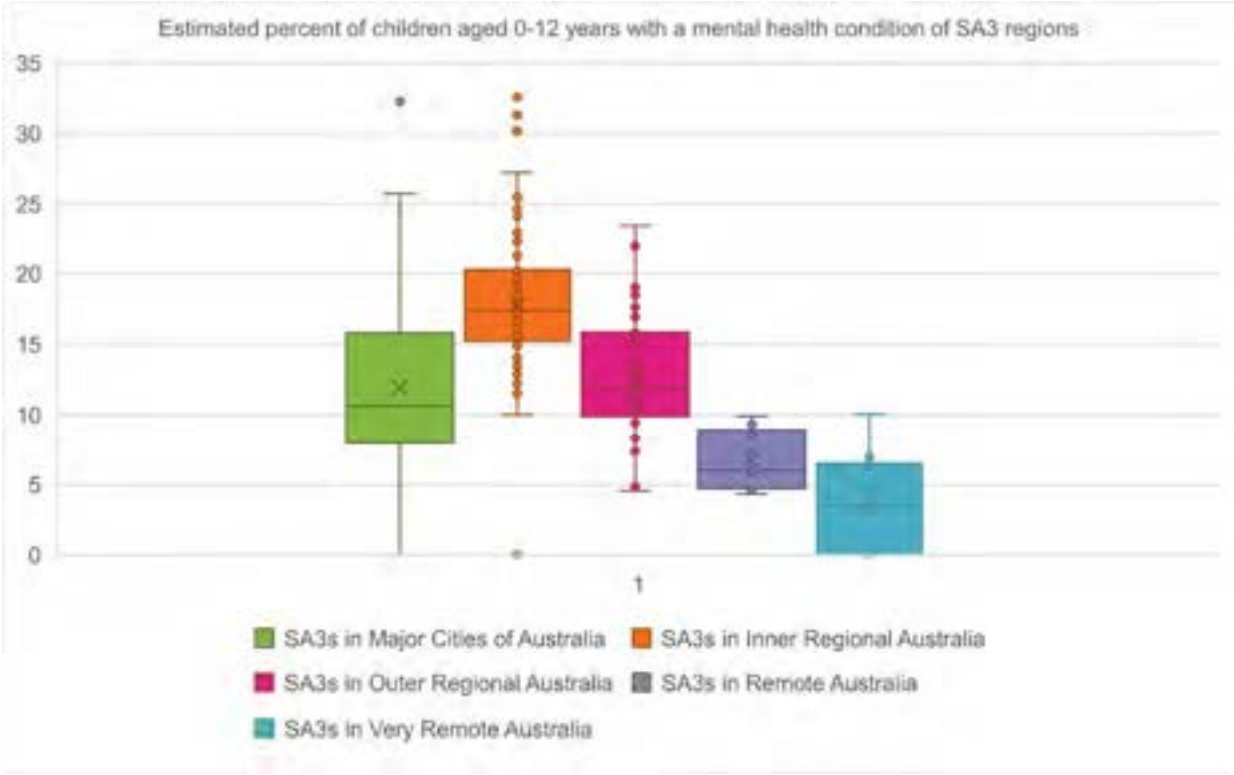
[18]Synthetic estimates were not produced for SA3s with less than 100 children aged 4–17 years.

Figure 4: Comparison of prevalence estimate models of child mental health disorders, by SA3 region, WA



Data source: ABS Census 2021, Lawrence et al., 2023.

Figure 5: Emerging Minds modelling of child mental health conditions prevalence in SA3 regions by remoteness area classification of regions



Data source: Emerging Minds scaled up modelling of Census 2021 health conditions data

Child development as an indicator of mental health vulnerability

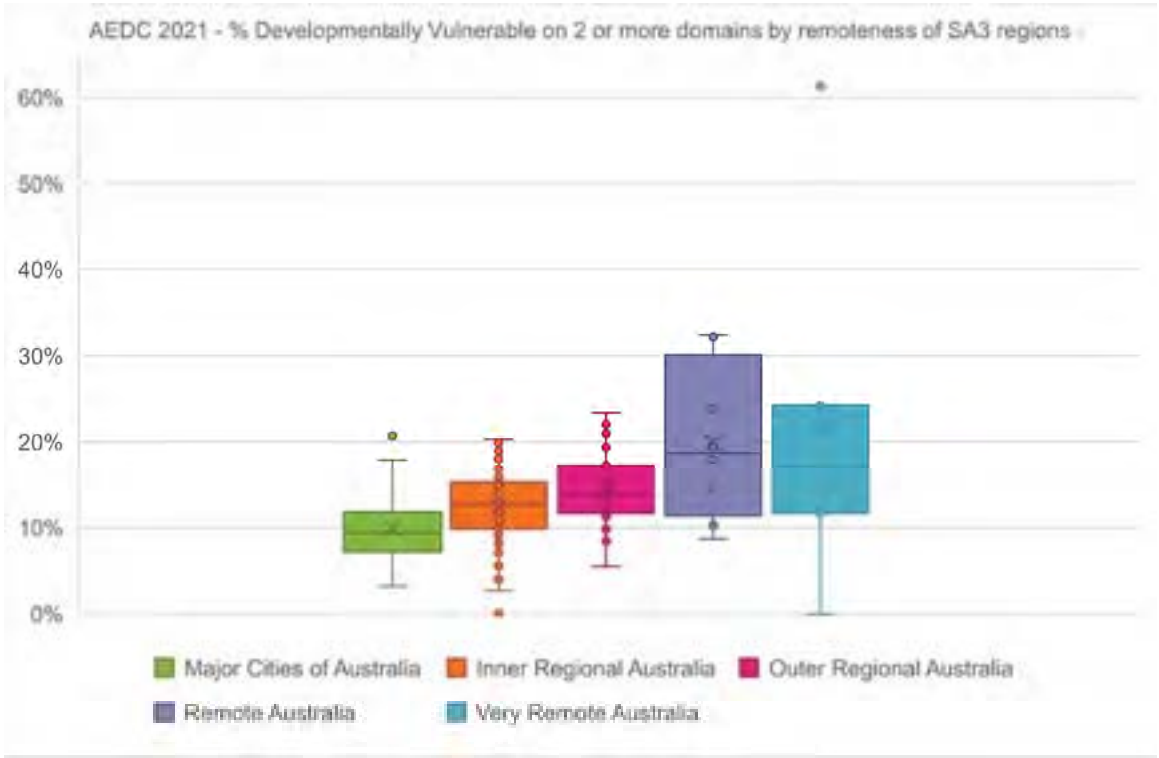
The most telling indicator of the level of severe developmental vulnerability from the available AEDC data is the proportion of children who were found to be developmentally vulnerable on two or more of the five domains of the AEDC testing. The AEDC is a national assessment conducted every 3 years to examine how children have developed by the time they start school. It looks at 5 areas of early childhood development in children: physical health and wellbeing, social competence, emotional maturity, language and cognitive skills (school-based), and communication skills and general knowledge in their first year of school.

Nationally, 11.4% of Australian children starting primary school are developmentally vulnerable on two or more domains, and 22% of children are developmentally vulnerable on at least one domain (AEDC 2021, online data cubes). Figure 6 plots the level of developmental vulnerability in SA3 regions, by the remoteness of the regions. As mentioned above, SA3s do not map directly to remoteness area (RA) classifications so we have allocated the regions to the most representative RA classification using ABS correspondences.

Major city SA3s tended to show lower percentages of children developmentally vulnerable on two or more domains, with half of the major cities regions having between 7.2–11.8%, the outlier being Playford, SA, a large metropolitan council area outside of Adelaide, where 20.7% of children were developmentally vulnerable on two or more domains. However, **as remoteness increases the range of levels of developmentally vulnerable children increases. Remote and very remote SA3 regions show higher proportions of vulnerable children but also broader range in these proportions, demonstrating both an increased need and increased diversity of that need across different regions**. Six remote or very remote regions (out of the 15 measured) had greater than 20% of children developmentally vulnerable on two or more domains. An outlier in very remote Australia being Barkly, NT where 61.3% of children in the 2021 AEDC were vulnerable on two or more domains.

The results for each SA3 region on selected indicators from the 2021 AEDC, including social and emotional competence is in Appendix 5 Australian Early Development Census tables.

Figure 6: Percent of children in SA3 region that are developmentally vulnerable on 2 or more domains, by remoteness area classification of the region, AEDC 2021



Data source: Australian Early Development Census 2021 Public table by Statistical Area Level (SA3) 2009-2021 (aedc.gov.au)

Service use

Exploring the current levels of service use by children for mental health concerns can add to the picture of prevalence of mental health concerns among children by indicating demand, as well as providing information about the extent of mental health treatment across regions.

Various data sources help us understand trends in service use among children and families, even when region specific data is not available. The evaluation of headspace in 2015 (Hilferty, 2015), indicated that among their target audience of 12–25-year-olds, the caseload was stacked towards younger clients with those who were aged 16 years making up the highest proportion (19 out of every 1,000 of this age group across Australia having sought support from a headspace centre in 2023/14). This could be seen as an indicator of need for early intervention support for even younger age groups. Approximately 3% of 12-year-olds across Australia sought support from headspace in that same period, and by age 13 it was closer to 10% of children that age. Evaluators also found that children aged 12–17 living in non-metropolitan areas were over represented among headspace clients in 2013/14.

The gap between disadvantaged and less disadvantaged areas is exacerbated outside of major city areas. PHIDU social health atlas indicates that among young people aged 15–24, those in the most disadvantage areas were much more likely to attend a public hospital emergency department for a mental health condition than those in the least disadvantaged areas. In metropolitan areas, young people in the most disadvantaged areas had a 61% higher rate of mental health presentations to an emergency department compared to least disadvantaged areas, and this gap widens in regional areas to a 79% higher rate.

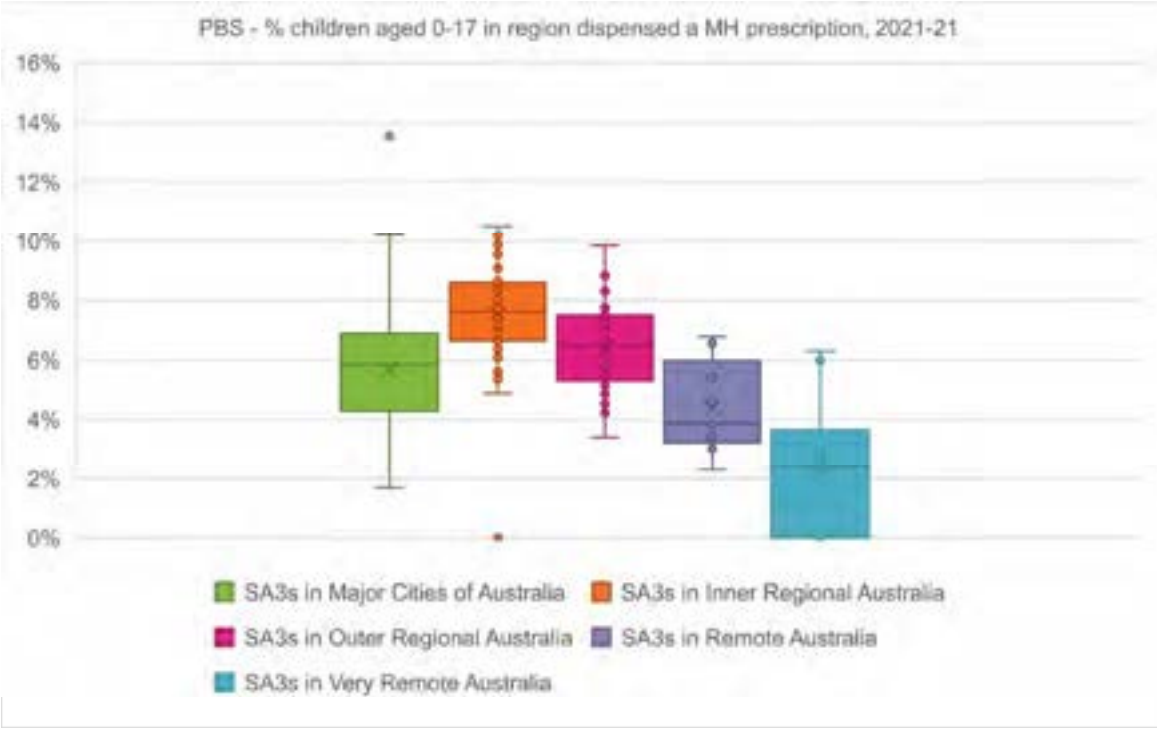
The Young Minds Matter team were able to use synthetic estimations of need through their modelling mentioned earlier in this report – whereby mental health conditions prevalence from the 2013 Young Minds Matter data was applied to Census 2021, to estimate service demand among children aged 4–11 and 5–17 (Pagliaro et al., 2022). Their modelling found that those children with an experience of a sub-threshold mental health concern in the previous 12 months were more likely to demand a service than those with an existing mental health concern that has been remitted for the past 12 months. Therefore, while we can look at service utilisation data that is available, understanding the demand for services needs to account for children with sub-threshold concerns which perhaps do not meet criteria for diagnosis as well as those who do, and we will explore this in the next section on risks.

The Australian Institute for Health and Welfare (AIHW) via their publication Mental Health Online, has produced data on use of mental health services and includes some data on mental health prescriptions and Medicare subsidised mental health specific services. Almost a third of mental health services were delivered by telehealth (phone or video) in 2021–22 (4.2 million services, or 30.9%. GPs were less likely to provide mental health services by telehealth than other practitioners (18% compared to 37% by psychiatrists, 39% clinical psychologists, 34% other psychologists and 27% other allied health providers) (AIHW, 2023). Other allied health professionals providing MBS subsidised mental health services include occupational therapists, social workers, Aboriginal health workers, and mental health nurses. The readily available data was unfortunately unable to be broken down by children or region.

Pharmaceutical Benefits Scheme (PBS) data was readily available for prescription of medication for the mental health of children in the age group 0–17 years. Figure 7 **shows children in SA3 regions located in inner regional and outer regional areas (average of 7.6% and 6.4% of 0–17-year-olds respectively) are dispensed mental health prescriptions at a higher rate than**

children in major cities (average 5.7%). The rate of prescriptions for children is lower in remote and very remote areas (average 4.4% and 2.3% respectively) although the length of the boxes in Figure 7 show the access to prescriptions is very variable among the ten very remote regions included, with several regions having no children prescribed medications.

Figure 7: Proportion of children aged 0–17 in region dispensed a mental health prescription in 2021–22



Data source: Mental health online report: PBS Mental health-related prescriptions data tables

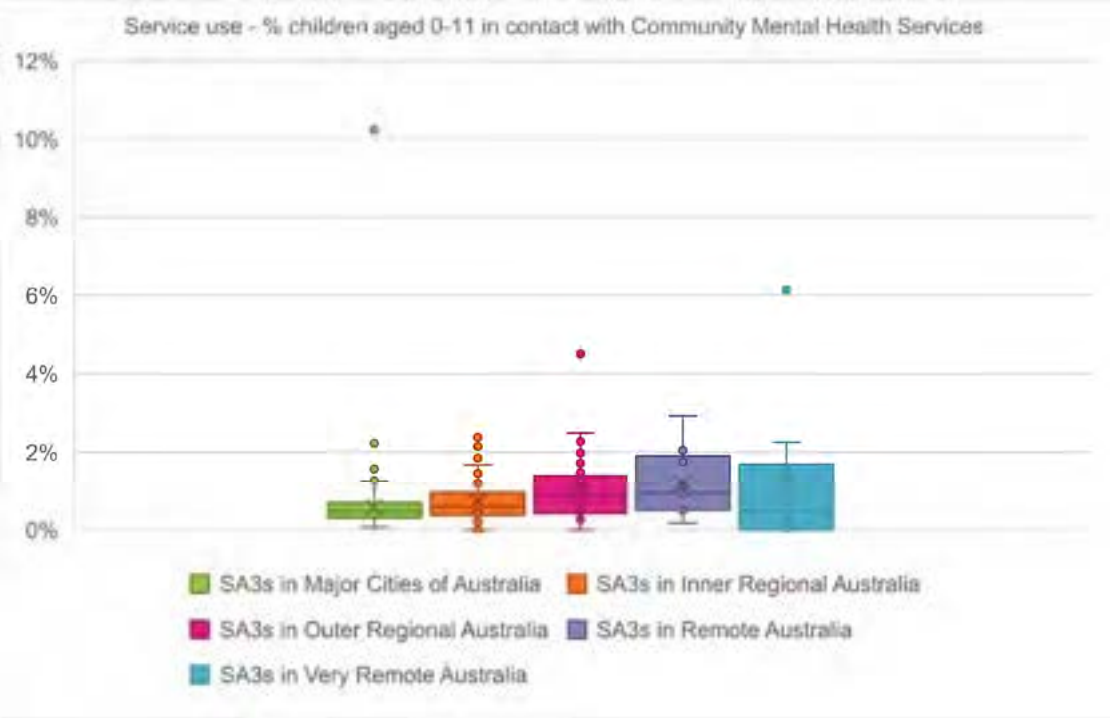
AIHW Data was also available for children in contact with Community Mental Health Services, and this was available for two age groups: 0–11 years and 12–17 years. As the project focus is on children aged 0–12 years, we present the data to the younger group here. Very small proportions of children aged 0–11 years are in contact with community mental health services across all regions, on average 0.7% (for comparison, an average of 4.6% of children aged 12–17 years accessed community mental health services in 2021–22). However, this rate is most consistently lowest among SA3 regions in major cities (average 0.6%) and increases with remoteness with remote and very remote regions average 1.2% of children aged 0–11 in contact with community mental health services) (Figure 8). An outlier to this pattern is Canberra East, ACT where 10.2% of children have accessed community mental health services. Conversely, when looking at the average number of contacts children have with community mental health services, children in major cities tend to have more occasions of service than their rural and remote counter parts (average number of contacts major cities 12.7 per child, inner regional 9.6, outer regional 9.3, remote 9.5, very remote 10.3) (Figure 9).

The service data we have obtained AIHW indicates **there is consistently higher utilisation of services in rural and remote areas, but also increasing variability within rural areas about**

whether that need is met with services or medication. Among those who do access services the amount of services provided appears to be less in rural and remote areas.

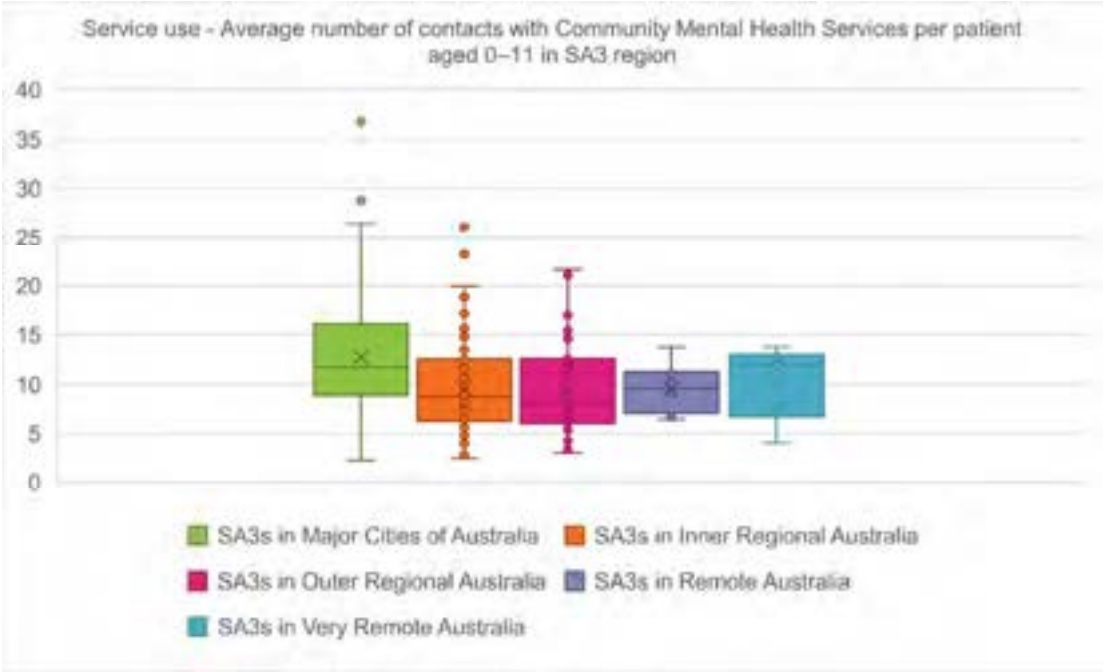
Proportions of children accessing prescriptions and community mental health services for each SA3 region is available in the summary of population needs in Appendix 7 Population need summary.

