

Scoping child mental health workforce
capability – State and Territory Snapshots

Australian Capital Territory

Regional data

**Emerging
Minds.**

National
Workforce
Centre for Child
Mental Health



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Scoping child mental health workforce capability

Why focus on workforce for children's mental health and wellbeing?

There are around four million children aged 0 to 12 years in Australia, and we estimate at least 500,000 (13%) are currently experiencing a mental health condition, while a further one million are currently at risk of developing mental health conditions. Demand for mental health support is growing in the context of access barriers and workforce shortages. The need to intervene early to support children's mental health is well recognised in policy. Equipping a broader workforce with the necessary skills to support children and families across the spectrum of mental health experiences, and the spectrum of practices, can play a significant role in prevention and early intervention.

How to create a picture of the current child mental health workforce need and supply?

The *Scoping child mental health workforce capability* 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 collated data from a range of readily available sources to create a picture of the current child mental health workforce situation. Firstly, we sought to understand the number and distribution of children in Australian regions and estimate the prevalence of established and emerging mental health concerns. Secondly, we 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. Thirdly, we analysed existing workforce competency by 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.

Where to next with the findings of the project?

Stakeholder consultations with targeted industry experts complemented the collated data to inform recommendations for future workforce initiatives that considered the contextual issues across rural and regional Australia. Governments, commissioning bodies and organisations can draw upon the findings of the project and use regional data in these state reports to inform their own workforce capacity building with projects that respond to local context. For implementation support with enhancing child mental health systems which respond to the local context in your region, contact info@emergingminds.com.au

Key strands of the project included a focus on 3 key areas



Population need

Distribution of children aged 0-12 across Australia

Prevalence of mental health difficulties among children across Australia

Existing service use by children for mental health support across Australia



Workforce availability

Workforces available to provide infant and child mental health and wellbeing support

Distribution of these workforces across Australia

Current availability of these workforces to support child mental health



Workforce competency

Current competency and areas for workforce development in child mental health support

Core workforce competencies needed to enhance child and family mental health outcomes

Workforce development strategies to enhance the scope and skill level of the current workforce

Recommendations

The project resulted in a series of recommendations that describe the need for 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 (1), opportunities to increase the scope and flexibility of service delivery models to enhance existing services locally, including the expansion of primary health (2) and building locally grown child mental health generalist role(s), and a broader concept of the potential mental health workforce (3).

We recommend that these report recommendations need to be implemented with the local service system in mind and can be supported by System Designer roles employed within regions that can help coordinate initiatives and target local areas of need (4).



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.



Statistics for Australia

Population need

Workforce availability

Workforce competency*



4,004,812 children aged 0-12 years



157,906 High opportunity specialists.
e.g. Psychiatrist, GP, Psychologist.



Moderate generalist-level child mental health competency.
Avg score 5.11.



216,450 Aboriginal or Torres Strait Islander children (5%)



980,672 High Opportunity Generalist/Med Opportunity Specialist.
e.g. Registered Nurse (Mental Health), AOD Counsellor, School Teacher.



Moderate specialist-level child mental health competency.
Avg score 5.09.



520,626 Children 0-12 years estimated