Figure 8: Proportion of children aged 0–11 in region in contact with Community Mental Health Services, 2021–22



Data source: Mental health online report: National Community Mental Health Care Database (NCMHCD) data tables

Figure 9: Average number of contacts with Community Mental Health services by children aged 0–11 in region, 2021–22



Data source: Mental health online report: National Community Mental Health Care Database (NCMHCD) data tables

Risk and protective factors for children's mental health and wellbeing

One particular way to estimate children at-risk is to examine data sources that might be able to indicate the number of children living in situations where they might be vulnerable to mental health issues. Children's mental health is shaped by the systemic environment in which they live. Building from the description given by Bronfenbrenner's concentric circles (Bronfenbenner, 1994), this environment contains both risk and protective factors that act on the child. Typically, risk factors are described as something that may increase the child's chances of adverse outcomes in the future. Conversely, protective factors buffer or moderate the influence of such risk factors on the child (Toumbourou et al., 2014). These factors are important to the current workforce stocktake project as they give insights to the need of Australian children but can also indicate potential areas of focus for both workforce policy and practice.

Within literature, these risk and protective factors are conceptualised, organised, described and utilised in many ways (Fox et al., 2015; Ungar & Theron, 2020). Commonalities to most descriptions include:

- Categorisation of factors by domains describing the proximity of each factor to the child, such as; Parent, Family, Peer and Community.
- A focus on modifiable factors that can be influenced by policy and practice changes.
- Description of factors in terms of their impact (i.e. amount of exposure to factors and their persistence over time).

Desktop research identified the limited attempts within the Australian context (see Green et al, 2018; Guy et al, 2016; Toumbourou et al, 2014) to describe these risk and protective factors using appropriate data (i.e. research reporting on Australian cohort studies), culminating in the findings presented in Table 9.

Table 9: Summary of relevant risk and protective factors for mental health and wellbeing of children aged 0–12 years of age

Domains	Relevant theoretical processes underpinning	Modifiable Risk Factors	Protective Factor that can be strengthened
Child	Theories relating to toxic stress Executive function and self-regulation	Family conflict	Social and emotional functioning Mental health conditions
		Maltreatment, neglect & abuse	
		Bullying & victimisation	Cognitive processes and temperament
		Irregular sleep patterns, feeding problems, and excessive crying (infant only)?	
		Pregnancy/birth complications (+alcohol use)	Self-regulation, mastery and autonomy
		Developmental delay	

Domains	Relevant theoretical processes underpinning	Modifiable Risk Factors	Protective Factor that can be strengthened
		Conduct	Family resilience processes School attendance Academic achievement
			Emotional competency
		Hyperactivity/ADHD	
		Bullying	
		Self-esteem	
		Numeracy, literacy and motivation (truancy etc)	
		Physical Health	
		Stressful life events	
Family	Social and emotional competence Family Systems theory	Family Violence	Stable caring and supportive relationship with adult
		Harsh & coercive parenting style	
		Parental Psychopathology	
		Marital Discord	
		Chronic disease and physical disease (e.g. cancer)	Family Cohesion
		Drug and Alcohol Issues,	
		Parental separation	Family Social supports
		Parental offending/incarceration	
Peer	Physical development	Early and frequent exposure to substances including recreational drugs and chemicals	Peer connection
Community	Behaviour development theories	Family history of Mental illness	School and community prosocial bonding Community attitudes
			Neighbourhood safety and connection
			Acceptance of cultural identity
			Natural environment
			Social inclusion

Domains	Relevant theoretical processes underpinning	Modifiable Risk Factors	Protective Factor that can be strengthened
		School suspension and low attendance	Healthy opportunities and effective services (e.g. access to psychological services)
			Environmental safety
		SES	
		Homelessness	

Health and wellbeing domains

Child

The concept of toxic stress emphasises the impact of prolonged adversity on a child's developing brain and stress response systems. Exposure to chronic stressors, such as abuse, neglect, or conflict in the home, can disrupt neurobiological processes, placing long-term pressure on cognitive, emotional, and social development (McEwen et al., 2015). This exposure of toxic stress can make it more difficult for children to manage regular stressors in daily life such as learning in a busy classroom. The creation of supportive environments that prevent children from experiencing toxic stress is an important pathway to positive mental health.

Executive function and self-regulation theories describe cognitive processes that govern a child's ability to focus attention, solve problems, plan ahead, adjust to new circumstances, regulate behaviour, and control impulses (Shonkoff et al., 2012. Adequate executive function and self-regulation skills are crucial for navigating the challenges and stressors of daily life. These skills can be strengthened through structured activities and supportive relationships.

Family

Children are impacted by their experience with the home environment and the family as a system. This impact can be through their direct exposure with the environment at home or mediated through their caregivers, via parenting practices. Family Systems Theory is an important theoretical framework in this domain that conceptualises the family as an interconnected and interdependent system (Walsh, 2003; Broderick, 1993; Dunst, 2023). It focuses on the dynamic interactions of family members, how it operates and how members communicate. This perspective describes a complex web of interactions between family members where one interaction influences another. The theory suggests that individuals thrive in families when they are closely connected but also have autonomy. At its heart, a holistic view of the family as a system allows practitioners, and policy makers to realise that individual issues are intimately connected to the broader family dynamic.

Peer

Physical development risk process theories relate to a child's social network beyond the family where they are impacted by their interactions with peers (see Toumbourou et al, 2014). Physical development risk process theories often conceptualise how brain development, social and emotional development and risk-taking behaviour interact with a child's peer relationship network. Important factors here are making and keeping friends, bullying behaviour and exposure, risk-taking behaviours and peer networks and parents' engagement with the child's networks beyond home.

Community

Behavioural development theories emphasise observational learning and modelling, understanding behaviours such as aggression and prosocial actions (e.g. helping others, cooperating and sharing) (Toumbourou et al, 2014). In this setting, these theories describe how children engage with the community, outside their home life. Often indirectly, interactions span from economic and societal to more proximal such as engagement with school and others community settings. Understanding the context of where children live and what services are directly available to them are important for practitioners and policy makers.

How should we use risk and protective factors for children's mental health and wellbeing?

A focus on practitioners

Practitioners play a role in monitoring child stress and identifying exposure to stressful environments or events. This includes prevention activities, identifying and addressing risk factors that may contribute to mental health difficulties and those factors that might offset risks. Early intervention requires another set of competencies that entails identifying signs of emerging mental health difficulties and providing timely support and resources. Overall, the evidence on risk and protective factors suggests practitioners should seek a broad understanding of the child's experience of the world as a first step to inform preventative and early intervention strategies.

Despite this, there is no agreed upon standards for practitioners to assess or monitor risk and protective factors. Cibralic et al (2022) argue that population-style ACE's screening, at this stage, might be unhelpful for several reasons. Creating a cut off score for risk factors could be problematic given the potential for each factor needing different weighting. Additionally, severity, timing and duration are often not considered in most screening tools (Cibralic et al., 2022). This suggests a need for thorough exploration about the effectiveness of screening tools to identify risk and protective factors for clinical use. More importantly though, it shifts the focus towards system-level stakeholders use of risk and protective factors to improve child mental health. Looking at complex systems related to other health challenges showcases this need to focus more on the system as a whole rather than focusing efforts on practitioners. Within obesity, research has identified that intervention efforts are skewed towards downstream stakeholders (Nobles et al., 2021), such as practitioners and individuals, when this complex problem has many causes beyond the control of these downstream stakeholders.

A focus on the systems level (integration of prevention, early identification and treatment support)

When considering risk and protective factors for child health and wellbeing, Toumbourou et al. (2014) outline the importance of risk aggregation theories. These theories explain the impact of

risk and protective factors as something that is *accumulated* through the amount, severity, timing, duration and sometimes type of risk or protective factor. Additionally, risk aggregation theories propose that risk and protective factors are *interconnected* and can accumulate and interact in complex ways. Given this, risk and protective factors should not be considered in isolation from one another and need to be considered as part of a system of influence, especially when only considering a single timepoint in a child's life.

System led solutions might include child mental health support provided by smaller systems such as local communities, geographical areas or PHN catchments and broader systems such as the primary health care system, in which practitioners participate in or contribute towards. Given that different geographical areas and cohorts of children are exposed to different combinations of risk and protective factors, understanding context is an important step for understanding child mental health needs. What works in one area may not work in another.

Although the logic is to focus broadly on risk and protective factors and to focus on contextual issues, there are potential exceptions to these rules, such as the causal relationship between child maltreatment exposure and mental health outcomes (Green et al., 2018; Grummitt et al., 2024). As a counterpoint to child maltreatment, one of the most well documented protective factors is having access to a warm and responsive adult. This protective factor has been suggested to ameliorate other risk factors (Shonkoff et al., 2015), including child maltreatment (van IJzendoorn et al., 2020). This evidence suggests the need to include a weighted focus on these factors regardless of contextual factors.

Estimating the level of risk to child mental health in regions

In collating risk factor prevalence by SA3, we are limited by data which has been readily available and able to be broken down by SA3 regions. In many cases these data are available for one indicator at a time and so collating the total number of children at increased risk of mental health concerns is difficult. This is because we know that many children will experience multiple risk factors and to simply sum the indictors would lead to both double counting children and underestimating complexity.

To understand then how a collection of single indicators could be used to compare the level of risk in each SA3 region, we calculate the average rate of risks per child using:

The sum of instances of each risk factor is divided by
the number of children aged 0-12 years in the region

Without knowing how many children are experiencing multiple risk factors and in what combination, this approach means the multiple risks are averaged out across the local child population to give a general impression of the load of multiple risk in this region. This method is also limited by the data available, meaning only risk factors that have region-level data are included. It also assumes all included risk factors have equal weight and equal impact on all children, when we know this is unlikely to be true.

The ratio of risks in region by children aged 0–12, includes the following indicators from the 2021 Census:

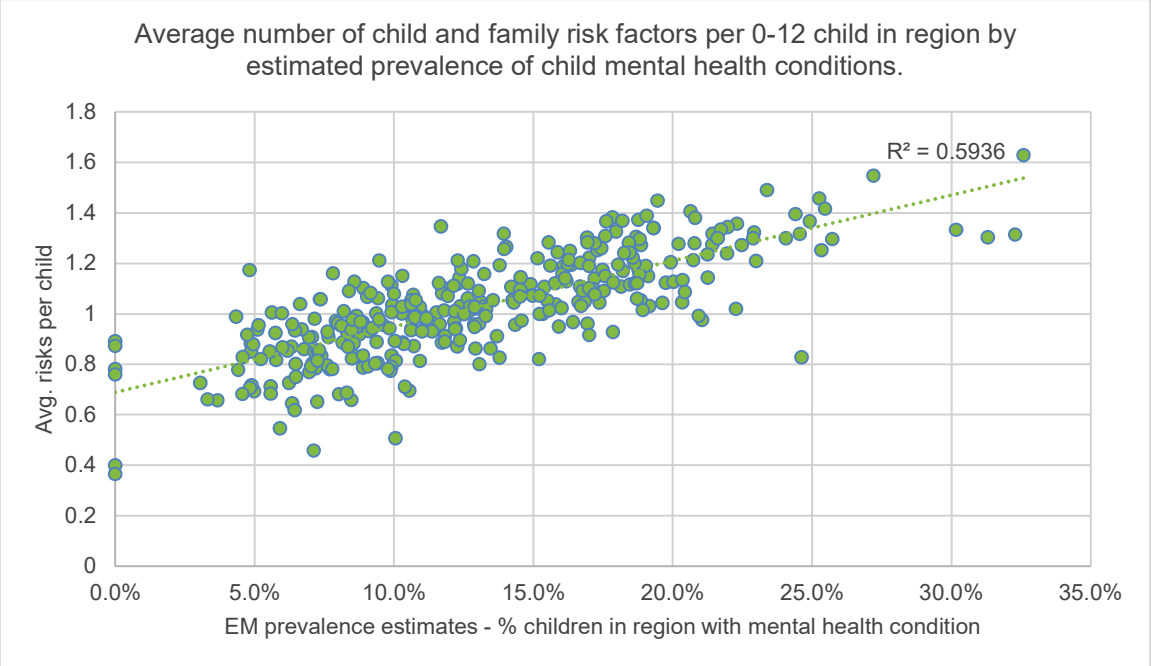
- **No. children 0–12 with any health condition/s** - *(nationally 7.5%)*
- **No. children 0–12 has need for assistance with core activities (disability)** – *(nationally 3.3%)*
- **No. parents with one or more long term health conditions** – *(nationally 27.7%)*

- **No. parents with mental health condition** – *(nationally 9.4%)*
- **Children who are a foster child** – *(nationally 0.3%)*
- **Parents who are a lone parent** – *(nationally 16%)*
- **Estimated no. homeless 0–12s in region** – *(nationally 0.9%)*

This method indicates a **national average of 1.03 risks per child aged 0–12 years.** Low levels of risk are shown in regions such as Lord Howe Island, NSW (0.4) and West Pilbara, WA (0.46) and higher risk in regions such as Bribie-Beachmere, QLD (1.63) and South East Coast, TAS (1.49). Figures 6a – 6h in Appendix 6 demonstrate how the ratios can show the differences in load of risk factors among local child population across different SA3 regions in each state and territory.

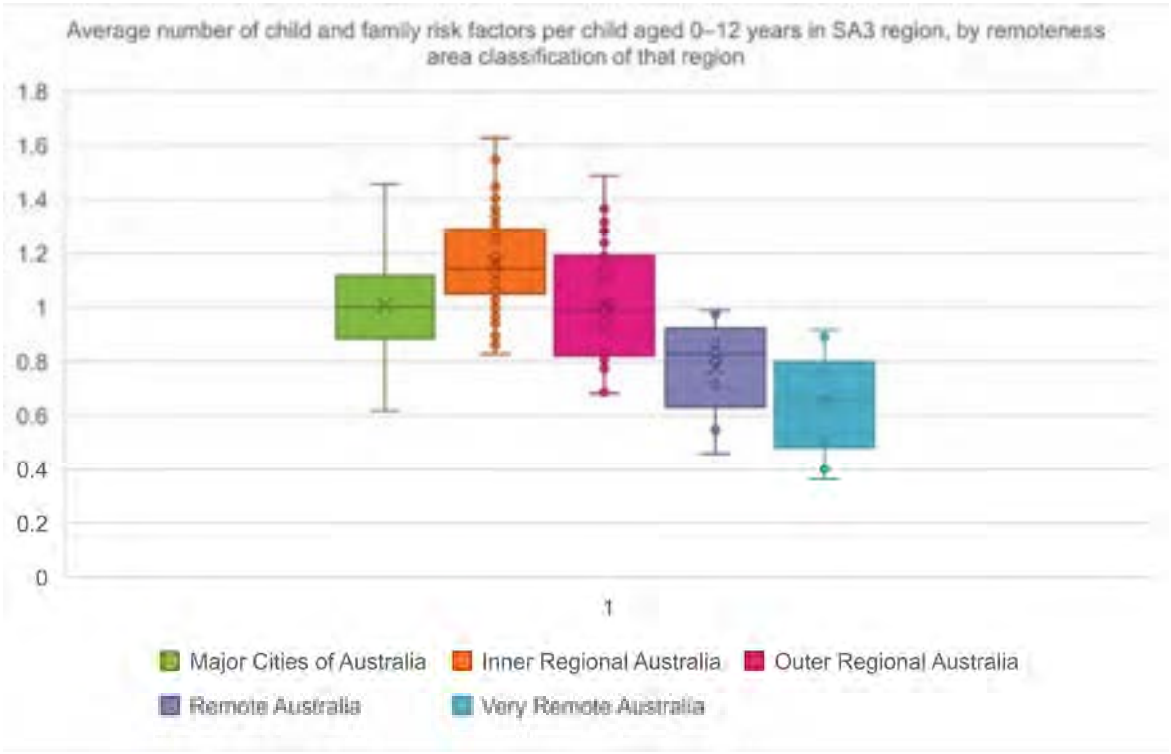
Figure 10 shows that the ratio of risks per child in an SA3 region is moderately predictive of the prevalence of child mental health conditions, demonstrating the importance of measuring sociodemographic and other risk factors to understand need in a community. When SA3s are considered in terms of their remoteness (Figure 8), **SA3s in inner regional and outer regional Australia tend to have higher rates and more variable rates of risks per child**. Remote and very remote regions showed lower rates of risks per child (Figure 11). However, in this analysis we are limited in the degree of detail for risk and protective factors that we can present as regional data. This results in the limited list of indicators above being used to describe the load of risk per child, and so we cannot yet create a holistic picture that includes those factors we know are important to children's development and wellbeing but are difficult to measure at a population level such as parenting styles.

Figure 10: Average number of risk factors for child mental health concerns per child aged 0–12 years, compared to estimated prevalence of child mental health conditions in SA3 regions



Data source: Emerging Minds calculation of risk factors based on Census 2021. Emerging Minds estimates of child mental health conditions based on scaled Census 2021 prevalence.

Figure 11: Average number of risk factors for child mental health concerns per child aged 0–12 years in SA3 regions, by remoteness area classification of that region

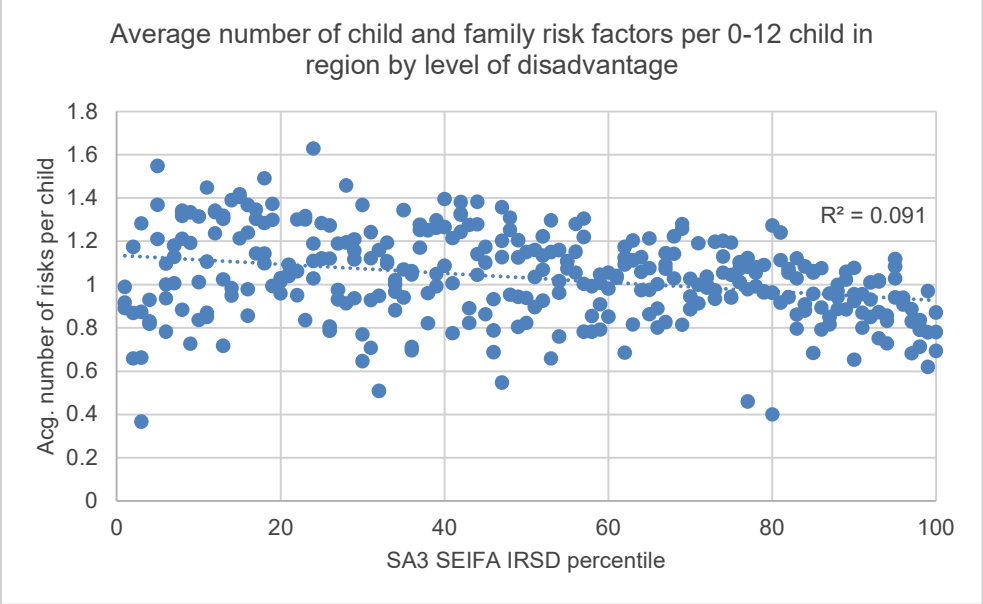


The impact of socioeconomic disadvantage

The ABS SEIFA Indexes are composite score of an area made up of multiple socioeconomic indicators which can indicate the level of disadvantage and advantage, and includes indicators such as education levels, employment, and income. We use the SEIFA Index of Relative Socioeconomic Disadvantage (IRSD) to compare disadvantage across regions as a major risk factor for child mental health outcomes. We excluded risks factors which are otherwise captured by the SEIFA, such as population homelessness and employment from our risk factor analysis above.

Figure 12 shows there is a small relationship between the SEIFA IRSD of a region and the level of other risks factors we have measured. **The figure shows that there is an inverse relationship, suggesting the less risk factors are present where there is more advantage**. However, we also acknowledge that this relationship is complicated given the capacity for community supports, family factors and other protective factors to foster resilience and buffer the effects of disadvantage (Green et al.,2023). The SEIFA IRSD of SA3 regions features in our summary population need for SA3 regions in Appendix 7 Population need summary.

Figure 12: Average number of risk factors for child mental health concerns per child aged 0–12 years, compared to level of disadvantage in SA3 regions



KEY POINTS:

- There are approximately 4 million children aged 0-12 years in Australia. Aboriginal and Torres Strait Islander children are not distributed evenly across regions, and culturally competent service responses should be co-designed with Aboriginal and Torres Strait Islander Communities.
- A national average of 13% of children aged 0–12 years of age are estimated to be currently experiencing a diagnosable mental health concern, equating to over 520,000 children. Child mental health conditions are more prevalent in regional areas than in major cities and research suggests may also vary according to sociodemographic profiles of local communities.
- A national average of 11.4% of children aged 4–5 years of age are severely developmentally vulnerable to developing a mental health concern in later childhood, with 22% of Australian showing at least one developmental concern that requires support.
- A relationship exists between the prevalence of risk factors to child mental health and mental health presentations, with the aggregation of risk factors likely to lead to poor mental health in childhood.
- Risk factors to child mental health are most prevalent in regional areas of Australia, and more risk factors are present with increasing disadvantage of an area.
- Prescriptions for mental health medications and access of community mental health services among children is more common in regional areas than in major cities, appearing to follow a need that increases with remoteness. However, there is notably lower access to prescriptions and lower number of service interactions for children in remote and very remote areas.
- There is a pattern of higher levels of need with increased remoteness from major cities, and although the prevalence of recorded child mental health conditions and service use appears to drop off for remote and very remote areas, the high levels of developmental vulnerability in remote and very remote regions suggest there is unmet or sub-threshold need present.
- Under-representation of the prevalence of child mental problems in available data sets is potentially linked to issues such as access to obtaining diagnoses, stigma, low child mental health literacy.
- Literature supports a system level response to supporting child mental health and wellbeing reflecting the complex interplay of risk and protective factors.
- System level responses need to be adapted to meet the specific needs of community, as described by data about experiences of local children and families.

Chapter 4.

Australia's child mental health and wellbeing workforce

4. Australia's child mental health and wellbeing workforce

Chapter 4 overview

In this section, we identify the occupations within the Australian workforce that play a key role in supporting infant and child mental health. As part of this, we outline a categorisation framework developed for this project, which defines the level of support the workforce may provide to support child mental health in their role. We use the framework to enumerate the available workforce and its distribution across Australia, with a particular focus on regional and remote areas. Lastly, we provide a summary of current workforce competency in supporting infant and child mental health and wellbeing.

Our analysis described in this chapter indicates that the workforce is maldistributed with low workforce availability in areas that need it most, including rural and remote areas and regions of greater disadvantage. Specialists in mental health and specialists in infant and child mental health are low in number nationally and usually represent a small proportion of the potential child mental health workforce in a local region. Other specialist level professionals, and generalists who to connect with families regularly, represent an opportunity to build capacity for child mental health.

The overall workforce shows moderate generalist competency to support child mental health and low competency in some key areas. Rural workers demonstrate skills particular to their needs of their regions that are higher than city workers. By exploring workforce availability and competency across Australia, we aim to provide a deeper understanding of how workforce may be utilised to support infant and child mental health and wellbeing into the future.

The diversity in an infant or child's experience of mental health and wellbeing requires a dynamic and varied workforce to provide support across prevention, treatment and continuing care (Figure 13).

Figure 13: Mental health intervention spectrum

Source: adapted from Mrazek & Haggerty (1994)

To ensure that the mental health needs of infants and children are met, it is critical that Australia's mental health workforce is geographically and economically accessible to the community. It is also vital that the workforce is available within appropriate timeframes and capable of effectively supporting the mental health and wellbeing of infants and children. However, mental health services across the country face complex challenges including worsening workforce shortages that pose a risk to patient care (Department of Health and Aged Care, 2023a; The Royal Australian and New Zealand College of Psychiatrists, 2024). The mental health workforce is unequally distributed across the country, with significant shortages found in regional and remote locations and supply differences seen across settings and specialisations (Department of Health and Aged Care, 2023a; Cleary et al., 2020). While there is no universal definition of the mental health workforce, there is widespread agreement that a range of occupations can influence the mental health and wellbeing of individuals and populations (World Health Organization, 2022). As such, within this report we explore the distribution of a varied generalist and specialist workforce who may be well placed to support the mental health and wellbeing of infants and children.

Identifying the occupations able to provide infant and child mental health and wellbeing support

Occupations across a wide range of sectors have a critical role in supporting the mental health and wellbeing of infants and children (World Health Organization, 2022). Recognising the need to capture the varied and dynamic workforce that exists in Australia, the research team reviewed the Australian and New Zealand Standard Classification of Occupations (ANZSCO). The 6-digit list of occupations were used to identify what specific occupations could potentially be well placed to provide infant and child mental health and wellbeing support. The ANZSCO includes five levels: major groups, sub-major groups, minor groups, unit groups and occupations, with occupations

being the most detailed level of classification (Australian Bureau of Statistics, 2022a). Selecting the most detailed classification allows for greater estimation of each occupations' ability to influence or support the mental health and wellbeing of infants, children and families.

Using the ANZSCO classifications included within the 2021 Australian Census of Population and Housing (Census), 1,358 occupations were identified and screened. The occupations were first screened based on the **related setting or sector** using the sub-major and minor group classifications as a guide. The criteria used for identifying the relevant sub-major and minor groups included not only health, education, social or welfare services, but also legal services, carers and aides, protective service workers and clerical or administrative workers. Occupations were then considered based on their **likelihood of being able to influence or support the mental health and wellbeing of infants, children and families**. Adhering to ABS recommendations, the supplementary 'not further defined' (NFD) and 'not elsewhere classified' (NEC) codes related to the selected occupations were also included within the analyses (Australian Bureau of Statistics, 2022b). After screening, 227 occupations were identified and included within the analyses for this project.

The Workforce Classification Framework

A review of Australian mental health workforce strategies and plans, plus international competency frameworks and reports,[19] was completed to identify a consistent way of conceptualising the broad child mental health and wellbeing workforce. As determined by the University of Queensland (Cleary et al., 2020) following its review for the National Mental Health Workforce Strategy 2022–2032, in both Australia and globally, there exists limited agreement regarding the definition of the mental health workforce, and the most effective way to classify the various types of providers and workers within it.

Approaches ranged from a straightforward delineation of workers between 'specialist' –those with mental health qualifications and providing intensive support – and 'generalist' –anyone else who may interact with a person experiencing mental health difficulties, through to more sophisticated methods, scaling roles from those found in universal settings to promote positive mental health and increasing in the complexity of support provided based on the mental health continuum/service spectrum.

Through this review it was recognised that a new framework was needed for this project to ensure that we captured the workforce available to support infant and children's mental health and wellbeing across all levels of need.

Based on the literature and the relevant ANZSCO 6-digit occupations identified, it was clear that the framework developed for this project must incorporate categories for both specialist and generalist workers. However, this project needed a framework that was specifically developed to categorise the influence and support different occupations *could* provide to infants and children's mental health and wellbeing.

[19] Ministry of Health (2018), Department of Health Victoria (2021), Centre for Mental Health Learning Victoria (2019), Queensland Health (2017), Mental Health Commission Western Australia (2020), World Health Organization (2022a), Cleary et al. (2020), National Health Service (2020), National Health Service (2014), University of Auckland (2019), Diminic et al. (2023), Department of Health Australian Government (2019), Department of Health Australian Government (2019), Department of Health Australian Government (2019a)

To categorise the selected ANZSCO 6-digit occupations into specialist and generalist categories within the context of infant and child mental health, the research team took into consideration the type and level of support each occupation could provide, their qualifications and education, and the settings where the workforce may be based.

From the accessible data, we could not identify how many of those in the workforce work directly with infants and children or what level of care they provide to the individuals or communities who they service. As such, the research team used the ANZSCO definitions (Australian Bureau of Statistics, 2022), and their knowledge and expertise, to inform the type and level of support each occupation could offer infants and children. The Australian Qualifications Framework (AQF) and the skill level assigned to each ANZSCO occupation were used to obtain education level for all occupations, and settings were identified using the ANZSCO definitions (Australian Bureau of Statistics, 2022) and the research team's specialised understanding of the workforce composition.

Four workforce classifications were defined within the framework:

- Specialist in Infant and Child Mental Health
- Specialist in Mental Health
- Generalist Trained; and
- Generalist Practicing.

Definitions for these four classifications are as follows.

Specialist in Infant and Child Mental Health
Highly skilled professional with specialist qualifications in infant and child mental health. This professional supports infants, children and/or parents, caregivers and families experiencing mental illness/es that has/have a high impact on their day-to-day lives (severe and persistent). This professional is likely working collaboratively with additional integrated/coordinated care services.

Specialist in Mental Health
Highly skilled professional with tertiary qualifications that have included a mental health component or focus, who may be working with infants, children or parents, caregivers and families. This professional is providing mental health support as the core or complementary support situated in a broad range of health, community/social service and educational settings.

Generalist Trained
Skilled professional with tertiary qualifications relevant to their profession or setting, who works with infants, children, parents, caregivers, families and/or the broader community, where mental illness is not the primary function of the service but clients may be at risk of mental health difficulties due to the presenting concern or life circumstances.

Generalist Practicing
Worker engaged with infants, children, parents, caregivers, families and/or the broader community in a range of health, community, social service and education settings. Worker's role encompasses mental health and wellbeing promotion where they may be in a position to observe early signs of mental health difficulties.

Once each occupation was classified, a level of assumed opportunity to support or influence infant and child mental health and wellbeing was also attributed to each occupation (Table 10 and

Figure *14*). Opportunity was classified using three levels ranging from low to medium to high. For example, a paediatrician or primary school teacher would be allocated a high opportunity rating due to their frequent interaction with infants and children in their work, while a law clerk would be rated as having a low opportunity rating. These occupations were then categorised into four meaningful groups for further analysis:

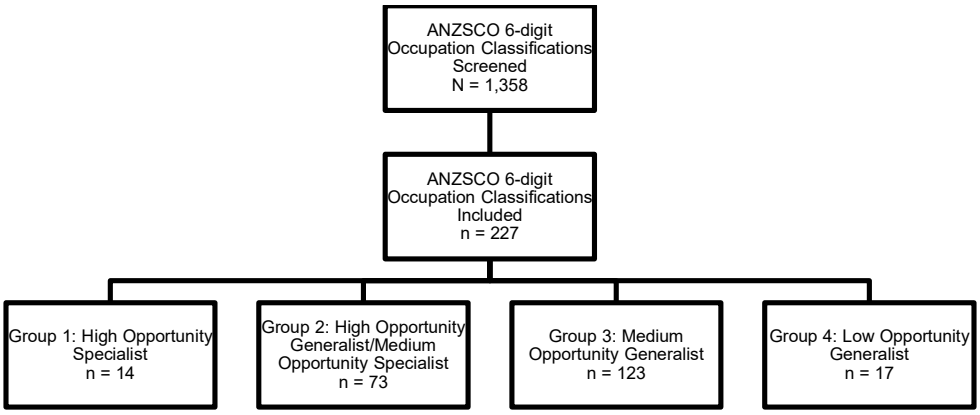
Table 10: Workforce Classification Framework

	Group 1 High Opportunity Specialist	**Group 2** High Opportunity Generalist/Medium Opportunity Specialist	**Group 3** Medium Opportunity Generalist	**Group 4** Low Opportunity Generalist
Criteria	High Opportunity + Specialist in Infant and Child Mental Health or Specialist in Mental Health	High Opportunity + Generalist Practicing or Generalist Trained OR Medium Opportunity + Specialist in Mental Health	Medium Opportunity + Generalist Practicing or Generalist Trained	Low Opportunity + Generalist Practicing or Generalist Trained
Example occupations^	Psychiatrist General Practitioner (GP) Psychologist	Registered Nurse (Mental Health) Drug & Alcohol Counsellor School Teacher	Health Promotion Officer Emergency Medicine Specialist Police Officer	Judge Interpreter Social Security Assessor

^ *See Appendix 8 for full allocation of occupations to groups*

Opportunity was primarily assigned to each occupation to allow researchers a view across the landscape of sectors that support children and families and see where *future potential* might lay in the service system to provide earlier and/or enhanced child mental health and wellbeing support. Opportunity was considered the most feasible way to do this as data for occupation by service setting is not readily available. Additionally, it is not possible to discern from current data, what proportion of time professionals are working with children, and therefore we have classified these occupations ourselves by opportunity.

Figure 14: Workforce Classification Breakdown



Method for enumerating the distribution of the Australian workforce

After identification of the relevant occupations and sorting of these occupations into the workforce framework, we aimed to understand the distribution of the workforce through examining both RA and SA3. The geographical method for RA and SA3 used for the workforce analyses is the same as that used for the population analysis (see Chapter 3). Results for these RAs and SA3s have been grouped by state or territory to assist in providing further context and understanding of the geographical characteristics of the workforce distribution.

Data was collected using the ABS TableBuilder platform. Within this platform, the research team acquired access to Census data including employment data, such as occupation (6-digit level OCCP Occupation data), hours worked (HRSP Hours worked data) and location (RA and SA3). The OCCP variable captures the occupation of each employed person in Australia in the week

leading up to Census night (Australian Bureau of Statistics, 2021a). Additionally, the HRSP variable asks the population who were employed in the week before the Census night how many hours they worked, excluding time off but including extra time and overtime (Australian Bureau of Statistics, 2021b). It is important to note that in the week prior to, and at the time of, the 2021 Census, COVID-19 pandemic lockdowns were in place in different jurisdictions and to varying degrees across the country. As such, the guidance in the Census asked the population to report their usual occupation if they were employed within the four weeks prior to the Census but were unable to work in the week of, due to the pandemic (Australian Bureau of Statistics, 2021a). For the Census question relating to the hours worked, the ABS advised people to accurately answer the number of hours they had worked in the week prior, regardless of impact due to the pandemic (Australian Bureau of Statistics, 2021b).

Occupation, hours worked and location data was tabulated using both state level RA (Table 11) and SA3 (Appendix 9 Workforce distribution by SA3 tables). Once data had been exported from TableBuilder into a spreadsheet format, occupations were grouped using the workforce framework. Next, total workforce for each group was calculated by geographical criteria (i.e. state level RA or SA3). We then standardised each workforce group per 1,000 children in the corresponding region. Finally, the proportion of each workforce group's reported hours per week per 1,000 children was calculated. This was first done by calculating the proportion of hours that would be distributed between the population of children aged 0–12 for each workforce group in each region, then this data was standardised to 1,000 children to allow for comparisons between regions.

Within this report, the national average has been used to provide an observational assessment of workforce supply. While we do not propose that the national average is the indicator of an ideal standard of workforce supply, the national average allows for indication of differences in supply across Australia. It is recognised that across Australia, different regions have unique social, economic and political characteristics. The data included in this report provides information about areas of high and low workforce numbers and hours which can assist in indicating the areas of need in both the present and future, however, if working with a specific region further exploration of the region's characteristics and needs is required.

Specialists in infant and child mental health or specialist in mental health, who have a high level of opportunity to influence children's mental health (Group 1) are considerably fewer in number in Australia than Group 2 and Group 3 professionals, who have a more generalist level occupation or more generalist mental health specialists with fewer opportunities to influence children's wellbeing (Figure 15). Fewer occupations are captured in Group 1, contributing to the smaller headcount of around 150,000, which highlights the limitations of relying heavily upon a workforce with a high level of specialisation towards infant and child mental health. The broader range of occupations in Group 2 and Group 3, and the corresponding cohort of around two million workers, offers a large potential pool of workforce to draw upon for increased capacity to support children and their families.

Figure 15: Number of workers in each Workforce Classification Framework group, Census 2021

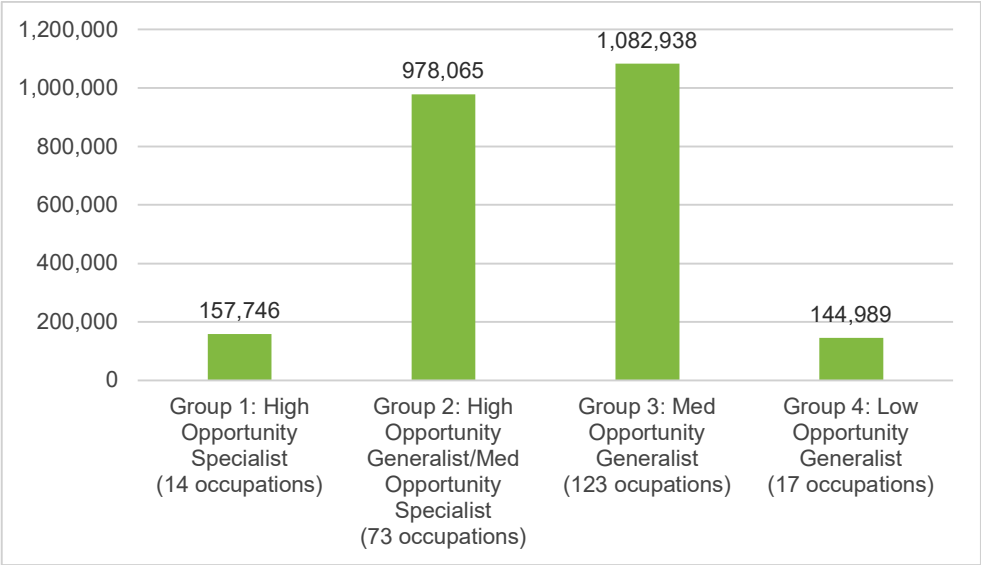

1,200,000
1,000,000
800,000
600,000
400,000
200,000
0
157,746
978,065
1,082,938
144,989
Group 1: High Opportunity Specialist (14 occupations)
Group 2: High Opportunity Generalist/Med Opportunity Specialist (73 occupations)
Group 3: Med Opportunity Generalist (123 ocupations)
Group 4: Low Opportunity Generalist (17 occupations)

Table 11: Workforce distribution grouped by RA

State	Remoteness Area Classification	Population Total (n)	Population 0–12	Group 1: High Opportunity Specialist (n)	Group 1: High Opportunity Specialist per 1,000 children	Group 1: Proportion of High Opportunity Specialist hours per week per 1,000 children	Group 2: High Opportunity Generalist/Med Opportunity Specialist (n)	Group 2: High Opportunity Generalist/Med Opportunity Specialist per 1,000 children	Group 2: Proportion of High Opportunity Generalist/Med Opportunity Specialist hours per week per 1,000 children	Group 3: Med Opportunity Generalist (n)	Group 3: Med Opportunity Generalist per 1,000 children	Group 3: Proportion of Med Opportunity Generalist hours per week per 1,000 children	Group 4: Low Opportunity Generalist (n)	Group 4: Low Opportunity Generalist per 1,000 children	Group 4: Proportion of Low Opportunity Generalist hours per week per 1,000 children
NSW	Major cities of Australia	6,080,428	967,362	38,118	39	212	218,197	226	1,089	240,298	248	1,154	42,431	44	267
NSW	Inner regional Australia	1,569,737	238,555	8,313	35	176	64,102	269	1,289	71,964	302	1,336	7204	30	160
NSW	Outer regional Australia	377,693	57,999	1,127	19	96	14,321	247	1,167	13,342	230	1,005	1,141	20	96
NSW	Remote Australia	26,219	4,648	53	11	33	1,173	252	1,212	724	156	629	34	7	37
NSW	Very remote Australia	6,708	1,156	20	17	18	333	288	1,131	235	203	633	16	14	46
VIC	Major cities of Australia	5,018,415	790,180	34,030	43	228	192,877	244	1,189	210,722	267	1,237	32,509	41	245
VIC	Inner regional Australia	1,214,965	185,474	6,750	36	175	50,198	271	1,275	56,850	307	1,309	5,497	30	158
VIC	Outer regional Australia	257,682	36,295	1,016	28	114	9,924	273	1,148	10,946	302	1,120	594	16	70
VIC	Remote Australia	3,305	417	0	0	0	112	269	591	131	314	512	0	0	0
QLD	Major cities of Australia	3,331,137	538,544	22,782	42	228	131,423	244	1,151	153,296	285	1,337	20,179	37	227
QLD	Inner regional Australia	997,806	153,868	4,698	31	160	38,126	248	1,164	43,399	282	1,270	3,091	20	107
QLD	Outer regional Australia	688,508	110,347	4,019	36	195	28,473	258	1,278	28,720	260	1,236	2,788	25	139
QLD	Remote Australia	71,351	12,719	259	20	80	2,766	217	1,042	2,095	165	714	122	10	39
QLD	Very remote Australia	52,481	10,369	155	15	84	2,704	261	1,349	1,724	166	807	107	10	23
SA	Major cities of Australia	1,344,200	198,443	10,088	51	249	53,235	268	1,198	71,703	361	1,540	6,876	35	179
SA	Inner regional Australia	175,307	24,145	657	27	98	5,930	246	955	7,161	297	1,038	412	17	72
SA	Outer regional Australia	201,259	28,827	775	27	129	7,490	260	1,099	8,170	283	1,072	670	23	102
SA	Remote Australia	43,592	6,891	165	24	77	1,654	240	911	1,586	230	784	95	14	42
SA	Very remote Australia	13,768	2,245	49	22	84	852	380	1,530	468	208	722	25	11	8
WA	Major cities of Australia	2,087,667	342,883	14,265	42	224	82,741	241	1,203	90,118	263	1,275	11,609	34	205
WA	Inner regional Australia	231,450	36,538	1,009	28	129	8,392	230	1,048	8,109	222	916	706	19	95
WA	Outer regional Australia	184,237	29,367	818	28	134	7,274	248	1,158	6,566	224	983	701	24	123
WA	Remote Australia	87,426	17,134	407	24	137	4,022	235	1,238	2,665	156	768	278	16	77
WA	Very remote Australia	60,672	10,635	272	26	94	3,067	288	1,343	2,201	207	911	234	22	69
TAS	Inner regional Australia	345,491	50,271	2,641	53	238	14,337	285	1,188	18,934	377	1,558	2,138	43	203

TAS	Outer regional Australia	199,732	27,528	827	30	109	6,599	240	864	8,258	300	1,047	479	17	58
TAS	Remote Australia	8,423	979	24	25	0	182	186	417	220	225	187	8	8	0
TAS	Very remote Australia	2,533	346	6	17	0	73	211	512	90	260	220	0	0	0
NT	Outer regional Australia	139,902	24,711	1,239	50	291	7,086	287	1,550	7,344	297	1,538	1,193	48	274
NT	Remote Australia	47,048	8,637	527	61	299	3,117	361	1,804	2,881	334	1,691	439	51	256
NT	Very remote Australia	42,054	9,011	170	19	77	2,524	280	1,604	1,195	133	683	107	12	51
ACT	Major cities of Australia	453,198	72,390	2,974	41	215	18,742	259	1,207	17,483	242	1,152	4,383	61	350
ACT	Inner regional Australia	690	138	0	0	0	24	174	290	11	80	0	3	22	0
Other	Inner regional Australia	310	55	0	0	0	9	164	0	6	109	0	0	-	0
Other	Very remote Australia	4,473	662	24	36	27	199	301	664	162	245	400	9	14	73

Source: ABS Census of Population and Housing, 2021
Note: Data displayed in this table may have been randomly adjusted prior to its release in the TableBuilder platform.

Key

Significantly below national average (<25%, Q1)
Below national average (Q2)
Equal to or above the national average (Q3–Q4)
Significantly above national average (>75%, Q4)

Workforce distribution across Australia

The national average was used to provide an observational estimate of workforce distribution and supply across Australia. It is recognised that the national average cannot be assumed to be the ideal standard for workforce distribution, however it does provide important data regarding areas that may have a relative undersupply or oversupply of workforce.

The four groups of the Workforce Classification Framework were used when enumerating the distribution of workforce across the country. These four groups were defined as follows:

- Group 1: **Specialists in infant and child mental health** or **specialists in mental health**, who have a **high level of opportunity** to support or influence infant and child mental health and wellbeing in their role.
- Group 2: **Generalist practicing professionals** or **generalist trained workers** who have a **high level of opportunity** to support or influence infant and child mental health and wellbeing in their role; OR **specialists in mental health**, who have a **medium level of opportunity** to support or influence infant and child mental health and wellbeing in their role.
- Group 3: **Generalist practicing professionals** or **generalist trained workers** who have a **medium level of opportunity** to support or influence infant and child mental health and wellbeing in their role.
- Group 4: **Generalist practicing professionals** or **generalist trained workers** who have a **low level of opportunity** to support or influence infant and child mental health and wellbeing in their role.

For a comprehensive list of occupations included within each group, please see Appendix 8.

As may have been expected, **workforce numbers in the major cities across Australia were above the national average for all workforce groups**, indicating that areas of the greatest population density are also the areas where the workforce is at its largest.

While we may expect to see higher numbers of specialists (Group 1) located within areas of high population numbers, this trend continues even when the data has been standardised to the number of children in a region. This indicates that there is an unequal distribution in the availability of specialists for areas that fall outside major cities throughout Australia. Furthermore, when exploring this relationship by RA, we see that **the more remote the area, the fewer specialists there are** and **less hours are available for infants and children to access specialist support**. This indicates that infants and children have limited access to specialists in remote areas. We also see a trend in some locations, such as Western Australia and the Northern Territory, where the number of specialists is below the national average **but the hours worked is above the national average**. This could be an indication of increased need in these areas and workforce shortages, where existing specialists are having to work high hours to meet the needs of the community.

Within the data we see that the number of high opportunity specialists (Group 1) is not evenly distributed across states. While all major cities have a higher concentration of these specialists, there are varying distributions across other regions across the states. For example, Victoria and Queensland have well above average headcount and ratio of workers to children in inner regional and outer regional areas, while South Australia shows quite a drop off in workforce headcount and ratio to children once outside of major cities, and New South Wales ratios drop from Outer

regional to very remote. This is also true for hours available, where typically, the more remote the area, fewer hours are available for infants and children to access these specialists. A curious finding is that in Western Australia where regional workforces are below average in ratio to children in the state, the hours they provide are within an average range possibly suggesting a workforce spread thin among population and working additional hours to compensate (Table 11).

With respect to Group 2 and Group 3, the more generalist professions, we see significant differences both within and between states when the workforce numbers and hours have been standardised to 1,000 children aged 0–12 years. The results for these workforce groups show the diversity in scope of the occupations included within these groups and the spread of these occupations across Australia. Within areas that have significantly above the national average workforce for Group 2 and Group 3 but have below the national average supply of specialists (Group 1), an opportunity may be available to utilise this workforce for early intervention support for child mental health, with additional training.

We see the distribution of low opportunity generalists (Group 4) follow a similar pattern as seen with specialists (Group 1), wherein areas of higher population there are more low opportunity generalists, even when headcount and hours are standardised to 1,000 children.

The results found in this report identify that access to specialist support is limited for infants and children living outside of major cities. These findings support those within the existing literature (Department of Health and Aged Care, 2023; Cleary et al., 2020) further substantiating previously reported findings.

Considerations and limitations of enumerating workforce distribution across Australia

The Australian workforce and its distribution were analysed within this report using Census data. While the Census provides the most extensive and representative dataset available in Australia, there are several limitations to using this data that must be noted.

The Census is self-reported, meaning that individuals complete the Census themselves, which may result in incomplete or inaccurate responses. Furthermore, data used within this report has undergone random adjustments by the ABS to mitigate the risk of confidential data being released. The ABS advise that no reliance should therefore be placed on cells containing small numbers due to the data being randomly adjusted and the potential processing or respondent errors.

The 2021 Census was conducted during a time of high unpredictability in employment and hours worked due to the COVID-19 pandemic. The impact the COVID-19 pandemic had upon the workforce must be recognised when reporting on data during this time. Questions relating to employment within the Census included additional guidance to account for the potential impacts the pandemic had on the workforce.

With regards to the location of the workforce, the data included within this report used place of enumeration as the variable for geographic location. Place of enumeration was the best option available within the TableBuilder platform at the time of writing this report, as place of work was not available within the platform. Conducting further analysis of the workforce using place of work may provide further insight into the distribution of the Australian workforce.

Within each state and territory there are individuals who report having no usual address on Census night. These individuals may be facing housing insecurity and may require high levels of support from a variety of workforce groups. A limitation to enumerating workforce is that workforce distribution cannot be mapped by no usual address and as such, there is a proportion of the population that may require high levels of support but we do not know what workforce may be geographically able to provide this support. We encourage further research into the potential location and needs of those who reported having no usual address.

There is no national dataset available that includes who within the workforce engages directly with infants and children. As such, the research team used their expertise and available information (e.g. ANZSCO 6-digit occupation definitions) to assign each occupation a rating indicating their opportunity to influence or support infant and child mental health. Due to the lack of data and information availability limitations, all calculations held the assumption that the workforce is equally distributed between children aged 0–12 years and the broader population. The absence of a dataset that captures who within the workforce engages with infants and children presents limitations on the reliance that can be placed on the data.

As mentioned throughout this section, the national average has been used as an observational measure of workforce numbers and hours. By using the national average when analysing this data, we are not recommending that the average provides ideal workforce numbers or hours, rather, that the national average provides important information regarding areas of low and high workforce distribution and hours. Information resulting from using the national average can be used to help indicate areas of current and future need.

Community profiles: Comparing population need and workforce availability

In this section we present summary data for population need indicators and workforce supply side by side, for example SA3 regions at the extreme end of the spectrum of service requirements. These provide an example approach to summarise data for a region which can inform a workforce and service response for each local context. Each indictor we used in Chapter 2 and Chapter 3 contributed to an overall index score of need and another index of workforce availability - allowing SA3s to be ranked in terms of their need and by their workforce availability.

We use the national average supply ratio for the workforce group as a unit of comparison; however while this does not necessarily tell us the extent to which the workforce meets the needs of the local child population, it does give an **indication of where there are shortages compared to other regions**. We use the traffic light system shown below in the table key to highlight where the level of need and workforce supply are dire, problematic, acceptable or optimal.

Table 12 presents the SA3 regions with the highest levels of need in each state and territory and combines the key indicators of population need from Appendix 7 Population need summary, and the workforce supply ratios from Appendix 9 Workforce distribution by SA3.

Table 12 shows the **highest need areas in states are most commonly in inner regional and outer regional areas**, but regions within major cities can also demonstrate high levels of need, and these areas vary widely in population size. **High need areas are mostly areas with high levels of disadvantage,** with the exception of those regions in ACT. Services which are culturally competent and developed with Aboriginal and Torres Strait Islander communities are essential for the regions identified in this analysis.

The supply of **child mental health specialists that are well placed to support child mental health is low in almost all of the highest need regions** shown in Table 12. Among the exceptions are two regions in New South Wales and one in Western Australia that show acceptable workforce ratios among the Group 2 and Group 3 workforces. Alice Springs (NT) also has extremely high workforce ratios across all groups, although we note that this is a hub area where it is likely workforce reside or travel and stay while servicing multiple communities surrounding Alice Springs.

This lack of local specialists does highlight a need to investigate the proportion of other workforce who could also support infant and child mental health in their role, for example, by drawing upon the Group 2 and Group 3 generalist workforce to increase support for children and families. However, for the most part the identified high need regions also show a low ratio of Group 2 and Group 3 generalist workforces compared to the national average, suggesting that a **boost is required of more generalist professions** that can support some aspects of infant and child mental health.

To explore the alternative starting point of workforce supply,
Table **13** lists the three SA3 regions in each state or territory with the lowest workforce availability based on the ratios of workforce to children and the hours of work available. Workforce headcount was not used for ranking because SA3 regions having different sized populations and land areas is expected to influence the number of workers in residence. The lowest workforce availability regions are not always the same as the highest need regions, but there is some overlap. **Low workforce availability regions are a mixture of mostly major cities, inner regional and outer regional areas, and are almost all marked by very low availability of both Group 1 High opportunity specialists and Group 2 and 3 generalist workforces**. When comparing with the summary data on local population need, this analysis indicates that the **lowest workforce availability regions commonly display an increased need for child mental health support services that is above average or high compared to the national average**.

Creating indexes and ranking SA3s allows us to examine where there is discord between the population need and the workforce supply, with Table 14 highlighting and describing the characteristics of areas where these misalignments are the greatest. Table 14 shows three of areas with greatest mismatch where high level of population need are combined with low availability of workforce living in that area. The top ten high need/low workforce areas included inner regional Queensland areas Beaudesert (see Table 14), Ipswich Hinterland, Beenleigh, Darling Downs East, Burnett, and metropolitan area Caboolture. Upper and Lower Hunter regions in New South Wales also featured, as did the Adelaide suburban area of Playford (see Table 14). Outer regional areas of Tasmania Central Highlands (see Table 14) and South East Coast also had significant mismatch between their level of need and workforce available.

The high need/low workforce identified regions all have very low availability of specialist workforce. While these areas typically also have very low ratios and work hours for Group 2 and Group 3 workers as well, there is at least higher numbers of these workers compared to Group 1 mental health specialists that could be drawn upon to provide support. For example Central Highlands Tasmania has a small and under resourced workforce overall where there are 18 Group 1 specialists, there are at least greater number among Group 2 (329) and Group 3 (450) workers. Playford in South Australia shows workforce ratios in all workforce groups that are well below the national average, it includes 202 Group 1 specialists but because of the region's size the Group 2 (2,928) and Group 3(3,955) workforces comprise a large headcount of workers.

Conversely at the other end of the spectrum, **there are high socioeconomic regions which indicate lower levels of need through less disadvantage, and lower prevalence of mental health conditions and risk, but have an exceedingly abundant workforce in residence.** The top ten low need/high workforce regions all areas in major cities – mostly affluent suburbs in South Australia; Norwood-Payneham-St Peters, Burnside Holdfast Bay, Mitcham (see Table 14) and Prospect-Walkerville, as well as in Victoria; Glen Eira, Brunswick-Coburg, Essendon, Yarra (see Table 14), and capital city area Perth City in Western Australian. The low need/high workforce areas are marked by very low levels of disadvantage and developmental vulnerability, and large numbers of specialist workforce living in the area.

It is important to note here that these data refer to workforce who were present in the region on Census night, many of which will be residents. And while these **workers will likely provide services elsewhere and workers from neighbouring regions will likely provide services within the region at hand – and therefore, we use this workforce location as an approximate indictor of the availability of workforce within reach of the local population.**

Table key:

Components of population need
Population characteristics descriptions
Workforce availability indicators
Significantly unfavourable compared to the national average
Unfavourable compared to the national average
Equal to or favourable compared to the national average
Significantly favourable compared to national average
ATSI – Aboriginal and Torres Strait Islander children
CALD – Culturally and linguistically diverse children
LOTE – Children speak a language other than English at home

Table 12: Three highest need regions in each state/territory

SA3 Region	0–12s pop.	RA[a]	SEIFA IRSD score[b]	% 0–12s with MH cond.[c]	Service use: % 0–17s with MH Rx[d]	Service use: % 0–11s with Comm. MH service contact[e]	% AEDC Vuln. on 2+ domains[f]	Average no. risk factors per child in region[g]	Summary level of need and population size impact	Service considerations	Group 1: High Opportunity Specialist per 1,000 children	Group 2: High Opportunity Generalist/ Medium Opportunity Specialist per 1,000 children	Group 3: Medium Opportunity Generalist per 1,000 children	Group 4: Low Opportunity Generalist per 1,000 children
NEW SOUTH WALES														
Taree - Gloucester	7,742	Inner regional	934	19.07%	9.09%	2.15%	15.42%	1.39	High need & Moderate pop. size	Significant ATSI community & Small CALD child pop. & small % speak LOTE	37	2,088	2,797	17
Richmond Valley - Hinterland	10,631	Inner regional	947	22.89%	9.55%	2.38%	17.99%	1.30	High need & Large pop. size	Significant ATSI community & Small CALD child pop. & % speaking LOTE is similar to nat avg	36	3,042	3,729	25
Kempsey - Nambucca	7,042	Inner regional	910	19.33%	9.76%	1.63%	18.95%	1.34	High need & Moderate pop. size	Significant ATSI community & Small CALD child pop. & % speaking LOTE is similar to nat avg	21	1,866	2,235	39
VICTORIA														
Maryborough - Pyrenees	3,476	Inner regional	935	20.64%	7.54%	0.54%	16.18%	1.41	High need & Small pop. size	Larger ATSI child pop. & Small CALD child pop. & small % speak LOTE	17	761	652	32
Latrobe Valley	11,776	Inner regional	931	21.43%	7.91%	0.70%	16.85%	1.32	High need & Large pop. size	Larger ATSI child pop. & Small CALD child pop. & % speaking LOTE is similar to nat avg	28	3,009	1,053	40
Glenelg - Southern Grampians	4,981	Outer regional	971	13.25%	6.35%	1.09%	11.33%	1.16	High need & Small pop. size	Larger ATSI child pop. & Small CALD child pop. & small % speak LOTE	25	1,347	970	13
QUEENSLAND														
Beaudesert	2,242	Inner regional	915	30.17%	10.20%	0.89%	19.87%	1.33	High need & Small pop. size	Significant ATSI community & Small CALD child pop. & small % speak LOTE	10	196	193	7
Burnett	7,065	Inner regional	890	23.00%	7.98%	1.05%	20.34%	1.21	High need & Moderate pop. size	Significant ATSI community & Small CALD child pop. & % speaking LOTE is similar to nat avg	20	254	238	6
Gympie - Cooloola	7,403	Inner regional	931	31.31%	9.15%	0.96%	13.02%	1.30	High need & Moderate pop. size	Larger ATSI child pop. & Small CALD child pop. & small % speak LOTE	21	221	255	9

SA3 Region	0–12s pop.	RA[a]	SEIFA IRSD score[b]	% 0–12s with MH cond.[c]	Service use: % 0–17s with MH Rx[d]	Service use: % 0–11s with Comm. MH service contact[e]	% AEDC Vuln. on 2+ domains[f]	Average no. risk factors per child in region[g]	Summary level of need and population size impact	Service considerations	Group 1: High Opportunity Specialist per 1,000 children	Group 2: High Opportunity Generalist/ Medium Opportunity Specialist per 1,000 children	Group 3: Medium Opportunity Generalist per 1,000 children	Group 4: Low Opportunity Generalist per 1,000 children
SOUTH AUSTRALIA														
Mid North	3,891	Outer regional	910	12.30%	7.22%	1.89%	17.70%	1.21	High need & Small pop. size	Significant ATSI community & Small CALD child pop. & small % speak LOTE	26	282	314	14
Murray and Mallee	9,822	Outer regional	919	15.62%	5.35%	4.50%	18.08%	1.19	High need & Large pop. size	Larger ATSI child pop. & Small CALD child pop. & % speaking LOTE is similar to nat avg	22	224	273	20
Playford	19,910	Major cities	851	18.44%	6.42%	1.25%	20.71%	1.28	High need & Very large pop. size	Larger ATSI child pop. & CALD pop. similar to nat avg & large % speak LOTE	10	147	199	11
WESTERN AUSTRALIA														
Bunbury	17,596	Inner regional	976	14.53%	7.61%	0.95%	12.71%	1.07	High need & Very large pop. size	Larger ATSI child pop. & CALD pop. similar to nat avg & % speaking LOTE is similar to nat avg	28	238	234	24
Albany	9,431	Outer regional	981	13.29%	7.78%	1.98%	13.36%	0.99	High need & Large pop. size	Larger ATSI child pop. & CALD pop. similar to nat avg & % speaking LOTE is similar to nat avg	36	265	255	29
Mid West	8,855	Outer regional	962	11.36%	7.75%	1.26%	13.88%	0.93	High need & Large pop. size	Significant ATSI community & CALD pop. similar to nat avg & large % speak LOTE	30	267	233	25
TASMANIA														
South East Coast	635	Outer regional	941	23.38%	7.73%	0.88%	20.93%	1.49	High need & Small pop. size	Significant ATSI community & Small CALD child pop. & % speaking LOTE is similar to nat avg	30	250	276	24
Central Highlands (Tas.)	1,753	Outer regional	941	16.94%	9.85%	0.57%	13.95%	1.28	High need & Small pop. size	Significant ATSI community & Small CALD child pop. & small % speak LOTE	10	188	260	22
Brighton	3,809	Inner regional	891	18.19%	8.37%	0.40%	19.87%	1.37	High need & Small pop. size	Significant ATSI community & Small CALD child pop. & small % speak LOTE	10	155	223	28
NORTHERN TERRITORY														
Barkly	11,25	Very remote	717	0.00%	2.52%	0.76%	61.33%	0.89	Above average need & Small pop. size	Significant ATSI community & Small CALD child pop. & significant % speak LOTE	21	319	217	27
Litchfield	3,245	Outer regional	1030	10.93%	8.34%	0.57%	20.08%	0.81	Above average need & Small pop. size	Significant ATSI community & CALD pop. similar to nat avg & % speaking LOTE is similar to nat avg	27	259	214	42
Alice Springs	6,846	Remote	883	4.58%	3.42%	2.05%	32.39%	0.83	Above average need & Moderate pop. size	Significant ATSI community & CALD pop. similar to nat avg & significant % speak LOTE	62	360	336	52
AUSTRALIAN CAPITAL TERRITORY														
Tuggeranong	14,951	Major cities	1054	18.26%	7.14%	1.28%	14.91%	1.24	Above average need & Very large pop. size	Larger ATSI child pop. & CALD pop. similar to nat. avg & large % speak LOTE	24	250	238	33
Belconnen	16,831	Major cities	1058	18.72%	7.46%	0.99%	16.65%	1.12	Above average need & Very large pop. size	ATSI child pop. similar to nat avg & Larger CALD child pop. & large % speak LOTE	31	289	239	43
Weston Creek	4,123	Major cities	1076	17.21%	7.03%	0.95%	11.26%	1.08	Above average need & Small pop. size	ATSI child pop. similar to nat avg & Larger CALD child pop. & large % speak LOTE	40	231	216	53

a) Remoteness area classification.
b) ABS SEIFA Index of Relative Socioeconomic Disadvantage. Lower scores indicate more of disadvantage and higher scores indicate less disadvantage.
c) MH cond. = mental health condition. Emerging Minds modelled estimates based on scaled up ABS Census 2021 prevalence.
d) MH Rx = mental health prescription. Source: AIHW Mental Health Online
e) Source: AIHW Mental Health Online
f) Vuln. = vulnerability. Australian Early Development Census 2021
g) Emerging Minds calculation based on sociodemographic indicators from ABS Census 2021

Table 13: Three lowest workforce availability regions in each state/territory

SA3 Region	0–12s pop.	RA[a]	Group 1: High Opportunity Specialist (N)	Group 1: High Opportunity Specialist per 1000 children	Group 1:Proportion of High Opportunity Specialist hours per week per 1000 children	Group 2: High Opportunity Generalist/ Med Opportunity Specialist (N)	Group 2: High Opportunity Generalist/ Med Opportunity Specialist per 1000 children	Group 2: Proportion of High Opportunity Generalist/ Med Opportunity Specialist hours per week per 1000 children	Group 3: Med Opportunity Generalist (N)	Group 3: Med Opportunity Generalist per 1000 children	Group 3: Proportion of Med Opportunity Generalist hours per week per 1000 children	Worforce availability description	Summary level of need and population size impact
NEW SOUTH WALES													
St Marys	10561	Major Cities	110	10	44	1766	167	803	1835	174	771	Very low Group 1 availability & Very low Group 2 & 3 availability	Average need & Large pop. size
Fairfield	29228	Major Cities	376	13	61	3948	135	538	4392	150	516	Very low Group 1 availability & Very low Group 2 & 3 availability	Average need & Very large pop. size
Merrylands - Guildford	30150	Major Cities	384	13	66	3852	128	627	4722	157	730	Very low Group 1 availability & Very low Group 2 & 3 availability	Average need & Very large pop. size
VICTORIA													
Loddon - Elmore	1668	Inner Regional	29	17	36	330	198	488	434	260	563	Very low Group 1 availability & Very low Group 2 & 3 availability	Above average need & Small pop. size
Brimbank	28084	Major Cities	438	16	67	4961	177	759	5775	206	802	Very low Group 1 availability & Very low Group 2 & 3 availability	Average need & Very large pop. size
Tullamarine - Broadmeadows	41615	Major Cities	517	12	68	6512	156	913	6642	160	830	Very low Group 1 availability & Very low Group 2 & 3 availability	Average need & Very large pop. size
QUEENSLAND													
Beaudesert	2242	Inner Regional	23	10	16	439	196	636	433	193	470	Very low Group 1 availability & Very low Group 2 & 3 availability	High need & Small pop. size
Ipswich Hinterland	10453	Inner Regional	137	13	31	2168	207	789	2279	218	783	Very low Group 1 availability & Very low Group 2 & 3 availability	High need & Large pop. size
Darling Downs - East	7313	Inner Regional	87	12	37	1407	192	789	1385	189	723	Very low Group 1 availability & Very low Group 2 & 3 availability	High need & Moderate pop. size
SOUTH AUSTRALIA													
Playford	19910	Major Cities	202	10	47	2928	147	759	3955	199	379	Very low Group 1 availability & Very low Group 2 & 3 availability	High need & Very large pop. size
Salisbury	24500	Major Cities	439	18	74	4214	172	803	6728	275	813	Very low Group 1 availability & Very low Group 2 & 3 availability	Above average need & Very large pop. size
Murray and Mallee	9822	Outer Regional	213	22	82	2198	224	812	2678	273	896	Low Group 1 availability & Very low Group 2 & 3 availability	High need & Large pop. size
WESTERN AUSTRALIA													
Wheat Belt - North	7979	Inner Regional	119	15	40	1734	217	756	1586	199	661	Very low Group 1 availability & Very low Group 2 & 3 availability	Above average need & Moderate pop. size
Wheat Belt - South	3091	Outer Regional	38	12	12	671	217	780	623	202	614	Very low Group 1 availability & Very low Group 2 & 3 availability	Above average need & Small pop. size
Kwinana	9207	Major Cities	88	10	42	1413	153	764	1955	212	984	Very low Group 1 availability & Very low Group 2 & 3 availability	Above average need & Large pop. size
TASMANIA													
Central Highlands (Tas.)	1753	Outer Regional	18	10	9	329	188	452	456	260	699	Very low Group 1 availability & Very low Group 2 & 3 availability	High need & Small pop. size
West Coast	2731	Outer Regional	29	11	6	604	221	786	511	187	395	Very low Group 1 availability & Very low Group 2 & 3 availability	Average need & Small pop. size
Brighton	3809	Inner Regional	38	10	43	590	155	557	848	223	864	Very low Group 1 availability & Very low Group 2 & 3 availability	High need & Small pop. size
NORTHERN TERRITORY													
Litchfield	3245	Outer Regional	88	27	92	842	259	801	696	214	600	Low Group 1 availability & Very low Group 2 & 3 availability	Above average need & Small pop. size

East Arnhem	2785	Very Remote	53	19	117	737	265	1377	290	104	491	Very low Group 1 availability & Low Group 2 & 3 availability	Average need & Small pop. size
Daly - Tiwi - West Arnhem	3044	Remote	75	25	73	869	285	1242	349	115	439	Very low Group 1 availability & Low Group 2 & 3 availability	Average need & Small pop. size
AUSTRALIAN CAPITAL TERITORY													
Canberra East	142	Major Cities	0	0	0	10	70	103	22	155	28	Very low Group 1 availability & Very low Group 2 & 3 availability	Average need & Small pop. size
Uriarra - Namadgi	134	Inner Regional	0	0	0	24	179	320	11	82	0	Very low Group 1 availability & Very low Group 2 & 3 availability	Lower need & Small pop. size
Weston Creek	4123	Major Cities	163	40	198	951	231	835	891	216	775	Average Group 1 availability & Very low Group 2 & 3 availability	Above average need & Small pop. size

Table 14: Example regions of greatest mismatch between population need for child mental health support and workforce available to provide support to children.

SA3	State	Remoteness Area	Population 0-12	Workforce availability description	Summary level of need and population size impact	Comment
High need and low workforce						
Beaudesert	QLD	Inner Regional	2242	Very low Group 1 availability & Very low Group 2 & 3 availability	High need & Small pop. size	Beaudesert is a small, very low socioeconomic community in regional QLD, with a significant Aboriginal and Torres Strait Islander community. We estimate as many as 30% of children aged 0-12 could have a mental health concern and children are likely to have more than one other risk factor. 10% of children under 18 years have a mental health prescription. Severe developmental vulnerability is twice the national average. Beaudesert has 23 High opportunity specialists in residence including 8 GPs and 5 psychologists, equating to just 10 available per 1000 children in the region. The region also has very low ratios of Group 2 and Group 3 workforce to children compared to the national average.
Playford	SA	Major Cities	19910	Very low Group 1 availability & Very low Group 2 & 3 availability	High need & Very large pop. size	Playford is a large metropolitan suburb and council area outside of Adelaide, South Australia with a young population where children aged 0-12 make up a larger proportion than the average. Playford is one of the most disadvantaged SA3 regions in Australia, where the rate of mental health conditions, developmental vulnerability and risk factors is highest compared to the national average. Over a third of parents in the region have one or more long term health conditions and a quarter of parents are lone parents. Playford has 175 high exposure specialists in residence, and these are mostly social workers (116), which is somewhat below the national average as well as high numbers of Group 2 (2,928) and Group 3 (3,955) workers. However, because of the large population in Playford these workforces are still well below the national average ratios of workers to children in the region
Central Highlands (Tas.)	TAS	Outer Regional	1753	Very low Group 1 availability & Very low Group 2 & 3 availability	High need & Small pop. size	Central Highlands is a very large outer regional area in the middle of Tasmania with a small sparse population, where children make up a smaller proportion compared to other regions. Central Highlands has a high level of socioeconomic disadvantage and high number of child, family or community risk factors. Children are estimated to experience mental health conditions at slightly higher rate than the national average but be prescribed mental health medications at a much higher rate than the average for regions. Both children and parents in Central Highlands have higher rates of chronic health conditions than in other regions. Only 18 high exposure generalists live in Central Highlands Tasmania, a very low ratio of 10 per 1000 children. Other workforce groups in the region are small, however there are slightly more availability that could be drawn upon in Group 3.
Low need and high workforce						
Perth City	WA	Major Cities	13135	Well above average Group 1 availability & Well above average Group 2 & 3 availability	Lower need & Large pop. size	Perth City is the SA3 that encompasses the CBD of Western Australia's capital city. It is an area of very low disadvantage, low child mental health concerns, low risk and low developmental vulnerability. Over 80% are developing on track socially and emotionally. However, slightly more children aged 0-17 are prescribed mental health medications in Perth City than the national average for regions. Over half of children in Perth City have parents born overseas, and a quarter speak a language other than English at home, most commonly Chinese. Perth City has very high numbers (almost 2000) of high exposure specialists, including 621 GPs. Similarly, the headcount and ratio to children of Group 2 and 3 generalists is well above the national average. However, the hours of support available from Group 2 (High Opportunity Generalist/Med Opportunity Specialist) is below the national average which may suggest a large proportion of the workforce is part-time or underemployed.
Yarra	VIC	Major Cities	8574	Well above average Group 1 availability & Well above average Group 2 & 3 availability	Lower need & Moderate pop. size	Yarra is a very high socioeconomic suburb inner city in Melbourne, Victoria. Rates of child mental health conditions, mental health prescriptions and service use among children are low in Yarra. There are very few Aboriginal children in Yarra, but a larger community of children with parents born overseas and speaking a language other than English at home, most commonly African languages. Over three quarters of children are socially and emotionally on track in their first year of school. Yarra has almost 1700 high exposure specialists in residence, including 439 GPs, as well as 3600 Group 2 and 4200 Group 3 professionals, demonstrating very high availability of workforce to children in the area.
Mitcham	SA	Major Cities	9616	Well above average Group 1 availability & Well above average Group 2 & 3 availability	Lower need & Large pop. size	Mitcham is a very high socioeconomic suburb in Adelaide, South Australia. The estimated rate of child mental health concerns is much lower than the national average at 7%, and rates of severe developmental vulnerability are almost half that of the national average. Mitcham has a multicultural community slightly larger than the national average, where the most common language group is Chinese. A large number of GPs (286), OTs (125) and social workers (163) live in Mitcham, there are 90 High opportunity specialists per 1000 children although it is conceivable these workers provide services in other regions around Adelaide.

Current workforce child mental health competency

The National Workforce Survey for Child, Parent and Family Mental Health (the NWS) is a broader activity of Emerging Minds, conducted every two years, with the aim to obtain a snapshot of child mental health competence across a broad range of health, social services and community services workers in Australia. The second survey was collected in late 2023 and expanded on the first NWS survey by exploring additional competencies relevant to specialists in child mental health. A total of 3,053 health, social and community services workers completed the survey. This included a range of professions working across all regions of Australia. A demographic profile of the survey sample was provided in the interim report for this project and appears in Appendix 10 NWS 2023 demographics of participation.

The survey questionnaire included questions asking respondents about their work role, modes of delivering services and work locations, as well as demographic questions. Several sections of competency statements asked respondents to self-rate their competence by indicating their agreement with the statement on a Likert scale of 1–7 (where 1 = strongly disagree and 7= strongly agree). We present these as mean scores out of 7. For ease of interpretation, average scores of between 6 and 7 are considered to represent a **high level of capability**, whereas scores between 5 and 6 represent **moderate capability**. Scores below the mid-point of 4 indicate a level of disagreement with the statement and represent **low capability**.

Competency questions were developed and co-designed with relevant internal and external subject matter experts, as well as the Emerging Minds' Aboriginal and Torres Strait Islander National Consultancy Group.

We conceived that competencies could be striated by levels, where some competencies are more relevant to specialists, and we sought to understand the extent to which these more specialist-level competencies exist in practitioners with the scope and opportunity to provide specialist level support. Therefore, while most questions in the survey were open to all respondents to complete, specialist competency sections were only available to respondents who indicated that supporting child mental health or wellbeing was a formally stated or intended part of their role *and* that they sometimes, often, always or almost always provide support around the wellbeing and mental health of children in the course of their work.

Principal components factor analysis revealed that competency questions in the survey could be grouped to create subscales measuring domains of generalist and specialist competency, outlined in Table 15.

Here we provide an overview of workforce competency as self-rated by respondents to the 2023 survey. Analysis of the survey data will be ongoing in 2024, with additional results provided to the Department of Health and Aged Care as part of Emerging Minds' annual evaluation report.

Overall, Australian professionals who responded to the survey showed **moderate self-rated capability**, on average, across the generalist child mental health competency domains. **Lower levels of workforce confidence were seen in infant mental health and in child-focused practice**, which is consistent with the findings of the 2020–21 survey where infant mental health and child mental health practice were rated low among a range of workforce groups.

While family resilience approaches appear to be a sphere of some confidence for much of the workforce, workers showed low capability in working with Aboriginal and Torres Strait Islander families, and working with children and families in the context of disasters.

Table 15: Domains of competency identified in the 2023 National Workforce Survey for Child, Parent and Family Mental Health

Components of child mental health competency	No. of items in subscale	Description
Generalist competencies		
Child-focused practice	5	Behavioural items about regular practices with children regarding their mental health. Includes talking with children about mental health, providing information and collaborating around children's wellbeing with parents and other professionals.
Identification and assessment	5	Confidence and abilities around identifying when children may be at increased risk of mental health difficulties, recognising early signs, and understanding and assessing children's strengths and vulnerabilities.
Workplace support	5	Indicators in the organisational environment that will improve practitioners' capability to provide child mental health support. Includes administrative structures, organisational culture, beliefs and attitudes, and feeling supported in practice.
Infant mental health	4	Knowledge and confidence of issues and strategies around perinatal mental health, and being able to recognise signs of mental health concerns in infants.
Facilitating support	4	Knowledge of how and when to connect children, parents or families with additional information supports, including mental health supports.
Working with Aboriginal and Torres Strait Islander families	10	Knowledge, confidence and capability to provide culturally informed practice which includes understanding the impacts of stigma, discrimination and colonisation; strength in culture, and trauma-aware, healing-informed practice. Includes knowledge of key strategic framework, workplace support and how to connect with Aboriginal Community Controlled services.
Family resilience approaches	7	Knowledge and demonstrated practices of family resilience approaches which focus on meaning-making and helping families communicate and draw on strengths. Note: These items were only completed by respondents indicating they worked directly with clients.
Child mental health in the context of disasters	5	Knowledge of how children's mental health can be impacted by disasters and confidence in being able to provide support in the context of disaster.
Specialist competencies		
Child mental health capability	5	Confidence delivering early interventions and therapeutic strategies to address mental health concerns in infants and children, adapting practice for different ages, developmental stages and neurodiverse groups.
Advanced child mental health practice	6	High level clinical discretion skills that include reflective and adaptive practice, risk assessment, applying current evidence and collaborative practice with children, parents and other trusted adults.
Specialist child mental health practice in disasters	4	Confidence and practice delivering therapeutic interventions that consider disaster and working with families following disasters.
Contextually driven practice	4	Ability to adapt practices to the unique geographical and cultural experiences of children and families, including challenges of rural and remote locations and working with families of cultural backgrounds different to the practitioner's own.

The professions captured by the 2023 survey have also been grouped according to the Workforce Classification Framework in order to:

- estimate the levels of competency among those groups; and
- extrapolate to the level of competency that might be expected in a given region with a given workforce profile.

Limited by the survey sample, the NWS results for the Workforce Classification Framework groups do not include all of the professions mapped to the groups listed earlier in this chapter and there is unequal distribution of the professions that are included (the survey sample grouped by Workforce Classification Framework is shown in Table 16).

Table 16 : Survey sample grouped according to Workforce Classification Framework groups

High Exposure Specialist	High Exposure Generalist / Med Exposure Specialist	Med Exposure Generalist	Low Exposure Generalist
• Child and family practitioner (n=184) • Child protection practitioner (n=127) • Occupational therapist (n=75) • Psychologist: Clinical (n=84) • Psychologist: Educational and developmental (or child and adolescent) (n=34) • Psychologist: Other (n=93) • Social worker: General (n=277) • Social worker: Mental health accredited social worker (n=89) • Doctor: GP (n=38) • Doctor: Psychiatrist, child and adolescent (n=17) • Doctor: Psychiatrist, other (n=18) • Doctor: Paediatrician (n=21)	• Family therapist (n=29) • Counsellor (n=130) • Nurse: Maternal and child health (n=88) • Nurse: Mental health (n=198) • Midwife or nurse-midwife (n=31) • Nurse: Community health nurse (n=44) • Speech pathologist (n=41) • Youth worker (n=67) • Community worker or support worker (n=192) • Peer worker (n=71) • School counsellor/ wellbeing officer (n=33) • Childcare worker (n=28) • Creative therapies (music/art/play) practitioner (n=19) • Family and domestic violence worker (n=44) • Educator: Teacher (n=39) • Educator: Early childhood educator (n=44) • Educator: School principal/leader (n=16) • Educator: Support officer/teacher's aide (n=16) • Case worker/case manager/support coordinator (n=7)	• Disability worker/inclusion professional (n=28) • Health promotion/Community development officer (n=51) • Nurse: Practice nurse (n=23) • Nurse: Other (n=103) • Physiotherapist, osteopath, or chiropractor (n=11) • Police, fire services, paramedic (n=15) • Doctor: Other medical specialist (n=1) • Doctor: Non-specialist or trainee (registrar) (n=17) • Dietitian or Nutritionist (n=5) • Program manager/administration (n=214) • Allied health: Other (n=59)	• Academic/Researcher (n=32) • Lawyer/Legal services worker (n=11) • Executive leadership/ senior manager (n=87) • Educator: Adult education and training (n=2) • Policy and advocacy professional (n=8)
Total: 1,057	**Total: 1,202**	**Total: 570**	**Total: 84**

Note: The survey sample also included 84 respondents who identified their occupation as 'Other' and could not be allocated to a group.

When the survey sample was grouped according to the level of specialisation and opportunity to influence children (distribution shown in Table 17 survey sample) high exposure specialists (Group 1) tended to rate their capabilities higher than the other profession groups across all generalist capabilities. The drop in capability between the top-level specialist workforce group and the middle two generalist workforce groups can be seen in Table 17, Figure 16 and Figure 17 (by Workforce Classification Framework groups).

Among respondents who specifically indicated child mental health was part of their job and who regularly see children, those in high exposure specialist roles again consistently rated their specialist capabilities higher.

Low exposure generalists rated their capabilities higher than expected although it should be noted that within the NWS survey sample this group is smaller than the other groups and also comprises large proportion of executive leadership professionals and academics/researchers. These could be individuals who, despite having fewer opportunities to interact with children and families, could be attracted to the survey because of subject matter expertise. The low exposure generalist group (in our Australian workforce analysis described earlier in this chapter) is a more diverse group where less child mental health capability is expected.

Across different remoteness areas, there is a pattern showing higher levels of capability in practitioners who do most of their work in major cities, which decreases with increasing remoteness, and for all competency domains there is a sharp drop off for practitioners in very remote areas (Table 18, Figure 18, Figure 19 and Figure 20). We note that the group of respondents from very remote parts of Australia is small (n=~26) and the very remote group is especially small for those who answered the specialist questions (n=~13), meaning the results around competency in very remote areas must be considered cautiously.

There are exceptions to this capability pattern for the competency domain *Working with Aboriginal and Torres Strait Islander families* and specialist competency domain *Contextually driven practice* (about adapting practice to suit cultural differences and service needs of rural families) –**capability in these domains increases with distance away from major cities before again dropping off for very remote workforces.** This reverse pattern may suggest these particular skills are grown through experience of working in communities which require more adaptive and culturally competent ways of working with families. While experience can be gained on the job by incoming workers, this trend suggests also there is a potential gain to be made by **building locally grown rural workforces** which due to their existing experience can start from a position of being naturally more responsive to local need.

The potential impact of place and experience upon workforce competency building also appears evident in the results for the disaster competencies. Understanding the impacts of man-made and natural disasters on children's mental health and having the skills to respond is an increasingly important competency for practitioners working with children and families, especially in disaster-prone areas. However, this is an area showing some of the **greatest need for improvement**, with mean scores for all remoteness areas below 5 out of 7, indicating **low capability**. A difference however is shown between practitioners who have found themselves needing to address the impacts of disasters with children and families in the past, compared to those without prior experience. The group with **previous experience had quite notably higher scores**, while the others scored very low on both generalist and specialist disaster competency. This suggests that merely being in a role that provides specialist care does not necessarily prepare practitioners for supporting families through a disaster. This indicates that there is a need to equip practitioners in disaster-prone areas with specific child mental health training, especially those who may have not yet lived and worked through a disaster and its immediate aftermath.

Based on these initial results of the NWS, it's strongly evident there is **a need for improved child mental health capabilities** among a range of practitioners working in Australia.

Practitioners responding to the survey across the breadth of remoteness areas report a **lack of services to refer parents or children to for additional support**. Average ratings of the availability of referral options was low across all remoteness areas, decreasing with increased

remoteness (Figure 20). Even in major cities, 36% of respondents were not confident there were local services to refer to (i.e. they scored this item 1-4 out of 7) and this proportion climbed as remoteness increased. Two thirds of respondents (65%) from very remote areas scored this item low, indicating **a severe lack of referral options**. This demonstrates **the importance of empowering practitioners in all regions with skills, confidence and support to respond to children and families within the scope of their roles because reliance on referral options seems unsustainable**.

Table 17: Generalist and specialist child mental health competency means scores out of 7[a] by Workforce Framework Groups, 2023 NWS

Components of child mental health competency	High Exposure Specialist (n~=888)			High Exposure Generalist/Med Exposure Specialist (n~=968)			Med Exposure Generalist (n~=379)			Low Exposure Generalist (n~=88)			Total sample (n~=2,373)		
	Mean	N	Std. Dev	Mean	N	Std. Dev	Mean	N	Std. Dev	Mean	N	Std. Dev	Mean	N	Std. Dev
Generalist competencies															
Child-focused practice	**5.19**	871	1.55	**4.63**	976	1.69	**3.60**	368	1.66	**3.56**	78	1.81	**4.62**	2,342	1.74
Identification and assessment	**5.64**	936	1.16	**5.15**	1,034	1.28	**4.59**	414	1.42	**4.93**	94	1.53	**5.23**	2,534	1.32
Workplace support	**5.62**	842	1.34	**5.46**	899	1.40	**5.15**	355	1.54	**5.64**	87	1.29	**5.47**	2,230	1.41
Infant mental health	**4.80**	853	1.53	**4.46**	881	1.71	**3.97**	329	1.72	**4.53**	83	1.78	**4.51**	2,190	1.67
Facilitating support	**5.94**	939	1.09	**5.64**	1,048	1.24	**5.16**	427	1.49	**5.46**	98	1.49	**5.65**	2,571	1.27
Working with Aboriginal and Torres Strait Islander families	**4.92**	778	1.34	**4.78**	812	1.44	**4.52**	307	1.58	**4.86**	70	1.34	**4.78**	2,010	1.43
Family resilience approaches	**5.76**	633	1.20	**5.46**	635	1.28	**4.63**	175	1.65	**5.76**	17	0.90	**5.48**	1,485	1.36
Child mental health in the context of disasters	**4.78**	739	1.52	**4.57**	770	1.53	**4.10**	284	1.67	**4.67**	63	1.75	**4.58**	1,894	1.58
Specialist competencies															
Child mental health capability	**4.98**	628	1.42	**4.66**	557	1.50	**4.29**	134	1.70	**4.56**	34	1.64	**4.77**	1,369	1.50
Advanced child mental health practice	**5.82**	639	1.05	**5.47**	578	1.23	**5.27**	138	1.32	**5.54**	35	1.01	**5.61**	1,409	1.18
Specialist child mental health practice in disasters	**4.82**	593	1.54	**4.54**	537	1.63	**4.15**	146	1.67	**4.66**	35	1.70	**4.63**	1,329	1.61
Contextually driven practice	**5.54**	637	1.14	**5.43**	580	1.20	**5.39**	142	1.34	**5.19**	36	1.37	**5.47**	1,414	1.19

a) Survey respondents indicated their agreement with competency statements on a scale where 1= strongly disagree to 7=strongly agree. Scores >6 indicate high competence; 5-6 moderate competence; 4 and below low competence.

Figure 16: Generalist child mental health competency means scores out of 7 by Workforce Stocktake Profession Groups, 2023 NWS

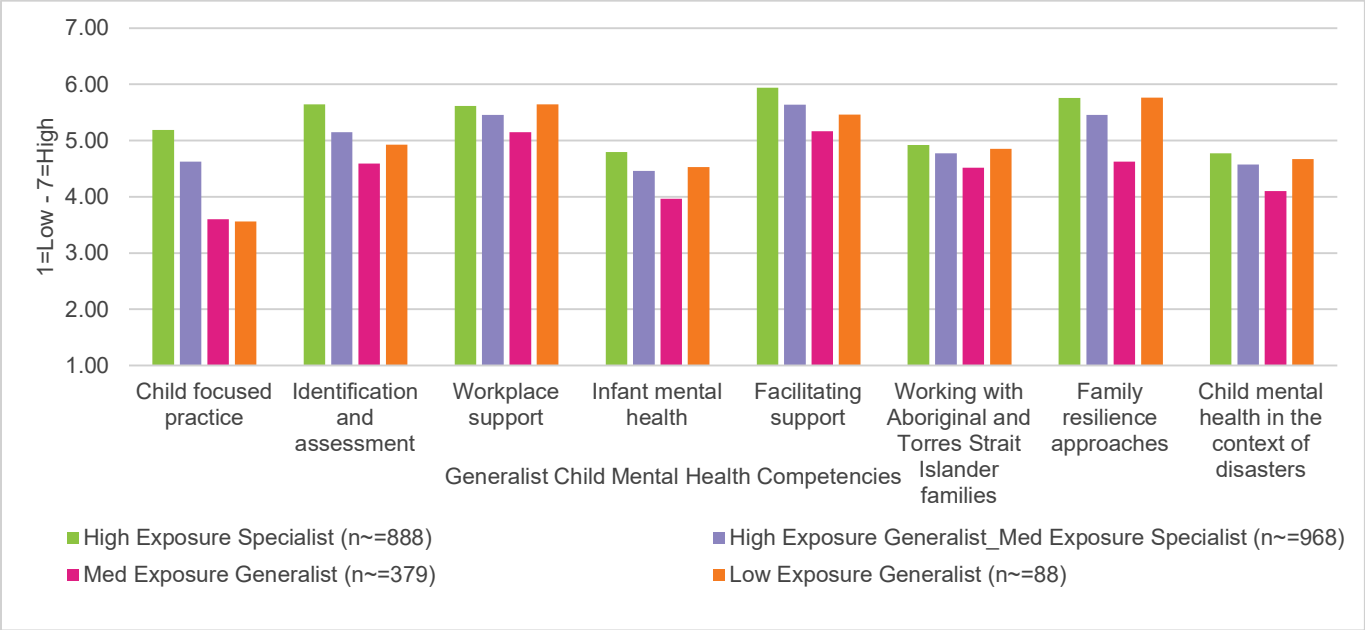


Figure 17: Specialist child mental health competency means scores out of 7 by Workforce Stocktake Profession Groups, 2023 NWS

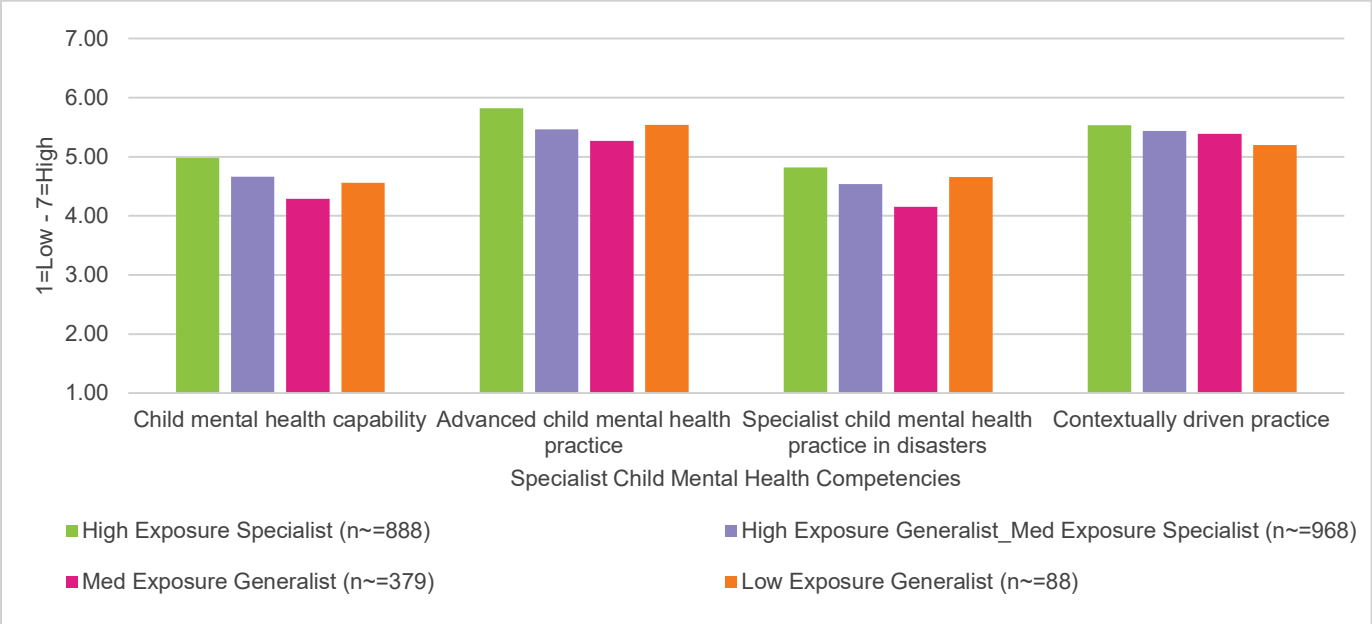
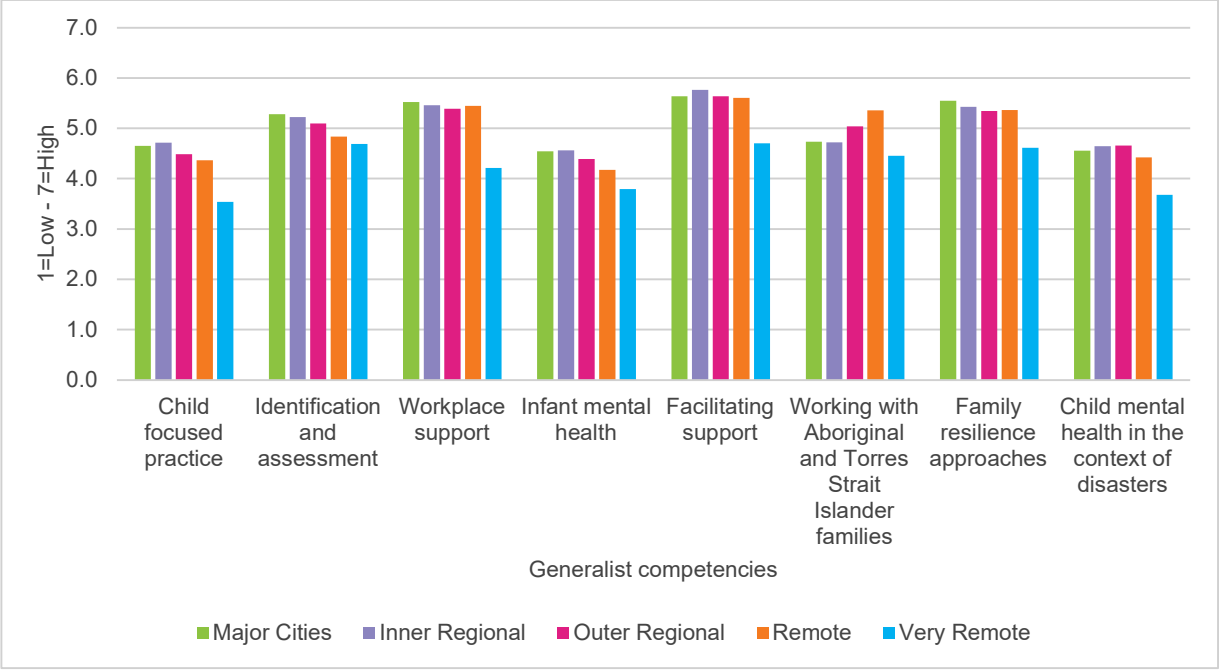


Table 18: Generalist and specialist child mental health competency means scores out of 7[a] by remoteness area classification, 2023 NWS

Australian Statistical Geography Standard (ASGS) Remoteness area classification	Major cities			Inner regional			Outer regional			Remote			Very remote			Total		
	Mean	Std. Dev.	N	Mean	Std. Dev.	N	Mean	Std. Dev.	N	Mean	Std. Dev.	N	Mean	Std. Dev.	N	Mean	Std. Dev.	N
Generalist competencies																		
Child focused practice	**4.65**	1.74	1,359	**4.71**	1.70	564	**4.48**	1.79	302	**4.37**	1.74	68	**3.54**	1.48	26	**4.62**	1.74	2,319
Identification and assessment	**5.28**	1.32	1,487	**5.22**	1.31	610	**5.09**	1.36	317	**4.84**	1.44	69	**4.69**	1.26	26	**5.22**	1.33	2,509
Workplace support	**5.52**	1.40	1,301	**5.46**	1.42	547	**5.39**	1.42	273	**5.45**	1.33	65	**4.21**	1.79	24	**5.47**	1.41	2,210
Infant mental health	**4.54**	1.69	1,283	**4.56**	1.66	530	**4.39**	1.62	270	**4.18**	1.67	62	**3.79**	1.61	24	**4.51**	1.67	2,169
Facilitating support	**5.64**	1.26	1,509	**5.76**	1.22	614	**5.64**	1.35	324	**5.61**	1.26	71	**4.70**	1.61	27	**5.66**	1.27	2,545
Working with Aboriginal and Torres Strait Islander families	**4.73**	1.41	1,166	**4.72**	1.44	499	**5.04**	1.49	246	**5.36**	1.24	59	**4.45**	1.77	22	**4.78**	1.43	1,992
Family resilience approaches	**5.55**	1.34	866	**5.42**	1.28	365	**5.35**	1.50	179	**5.36**	1.20	44	**4.61**	1.75	18	**5.48**	1.35	1,472
Child mental health in the context of disasters	**4.56**	1.56	1,101	**4.65**	1.58	470	**4.66**	1.58	230	**4.42**	1.80	55	**3.68**	1.67	22	**4.58**	1.58	1,878
Specialist competencies																		
Child mental health capability	**4.83**	1.46	814	**4.80**	1.49	348	**4.66**	1.57	152	**4.41**	1.76	32	**3.00**	1.91	13	**4.78**	1.50	1,359
Advanced child mental health practice	**5.66**	1.13	836	**5.63**	1.17	356	**5.53**	1.25	160	**5.28**	1.40	32	**3.86**	1.51	14	**5.61**	1.18	1,398
Specialist child mental health practice in disasters	**4.61**	1.60	783	**4.70**	1.59	343	**4.64**	1.65	149	**4.42**	1.82	31	**3.54**	1.81	13	**4.62**	1.61	1,319
Contextually driven practice	**5.32**	1.20	834	**5.67**	1.10	366	**5.80**	1.20	159	**5.77**	1.09	31	**4.57**	1.40	14	**5.47**	1.19	1,404

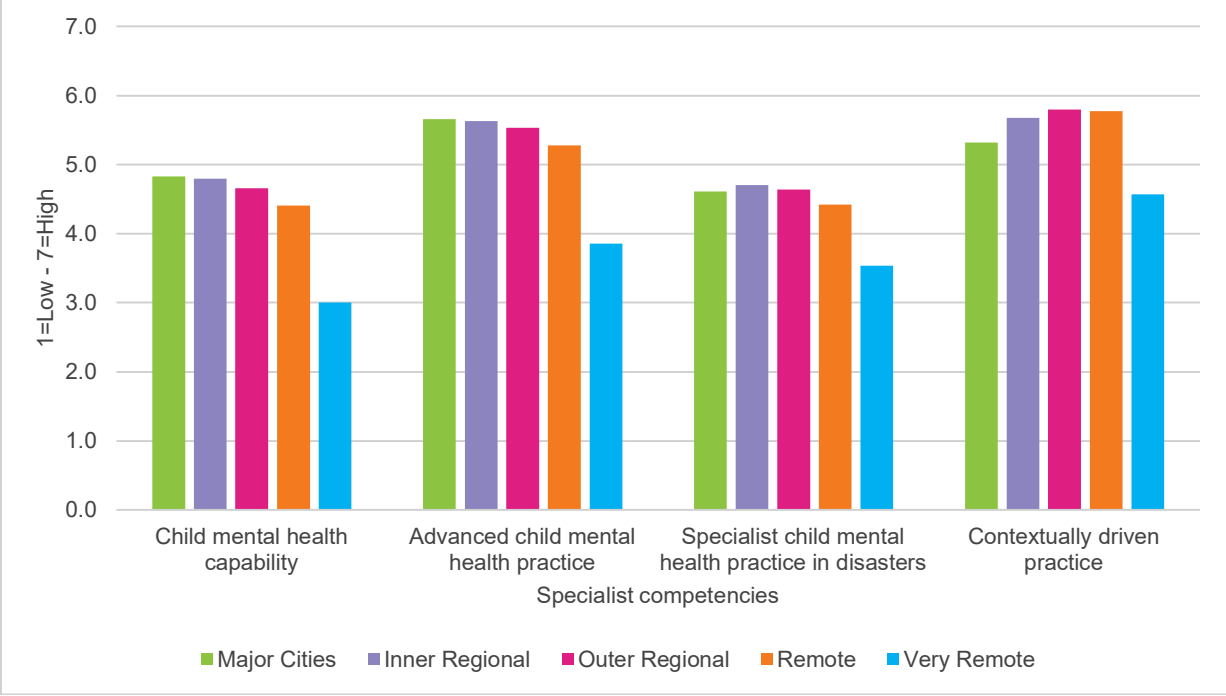
a) Survey respondents indicate their agreement with competency statements on a scale where 1= strongly disagree to 7=strongly agree. Scores >6 indicate high competence; 5-6 moderate competence; 4 and below low competence.

Figure 18: Generalist child mental health competency means scores out of 7[a] by remoteness area classification, 2023 NWS



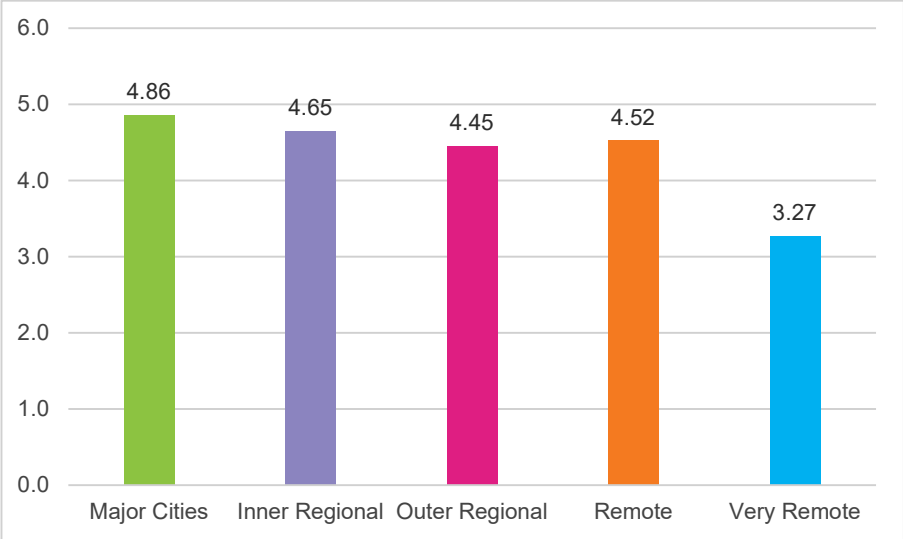
a) Survey respondents indicate their agreement with competency statements on a scale where 1= strongly disagree to 7=strongly agree. Scores >6 indicate high competence; 5-6 moderate competence; 4 and below low competence.

Figure 19: Specialist child mental health competency mean scores out of 7[a] by remoteness area classification, 2023 NWS



a) Survey respondents indicate their agreement with competency statements on a scale where 1= strongly disagree to 7=strongly agree. Scores >6 indicate high competence; 5-6 moderate competence; 4 and below low competence.

Figure 20: Local support services are available to refer parents or their children needing additional support, mean scores out of 7[a] by remoteness area classification, 2023 NWS



a) Survey respondents indicate their agreement with competency statements on a scale where 1= strongly disagree to 7=strongly agree. Scores >6 indicate high competence; 5-6 moderate competence; 4 and below low competence.

Summary of current competency findings

The Australian workforce showed moderate self-rated capability in a range of child mental health capabilities. There was lower confidence in specialist level competencies than in generalist competencies. Infant mental health and child-focused practice were areas of low capability, which is consistent with findings of the previous survey. However, approaches which centre the family and focus on resilience are well understood by the workforce, showing opportunity to shift service models and skill development to more holistic family approaches.

Competencies that are key to successfully supporting children and families in rural and remote areas such as working in the context of disasters and working with Aboriginal and Torres Strait Islander families were rated low by the workforce overall. Although these competencies are higher among rural and remote workers, the lack of confidence working in culturally competent ways is particularly concerning given the population characteristics of some of the highest need areas. Rural workers are also more confident adapting their practice to local context, suggesting the experience of being rural helps shape these skills and highlights the benefits of a locally grown workforce.

For most child mental health skills and practices, the competency levels are lower in rural and remote areas. The availability of local services to refer to is considered low in all areas but especially in rural and remote areas. This indicates a need to develop and support those practitioners already working in rural and remote areas to increase their skills in child mental health practice.

KEY POINTS:

- There is a broad range of occupations currently and potentially available to provide child mental health and wellbeing support, with varying levels of expertise and opportunity, and spread across different regions of Australia.
- The workforce is maldistributed with workforce numbers higher in urban areas. Workforce numbers and hours generally decrease as remoteness increases (with some exceptions).
- It's important to consider unique workforce mix by location – data shows intrastate and interstate differences, which make it challenging to suggest a 'one size fits all' response to supply constraints.
- The availability of specialist workforce is low in most areas that have average or greater than average need for child mental health support. The more remote the region, the fewer specialists per child population and fewer hours of specialist support are available to infants and children to access.
- There is significant potential professionals including mental health specialists with some opportunity and generalists with greater opportunity available to support child mental health and wellbeing.
- Workforce availability is well above the national average in major city locations, in fact there were examples of significant mismatch of need in some city areas with low levels of need having abundant specialist and generalist workforce.
- There are however, limitations in the ability of current data sources to measure the extent to which the broader workforce currently is or potentially can support child mental health and wellbeing, where need is being met, and to contribute to developing workforce solutions.
- Emerging Minds' National Workforce Survey results showed moderate generalist-level skills across the workforce, but highlighted lower levels of workforce confidence in infant mental health and child-focused practice, along with low levels of capability in working with Aboriginal and Torres Strait Islander families and in the context of disasters.
- Workers in medium-opportunity specialist and generalist roles showed lower competency than specialists, as could be expected, highlighting the need to support capacity building in these groups to improve them as a resource for child mental health support.
- Location and experience impact practitioner competency – higher levels of capability in child mental health exist in urban-based professionals with competency decreasing with increased remoteness, highlighting the need for access to capacity building in rural and remote areas.
- However rural and remote practitioners reported higher capability in working with Aboriginal and Torres Strait Islander families, working in the context of disasters and for contextually driven practice that is adaptable to local need. This suggests initiatives that draw upon city workers to fill gaps in rural and remote areas must include rural generalist, disaster and cultural competencies.
- A lack of referral services for rural and remote based workers highlights the need for broader skillset available in these locations.

Chapter 5.

Building child mental health and wellbeing workforce competency in the Australian context

5. Building child mental health and wellbeing workforce competency in the Australian context

Chapter 5 overview

In this section we report the results of our desktop literature review and consultation in relation to core competencies and identify the essential workforce competencies needed to support the development and social emotional wellbeing of Australian children. We first identify and consider broader international trends in health and mental health service design. We then identify a range of existing frameworks and consider the potential strengths and limitations of these for the contemporary Australian context. We review what has been learnt from the implementation of similar workforce initiatives in the UK. Drawing on this knowledge we outline and recommend a set of core abilities that can support and enhance the development and wellbeing of Australian children and families. In this work, we had a particular focus on a flexible competency model that may be generalised to address a variation of available resources, access and equity issues, and social determinants of health in the Australian context.

Method

A desktop search was completed which covered grey literature and peer-reviewed publications applying broad search terms such as: evidence-based; child mental health; health; review; plus 'competency', 'skills' or 'frameworks' to identify publicly available information (policy, publications and websites) related to developing mental health and health workforce competencies. Citations and secondary references from publications related to the child mental health workforce were also reviewed.

Following this, key competencies were reviewed within Emerging Minds through a series of workshops and gaps were identified. The proposed set of competencies representing a range of service sectors was then examined further by Emerging Minds staff. Feedback was incorporated into the competency framework outlined in this chapter and detailed further in Recommendation 3.

Summary of emerging trends in mental health service design

Our review identified several publications related to workforce planning, competencies and service design in *adult* health and *adult* mental health sectors that are relevant to this project. Several trends were identified within the literature that help to reimagine the child and family facing workforce. These include:

- the potential applicability of innovations in health service implementation in 'low resource' settings
- task shifting approaches aimed at devolving components of specialist skills to a broader workforce

- a focus on transdiagnostic approaches; and
- an emphasis on adopting tiered capability models/levels of capability designed to meet the needs of a diverse range of workforces.

These emerging trends are both evidence-informed and have clear implications for the re-design of a child and family facing workforce, outlined as follows.

- **Risk relative to resources – service delivery in 'low resource' settings:**

  Although the term 'low resource' was originally applied exclusively to the delivery of health services in low income countries, there is increasing recognition that middle- or high-income countries can also face comparable resourcing challenges, albeit for different reasons. In Australia, wait times and access gaps for tertiary mental health services can be understood as resourcing issues that place demand on services and create a need for alternate solutions. Arguably, Australia's unique demographic and geographical features present additional resourcing challenges for rural and remote communities.

  Parallels with the support needs of rural and remote populations in first world countries exist in terms of underdeveloped infrastructure, knowledge barriers, geographical factors, and human resource limitations (Van Zyle et al., 2021), meaning solutions for low resource settings may be relevant for under-served populations in Australia. These parallels may be particularly relevant in remote settings where the ratio of mental health burden and a lack of tertiary trained mental health professionals may be higher, as shown in Chapter 4. Our consultations have also suggested that innovations focused on transferring mental health capability and skills may hold promise for addressing the needs of rural and remote communities, in which 'risk' may be high relative to 'available resources'.

- **Task shifting:**

  An approach related to innovations targeting health service delivery in low resource settings is 'task shifting' (Dorsey et al., 2020; Patel et al., 2007). In a health context, it involves the transferral of 'core' health interventions and supports to non-specialist settings and/or paraprofessional workforces where feasible.

  Evidence suggests that task shifting may be an effective strategy for addressing the mental health treatment gap for adults needing care for a range of mental health conditions where access to these services is limited by resourcing or demand issues (Dorsey et al., 2020; Van Ginneken et al., 2013). The approach typically involves 'upskilling' workforces that may have more opportunity for accessing and supporting the target demographic. The potential of this approach has been demonstrated in low resource countries and with populations who work with children, such as the health and education workforce (Dorsey et al., 2019). Early evidence suggests that the delivery of interventions, such as cognitive behavioural therapy, which normally require specialist training, may also be effective when delivery is transferred to non-mental health professionals (Sijbrandihj et al.,2020).

- **Tiered skills approaches:**

  A tiered skill approach recognises that many opportunities for mental health intervention exist outside of formal mental health services, and that many people with emerging

mental health concerns can benefit from 'lower intensity' support delivered in the context of existing relationships and naturalistic service settings. An assumption of this approach is that support can be delivered in an acceptable, naturalistic and effective way by drawing on lower intensity forms of evidence-based interventions prior to the onset of significant mental health concerns. Recent evidence suggests the potential value of identifying and leveraging tailored training for a wide range of lay, paraprofessional and non-traditional professional groups to support early intervention and support for emerging mental health concerns (Barnett et al., 2018). In practical terms, this might translate into stepped care 'levels' of competency shaped to the needs of distinct communities (e.g. parent groups, community services, education setting or health promotion settings).

- **Transdiagnostic approaches:**

  There is growing recognition of the limitations of relying on formal diagnostic categories in understanding the nature of mental health experience and in determining access to mental health support (Dalgiesh et al., 2020). Increasingly, transdiagnostic approaches are being advocated for (e.g. the Research Domain Criteria Initiative framework, US National Institute of Mental Health, nd). These approaches highlight common components of diverse mental health presentations and, importantly, place emphasis on addressing the difficulties that underpin and predict the emergence of common mental health concerns. Arguably, transdiagnostic approaches that address underlying risks such as temperament, emotional regulation, arousal mechanisms and externalising/impulsive expression create opportunities for early intervention prior to the onset of mental health concerns (Insel et al., 2010; Sawrikar et al., 2022; Scott & Henry, 2017).

These promising emerging trends, together with our data analyses, have helped shape recommendations that seek to expand the available child mental health workforce. This can be done through considering where and how families engage with health and human services, and realising opportunities to offer better support earlier in the journey of mental health concerns in children. A critical component of achieving this is to clarify the competencies required for an expanded workforce to provide safe and effective support to children and families.

Summary of existing child competency frameworks

Emerging Minds identified a small number of international workforce models that described the critical competencies, skills and approaches necessary for working with children with established mental health concerns. These programs summarised the practice principles, individual skills or transdiagnostic components of applying evidence-based interventions for common child mental health diagnoses such as anxiety and depression. A sample of the workforce models identified in our review are outlined in Appendix 1. Published frameworks generally describe one or more of the following:

- Competencies needed for specific areas of practice or developmental stages (e.g. perinatal).
- Competencies needed for specific settings (e.g. CAMHS or psychiatric inpatient).
- Differentiated competency 'levels' needed for different workforce settings (e.g. generalist versus specialist; tiered workforce models).

Box 2: List of identified international competency frameworks for supporting child mental health

- Child and Young People's Improving Access to Psychological Therapies (CYP IAPT) model[20] – United Kingdom (UK) (National Health Service, 2014)
- Improving Access to Psychological Therapies (IAPT) model / University College London Child Outcomes Research Consortium (CORC)[21] – UK (University College London, nd)
- Unified protocol for transdiagnostic treatment of emotional disorders in children (UP-C)[22]
- A knowledge and skills framework for the Scottish workforce[23] – Scotland (National Health Service, 2020)
- New Hampshire children's behavioural health core competencies[24] – United States (US) (University of New Hampshire, 2019)
- Real Skills Plus ICAMH/AOD Competency Framework[25] – New Zealand (NZ)

See Appendix 1 for more detail regarding examples of these.

The Children and Young People's Improving Access to Psychological Therapies (CYP IAPT) framework

Amongst the frameworks reviewed, the CYP IAPT model from the UK is noteworthy for several reasons as it:

- stands out as a program of workforce development that has been in existence for over 10 years, and is evidence-informed (based on National Institute for Health and Care Excellence (NICE)[26] evidence reviews),
- has been subject to evaluation; and
- expanded over time from a child mental health specialist program to one accessible to a wider child facing workforce (such as teachers and community workers).

The contents of many of the frameworks identified in our search can be traced to the original CYP IAPT training modules.

The CYP IAPT workforce package was originally developed to upskill interdisciplinary CAMHS staff in the delivery of evidence-based practices for addressing common child mental health concerns such as anxiety, depression, and conduct disorder. The competencies identified in the model were based on best available evidence and NICE guidelines and reviews, where these were available. The original program has expanded in content to include skills for working with families and skills suited to delivering low intensity supports in early intervention settings.

The CYP IAPT initiative is exemplary in its commitment to supervision, leadership and accreditation using a range of methodologies such as guided learning, video instruction and competence assessment as part of its workforce training. Initially developed for the CAMHS workforce, the program has now broadened its focus and has extended nationwide across the UK to offer lower intensity training and development for other workforces such as community welfare

[20] National Health Service, United Kingdom (2014).
[21] University College London, United Kingdom (nd).
[22] Ehrenreich-May et al., (2017).
[23] National Health Service, UK (2020).
[24] University of New Hampshire, US (2019).
[25] University of Auckland, NZ (2019).
[26] National Institute for Health and Care Excellence (NICE), UK, https://www.nice.org.uk/

and education workforces through guided self-help manualised modules of learning (Ludlow et al., 2020).

While only very limited data for programs based on this model is currently available in the Australian setting (Dalton et al., 2017), tailored iterations derived from the original CYP IAPT framework can be found in the University College London (UCL) and the National Health Service Education for Scotland (NES) publications. Drawing on the CYP IAPT framework, the Scottish workforce model also introduces 'tiered' skill levels to address the need of a wider range of mental health workforce roles and service settings. In the UK, the Child Outcomes Research Consortium (CORC) have extended the framework to specific service settings, disciplines or presenting issues.

Lessons from the IAPT implementation

High demands on specialist services, limited available provision and long waiting lists present key barriers to accessing child and adolescent mental health services (Radez et al., 2021).

The concept of a 'core set' of skills for working in evidence-based ways with children and youth is central to the CYP IAPT initiative in the UK. Clinicians receive training in a range of evidence-based approaches to working with common clinical conditions of childhood. However, early evaluations of this initiative identified the need to broaden the training to include competency to work in relational ways and effectively with families.

The CYP IAPT program's initial evaluation identified that interdisciplinary CAMHS team members felt that core skills based on CBT alone were insufficient to meet the needs of some children and families. CAMHS team members also wanted skills for working in more specialised areas of practice (such as eating disorders) and to help them work in more systemic ways with family members. As a result, the training program was expanded to include interpersonal therapy training for adolescents and family therapy training (structural, functional and systemic) in order to assist CAMHS practitioners to feel confident in working in more relational and systemic ways (Fonagy et al., 2017).

Reviews of UK teams using the CYP IAPT approach have highlighted the value of attending to implementation factors such as supervision (leaders as 'change agents'), as well as the value of collegial partnerships and opportunity to share experiences within organisations and within local areas (Burn et al., 2020). Staff turnover and consequently loss of skilled workers was also identified as a risk factor for the successful implementation and maintenance of workforce competencies in CAMHS settings.

Core competencies for the Australian context

Emerging Minds' detailed review of the existing frameworks involved collating common competencies across a range of sources. While there are several strengths to existing frameworks such as the CYP IAPT (e.g. evidence-based), there are also gaps that could be addressed in any new Australian framework.

For example, the frameworks identified in our search provide limited acknowledgement of the social and cultural aspects of mental health (especially for Aboriginal and Torres Strait Islander children and families but also more generally for CALD communities); the ability to identify and address psychosocial and ecological factors impacting on mental health; supporting children based in rural and remote areas; or skills in responding to contemporary issues impacting on

children's wellbeing (e.g. cyber safety). We deemed it important to include consideration of these factors explicitly when recommending competencies with potential to impact on the wellbeing of Australian children. Further, in light of the lessons learnt from implementing CYP IAPT, the need to emphasise implementation and service delivery factors was also highlighted.

We also identified 'meta-competencies' that underpin the successful practice of all skills such as the confidence and ability to work in partnership with families and peers; the ability to share expertise and engage in reflective supervision and mentoring; and the ability to communicate across a range of settings such as telehealth, online support, group work, community consultation and face-to-face service delivery. It is envisaged that confidence with a range of service modalities will increase capacity of the workforce to service hard to access communities such as rural and remote settings. As a result, Emerging Minds has recommended additional competencies be included to better reflect the range of factors that contribute to effective and timely support for children and families, the social and family determinants of mental health, and to fill gaps identified in recent literature and our stakeholder consultation process.

Our internal consultations highlighted the value of using language that is less diagnostic in nature to make the framework more accessible to a wider workforce audience. As a result, the framework describes the mental health care processes of 'identify, assess, and support' in more simple language as 'recognise, reflect, and respond'. The proposed competencies identified through this process are outlined in Table 19 below.

Table 19: Suggested generalist competencies for supporting child wellbeing and mental health

Competency	Reference ^
Recognise	
Able to talk to children/ask about mental health and wellbeing	UP; NES
Able to ask parents about their mental health and wellbeing	EM
Able to recognise emerging and established (transdiagnostic) indicators of risk*	UCL
Able to recognise neurodevelopmental difference in children*	UCL
Able to understand children's developmental needs**	UCL; NES
Able to recognise the role of families in children's wellbeing	IAPT
Able to recognise when families need support/are not travelling well	EM
Able to consider the impact of big events on children (trauma, moves, divorce, bereavement)	NES; UCL
Able to recognise when a child is at risk of harm (e.g. suicidal thoughts, self-harm, drug use)**	UCL; NH
Reflect	
Able to consider a child's development/mental health support needs***	UCL

Able to consider a child's strengths/privileging strengths	NH
Able to consider a family's support needs	NH
Able to consider a family's strengths and privilege strengths	NH
Able to consider the impact on parent- child relationships	
Able to consider the child's connection to family and community	EM
Able to consider cultural/diversity needs	EM
Respond	
Able to form collaborative partnerships and engage with children's families – work with families as partners	NH
Able to support parents to talk about children's mental health and support needs	UP; NES
Able to encourage and support parenting 'capacity' building and the use of positive parenting 'strategies'*	IAPT; UP; NES
Able to support diverse families (e.g. families with low literacy, parents and children with neurodiversity, culturally and linguistically diverse (CALD) families, Aboriginal and Torres Strait Islander families)	NH
Able to support children of parents with additional considerations (children of parents with mental illness, AOD, intellectual disability, other)	EM
Able to support and strengthen parent-child relationships	EM
Able to support and stregnthen sibling relationships	EM
Able to develop strategies with family members to support their children's mental health and development	IAPT
Able to facilitate and support families to incorporate play and joint activities in children's lives	UCL
Able to develop strategies to minimise the impact of parental issues on children's wellbeing and mental health	NES
Able to support parents and families in family transitions – perinatal period, adolescence, separation, loss	UCL
Able to work with principles derived from Cognitive Behaviour Therapy for fostering social and emotional wellbeing (connection between thoughts, emotions and behaviours)	IAPT
Able to support children with developmental delays (e.g. language, self-regulation, attention)	EM

Able to adapt evidence-based interventions according to a child's needs (e.g. developmental age and stage, current functioning)	NH; UCL
Able to support children with (neuro)diversity (SLD, intellectual disability, gender identity, higher body weight)	NES
Able to address contemporary issues impacting on child wellbeing (sleep hygiene/cyber safety/ vaping)	EM
Meta competencies	
Collaborate Able to connect with colleagues and other services to support children and families; formal and informal connections Able to make, identify and initiate effective referrals to other agencies when needed Able to form partnership with children and families	NES NH
Communicate Able to deliver effective support via a range of modes (e.g. telehealth, group work, guided self help, face to face. Able to participate in consumer-driven service development (e.g. lived experience consultations, placed based community development)	IAPT EM
Coach Able to engage in supervision and supervise peers where appropriate Able to access additional learning, supervision and support about your work with children and families Knowledge of relevant legislation, mandates and services (e.g. eligibility, service parameters)	UCL; NES EM

* Transdiagnostic indicators according to age and setting, ** Indicators of adjustment difficulty according to age and setting, *** Transdiagnostic lens

^ UP refers to the Unified Protocol for Transdiagnostic Treatment of Emotional Disorders in Children; NES refers to the NHS Education for Scotland framework; UCL refers to the University College London Child Outcomes Research Consortium led framework; IAPT refers to the Improving Access to Psychological Therapies framework; NH refers to the New Hampshire framework; EM refers to Emerging Minds proposed competencies, based on consultations and following literature: Allchin et al., 2022; Brett et al., 2023; Cliffe et al., 2019; Dantchev et al., 2019; Essex et al., 2006; Hawes & Allen, 2016; Nicholson et al., 2022; Renk et al., 2016; Repetti et al., 2002; Tucker & Finkelhor, 2017; Wass et al., 2023; Wright & Edginton, 2016; Zimmer-Gembeck et al., 2022.

Consistent with emerging trends in health service design, the proposed competency framework emphasises transdiagnostic indicators and competencies that focus on common behavioural indicators of emerging risk that can be identified in very early childhood, as opposed to a model purely based on diagnostic or clinical criterion-based treatments.

Additionally, in line with 'task shifting' approaches in health service design, this proposed competency framework outlines skills that a wider, non-clinically trained workforce can apply to recognise and respond to emerging risk in a timely manner. In keeping with stepped care approaches and tiered models of workforce competency, the skills outlined here can be further broken down as those appropriate for community settings versus low-medium intensity service settings respectively.

The proposed competency framework outlined above is also compatible with key Commonwealth Government mental health initiatives such as the draft Initial Assessment and Referral guidance documents (for children) and the broad objectives of the National Children's Mental Health and Wellbeing Strategy (Department for Health and Aged Care, 2021; National Mental Health Commission, 2021; Robertson & Eapen, 2024). The competencies articulate the minimum skill set required by different service settings to support child wellbeing along a tiered continuum of services response. Emerging Minds is defining these as 'Level 1' skills for lay, paraprofessional, childcare and community settings and 'Level 2' for low intensity support services). For simplicity, an overview of the key competencies and sources are outlined in Table **19** above and further detail about the proposed Level 1 and 3 tiered competencies by workforce settings is presented under Recommendation 3.

Building workforce capacity for responding to child mental health needs: the need for a generalist workforce

'Despite at least two decades of mounting evidence of the human and economic value of investing earlier in prevention and early intervention, and in creating the conditions to support children and their families, we have been unable to shift investment upstream and right now we are continuing to pay more for expensive late reaction policies. Ambulances at the bottom of the cliff.'

– Ann Hollonds, Children's Commissioner[27]

Demand for mental health support exceeds workforce capacity

The demand for mental health supports exceeds current workforce capacity; indicating the need to improve access to early mental health supports. The development and promotion of generalist workforce positions able to deliver a range of mental health supports is one way to address this issue.

In developed countries, the most common causes of morbidity among children and youth are mental health issues and addictions, affecting as many as one in five children by the age of 15 years (Campbell et al., 2019; Lawrence et al., 2015; Offord et al., 1987; Waddell et al., 2002; Waddell et al., 2005; Sadler et al., 2018).

Untreated mental health disorders in children and adolescents are related to adverse health, academic and social outcomes (Green et al., 2005; Lycett et al., 2023; Pompili et al., 2012; Riegler et al., 2017), often persist into adulthood (Ford et al., 2007) and represent a significant socioeconomic burden (Prince et al., 2007). Globally, the burden of mental illness is estimated to

[27] Speech by Ann Hollonds, Children's Commissioner, delivered to the Parliamentary Friends of Early Childhood, 25 February 2021. https://humanrights.gov.au/about/news/speeches/towards-national-child-wellbeing-strategy

account for 32.4% of years lived with disability (YLDs) and 13.0% of disability-adjusted life-years (DALYs) (Cortina, 2020; Vigo et al. 2016).

Globally, there are increasing rates of mental health problems in children and young people (Kieling et al., 2011; Cortina, 2020). Many significant mental health and developmental concerns arise early in a child's life and there is a need to re-think how we offer mental health supports to children and families.

It is estimated that 13.6% of children 4-11 years of age have experienced a diagnosable mental health disorder in the past 12 months (Lawrence et al., 2015), and this is consistent with the findings of international research (e.g., Polanczyk et al., 2015). Half of the lifetime mental health problems start by the age of 15 and nearly three quarters by the age of 18 (Kim-Cohen et al., 2003). One recent meta-analysis on the findings from 192 studies examining the onset and trajectory of childhood mental health concerns indicated that 34.6% of children with any mental health concern and 61.5% of children with a neurodevelopmental issue could be identified before age 14 (Solmi et al., 2022).

One UK study identified that only 30-40% of children and young people who experienced clinically significant mental disorder were offered timely evidence-based interventions (Green et al., 2005; Cortina, 2020). Some research suggests that children with identified mental health concerns may not receive sufficient specialist mental health support (Sawyer et al., 2018), and less than two thirds of young people with mental health problems and their families access any professional help (Sadler et al., 2018).

Access to tertiary mental health services can be limited for a range of reasons. A recent systematic review of this issue identified a range of barriers for young people including poor mental health literacy, beliefs about help seeking including stigma and embarrassment and concerns about confidentiality and disclosure involved in getting support from an unknown person (Radez et al., 2021). Other structural barriers were also identified such as cost and availability of services (Radez et al., 2021), with these factors exacerbated in rural and remote settings (National Rural Health Alliance, 2021).

To summarise, it is estimated that the prevalence of mental health issues in children will continue to grow with considerable long term economic and social costs that are projected to increase for developed countries into the future. Currently, the demand for mental support is growing in the context of access barriers and workforce pressures. The need to intervene early to support children's mental health is well recognised in policy. The National Children's Mental Health and Wellbeing Strategy, released in 2021, specifically recommends early preventative intervention and provision of needs-based supports. We argue that the development and implementation of a generalist wellbeing workforce is an important means by which to grow the potential workforce that can support children and families in a timely manner.

The potential of the generalist practitioner role for supporting child mental health

Equipping a broader workforce with the necessary skills to support children and families has the potential to play a significant role in mental health prevention and aligns with national and international policy recommendations.

Internationally, there have been consistent calls to rethink child mental health services to enable supports to be delivered early and to those at risk. Amongst the primary recommendations made by the World Health Organization (WHO) include the deinstitutionalisation and integration of

mental health care with general health care and the development of community based mental health services (WHO, 2022a). Major reviews of services and system design have recognised the value of task shifting and task sharing, more seamless partnerships at the interface of primary health care and stepped care options, implementation of community-based solutions and the adoption of innovative service delivery options better suited to the continuum of care needs (Patel et al., 2018; Colizzi et al., 2020).

There is now wide acceptance of the importance of prevention and early intervention for a range of health conditions. Prevention and early intervention are recognised as key elements of minimising the potential for developing any serious health condition, including mental health conditions. Early childhood years in particular are critical considering the sensitivity of early brain development during this period and the potential for developmental vulnerabilities to impact on the cognitive, social, behavioural and emotional development of the child, laying the foundation for later mental health vulnerabilities (Black et al., 2017; Raviola et al., 2019; Solmi et al., 2022).

We know that of the 20% of young people that are likely to be experiencing clinical mental health conditions before age 25, approximately 50% of those are symptomatic by age 14 (Kessler et al., 2005). This argues for a workforce that is able to support child wellbeing both:

- early in the life of the child; and
- early in the life of the 'problem'.

Collectively, the available research strongly suggests the value of rethinking how we build capacity in workforces that can respond in more timely way to emerging needs. This includes providing non-clinical workforces with the confidence and skills to respond to children and families within schools and communities when opportunities arise. It also includes supporting clinical health and allied health workforces to adopt new skills to enable them to respond to emerging child and family indicators of distress using a range of low intensity supports directed at risk factors.

The development and implementation of a 'generalist' child and family practitioner pathway represents a promising public health response. Incorporating similar child wellbeing roles in CAMHS services appears effective in providing brief, cost effective support for children and adolescents (CYP IAPT Midlands Collaborative, 2018; Turnbull et al., 2023); suggesting the value of expanding these skills to a wider workforce. In summary, the proposed competency framework can build workforce capability to support children's mental health and wellbeing through a core skillset as it:

- reflects skills compatible with the workforce development needs of staff across national mental health initiatives such as rural mental health workforce development initiatives, and programs such as Child and Family Hubs and Head to Health services (Honnisett et al., 2023), as well as contributes to the strategic workforce needs of sectors such as primary health, early childcare and education services.
- reflects competencies that are broadly aligned with stepped care pathways proposed in the Initial Assessment and Referral (child) guidance document and integrated continuum of connect and care (I-CCC) pathways as individual needs change (Eapen et al., 2023).
- provides a wider workforce with a 'common language' and transferable skills, offering a buffer against high levels of workforce turnover and cross-sector mobility that exists in a range of support, education, disability and social service workforces.

- includes tiered skill development (Level 1 and Level 2), providing competencies that are flexible enough to meet the needs of a range of sectors and services, including adult and child and family serving sectors, and across health, education and social welfare services.
- can be used to address emerging support needs both early in life, and early in the life of a mental health concern.
- can help workers to feel confident to deliver supports in flexible ways including online, group work and face-to-face.
- includes modules that can be manualised or standardised to align with relevant industry, organisational or regulatory credentialling/micro-credentialling.
- supports fundamental capabilities of recognising and responding to child and family concerns in evidence-informed and non-stigmatising ways.
- is not limited to tertiary qualified mental health professionals but is accessible to a range of professional and paraprofessionals involved in children's lives.
- may incorporate skills of guided support delivery of evidence informed principles and practices that can increase the self-sufficiency of families and communities in need and support a timely response to emerging concerns.

KEY POINTS:

- Access to specialist mental health support is limited for a range of factors and can be experienced as stigmatising, with a significant proportion of children likely to experience mental health concerns that are distressing but will not meet criteria for accessing tertiary specialist mental health services (the 'missing middle').
- Many mental health concerns in children are established much earlier than previously believed and there are benefits of developing a workforce that can support children early in life to disrupt and correct their mental health trajectory.
- While several child mental health workforce frameworks were identified, these needed further development to consider the unique needs of the Australian workforce (e.g. to consider content and delivery modes more suited to rural and remote populations or Aboriginal and Torres Strait Islander population).
- Emerging trends from the design of adult health systems provide guidance for improving equitable access to early child mental health supports for children and families including learnings from low resource settings, task shifting, tiered skills approaches and transdiagnostic approaches.
- A range of competencies for supporting child mental health were identified from existing frameworks, research evidence and sector consultation, which can be deployed across a range of service settings to support early intervention for improved children and family outcomes.
- Where similar workforce development initiatives have been evaluated (e.g., CYP IAPT initiative), these evaluations support the inclusion of broader skills such as working with families and systems, working collaboratively with colleagues and families, the importance of leadership and 'change agents', and improving access through staff competency in a range of delivery options.

Chapter 6.

Stakeholder consultation – findings and implications

6. Stakeholder consultation: findings and implications

Chapter 6 overview

This chapter presents the findings from stakeholder consultations aimed at understanding the deeper context of the supply-demand imbalance for child mental health services in Australia. The goal was to engage with strategic stakeholders who possess deep knowledge across various aspects of child mental health service delivery, including commissioning, service planning, workforce, program leadership, clinical expertise, academia, families with lived experience, and peak industry bodies.

The research team prioritised engaging stakeholders with experience and perspectives from regional, rural, and remote parts of Australia, as well as those with expertise in rural and remote health, workforce barriers and enablers, those with lived experience and mental health care. The consultations provided valuable context, nuance, and insights beyond population-level data (as presented in section Chapter 3), helping to identify implementation considerations and potential strategies that could be scaled or adapted from successful local initiatives.

Conclusions drawn from this section highlight the need for supportive funding models and to focus on early intervention and prevention. Similarly with Chapter 3 there is also a call for system level responses, beyond a focus on practitioner change, that allow for contextual adaptation for local contexts.

Method

Data collection and sample

Recruitment of consultation participants used a basic snowballing sample technique that relied on the experience of Emerging Minds staff and their relationships across the country, especially the (national) Child Mental Health Advisors from the Partnerships and Implementation team. Initial consultations then snowballed to additional potential participants using standardised email templates, helping potential participants become informed before consenting to participate.

Overall, between December 2023 and April 2024, 59 people participated in the consultations from 30 different organisations, bodies and professional groups from across the country.

Consultations were predominantly online as either individual interviews or focus groups, with two stakeholders submitting written responses against the interview schedule. Interviews were transcribed using Rev transcription service for analysis. Participants were shown the interview schedule beforehand to prepare for the consultation.

The interview schedule was broadly focused on two sections; (1) uncovering the stakeholders understanding of local supply versus demand barriers and issues; and (2) outlining participant ideas regarding future solutions.

Thematic analysis

Familiarisation with transcriptions, coding and theme identification were conducted by five researchers and each theme was cross checked within the team. Key themes from both sections of the consultations were integrated and are represented below.

Limitations

Researchers attempted to reach saturation of themes explored through the consultation process.

We also acknowledge that there is a lack of involvement from Aboriginal and Torres Strait Islander voices in this consultation.

Strategic stakeholder thematic analysis

System level stewardship

The child mental health system in Australia was described as highly fragmented and siloed, both within the health sector and across other relevant sectors such as social welfare. Participants discussed a lack of understanding and coordination between different organisations and sectors, leading to confusion and overlap in service delivery. There were significant gaps as well as duplication of services, resulting in a mismatch between available supports and the actual needs, particularly in rural and remote communities. For example, one participant explained that children with autism diagnoses were being repeatedly referred between mental health and disability services, with unclear ownership of their care.

Specific consultation examples from participants:

- Families often saw many services in a complex system and often told their story more than once
- Families and services had difficulty navigating complicated referral systems
- There were many inappropriate referrals to more specialised services, adding to workload
- Service mismatch: Participants described having the wrong services in the area (e.g. having access to social work and allied health in a local area but needing psychology services)
- All participants mentioned long waitlists for important services suggesting the need to pull many levers to increase the capacity of the wider workforce
- Participants called for a focus on system level responses with consideration for context (i.e. localised implementation, built-in flexibility and adaptability).

As a way forward, through this systemic dysfunction, participants pointed towards the need for stronger “stewardship” (at national, state and community levels) and centralised leadership to champion more integrated, system-wide changes that considered local context. Yet, participants emphasised that addressing these issues required sustained implementation efforts, beyond a focus on upskilling or incentivising individual practitioners. It was also noted that any creation of new services and resources should consider reducing the “cannibalising effect” of moving practitioners and resources from one service to another. This means changes (e.g. creation of

new services such as Head to Health Kids) should consider the impact on adjacent services within the community being served.

Strength of innovation in the bush

Despite fragmentation across the system and workforce shortages, participants painted a picture of innovation in rural and remote settings. Services, programs and individuals were adept at utilising what they had (i.e. resources, funding, professionals) to attempt to meet the needs of children and families. This often meant collaborating across professions and working beyond funded roles and scope of practice. Yet this innovation was stifled when funding arrangements expired regardless of the usefulness to community. Funding was also labelled as inflexible when community needs changed, such as needing to respond to an increase in suicidality or school refusal.

Flexible and continuous funding

Compounding the fragmentation were significant workforce shortages and other workforce issues, particularly in rural and remote areas, including technology and infrastructure challenges. This created further barriers to equitable care for families.

Specific consultation examples from participants:

- the lack of basic services for workers (e.g. safe housing, access to healthy food, spouse employment and community integration)
- technology issues such as basic internet connectivity and incompatible data systems
- thin markets for individuals and businesses made it hard to be profitable
- lack of competitiveness of mental health workforce development incentives with physical health (e.g. one stakeholder reported low uptake into advanced GP fellowships for mental health)
- innovations should be built “by country on country” to build motivation and increase sustainability
- there was general support for telehealth if it was the right service but service models that created community connection were more highly favoured.

Funding models were cited as a key mechanism for creating change to address some of these issues. Participants suggested that funding should consider essential workforce development needs beyond direct service delivery such as training, supervision, implementation and systems improvements. This is in line with evidence suggesting that support interventions are needed to sustain rural and remote workforces (Moran et al., 2014). Participants also mentioned the need to create flexibility in current funding to allow organisations, individual practitioners and communities to adapt to meet changing needs of families. For example, one participant talked about practitioners leaving their rural town due to thin markets. Participants suggested that practitioners should be funded to work across different sectors to widen markets (e.g. help allied health workforce work across not-for-profit, hospital and primary health care).

Consultations revealed that current funding models tend to focus narrowly on direct service delivery, without adequately accounting for the critical supporting elements such as training, supervision, staff support, and systems improvement. As a result, there is often insufficient dedicated funding for these essential workforce development activities. Participants argued that more comprehensive service agreements are required - agreements that provide the resources necessary to build, retain, and empower a skilled, resilient mental health workforce capable of meeting the complex needs of children and families.

Additionally, participants voiced concerns about the lack of sustainable funding for services. They noted that much of the funding was tied to time-limited pilot programs or grants, which often led to the discontinuation of community supported and effective programs and services. Participants emphasised the need for funding models that can continue supporting effective programs over the long term, rather than constantly shifting resources towards the latest short-term initiatives. This included time and resourcing to make iterative improvements to services and how they are measured over time. This flexibility and commitment to ongoing support, they argued, is essential for creating lasting improvements in child mental health service delivery.

General practice as a place for multidisciplinary teams

Participants advocated for a re-evaluation of the Medicare Benefits Schedule (MBS) incentives for the general practice clinical workforce (including social workers, allied health and practice nurses) to better support child mental health. The current MBS structure appears to incentivise a transactional, high-turnover model of general practice that is not well suited for the time and effort required to provide thorough mental health support. Given the high volume of patients, justification to spend more time on patients with mental health concerns was difficult when their clinic was already full of sick patients. Additionally, mental health sessions were not financially comparable to a standard fifteen-minute appointment, even if practitioners had access to higher level mental health items. Participants also pointed towards longitudinal data suggesting that most GP visits for child mental health are a single session. To address this, stakeholders suggested that the MBS should better recognise and remunerate GPs for the skills, training, and time needed to identify, triage, and provide initial mental health support, rather than incentivising quick referrals to specialists.

Participants also suggested that the MBS should consider expanding item numbers to support the involvement of a wider range of professionals working within multidisciplinary general practice settings, such as social workers, allied health providers and practice nurses. They viewed this as recognition of the skills and scope of practice these practitioners already possessed. Additionally, participants noted the importance of fostering stronger collaboration between GPs and professionals outside general practice such as peer workers, teachers and allied health professionals. Incentivising collaborative approaches between general practice and other services could help overcome the limitations of individual practitioners, especially in the absence of multidisciplinary general practices in many areas.

Despite all these suggestions, participants cautioned that changes to incentives would not work alone, particularly in under resourced communities in remote settings where even GP access was difficult. Participants made reference to thoughtful integration and systemic changes that supported any changes to incentives.

Earmark prevention and early intervention

It is well established that prevention and early intervention is effective for modifying the course of a mental disorder with important benefits such as reducing future service burden and costs. Notably, despite the fact participants recognised the importance of prevention and early intervention for modifying the course of mental health difficulties, many services had shifted towards acute, crisis-oriented care. Participants reported that general practice, child and adolescent mental health services, and social services were increasingly focused on moderate-to-severe cases, with less capacity for proactive early support. There were many programs and services in Australia that had at least some focus on prevention and early intervention of mental health difficulties. Despite this, participants discussed the fact that many of these services have changed their service agreements or have gravitated over time towards more acute service delivery.

Specific consultation examples from participants:

- General practice stakeholders reported that GPs were time constrained and often focused on moderate to severe difficulties
- Child and Adolescent Mental Health Service participants reported only seeing children with severe difficulties, typically older i.e. not 0-12. One particular clinic reported seeing children 13 and above who were referred (but not accepted) when younger;
- Participants reported that many child and family welfare services are now exclusively seeing children with allocated child protection workers despite starting out as an early intervention services.

Participants were unanimous in arguing for early intervention and prevention activities that were not bound by the capacity of the service to deliver crisis intervention and acute services. This was articulated as the need for (1) more formalised understanding of ‘who does what’ along the stepped-based care continuum, and (2) a system to earmark funding service provision for early intervention and prevention.

Using and supporting local professions

Similarly, participants advocated for more localised, flexible and multidisciplinary models of care that were better integrated across sectors. Strategies suggested including greater utilisation of allied health assistants, cultural community workers, navigators and single points of access workers to reduce the burden on specialist services.

Need for implementation support for changes within the system

Importantly, participants highlighted a persistent mismatch between the development of standards, practice guidelines and other changes to the system and their actual implementation, emphasising the need to better "operationalise" best practice on the ground and help organisations contextualise changes to their local context.

Feedback from Emerging Minds Family Forum

The voice of lived and living experience has been included via the Emerging Minds Family Forum. Qualitative feedback was provided during the February 2024 meeting, where eight forum members discussed several targeted questions about their experiences of accessing mental health support for children and their families.

The eight family forum members were also asked about their lived experience in accessing support for their child's mental health concerns. Participants identified several important types of support they would like from practitioners who are less specialised in child mental health. This included making sure practitioners could impart practical skills and strategies families can apply during difficult times; and, helping them access online, phone and other 'quick-access' support services or community supports (e.g. Big Brother Big Sister). Participants emphasised the value of these professionals acknowledging the limits of their expertise while still providing resources and a safety net while families wait for more specialised care. While on waitlists for mental health support, participants expressed the desire for ongoing contact, regular check-ins, and joint family discussions (where appropriate) to avoid feeling abandoned. They also highlighted the need for practical support like bulk billing, child-friendly waiting areas and clear communication about wait times and next steps.

Participants shared positive experiences with certain professionals, such as psychologists, who used creative techniques like metaphors and visual aids to help children and families express and understand their experiences. Holistic, family-centred approaches from GPs and psychiatrists were also appreciated, including checking in on caregiver wellbeing and providing medication reviews. Participants highlighted the need for family-centred practice even if services were designed for children. Participants stressed the importance of professionals having cultural awareness, empathy, and a willingness to go above and beyond, such as following up with families after appointments.

The family forum made a clear rationale for a more integrated, community-based approach to supporting child mental health, with professionals who can provide practical, flexible, and empathetic care - both for the child and the family.

KEY POINTS:

- A fragmented, siloed system within health and across other sectors is leading to service gaps and overlaps, and difficulty for families to effectively navigate the system landscape.
- Demand for high-intensity support is skewing service delivery away from prevention and early intervention, which stakeholders recognise as essential to improving outcomes for children and families and reducing future service burden and costs.
- There is a need for sustained implementation and centralised stewardship to lead system-wide improvements that reflect local needs and are integrated across sectors.
- Funding models are not enabling the flexibility required by services to support local needs nor enabling pilots or programs valued by communities to transition to sustainable funding, leading to stifled innovation, particularly for rural and remote areas.
- Funding model design should enable multidisciplinary care in primary health settings to enhance the capacity of the child mental health system.
- Commissioning of services should recognise the ongoing need to develop and retain the workforce.
- Greater clarity required around activities delivered across the stepped care model.
- Feedback from family forum reflected need for increased family engagement and holistic, family-focused approaches.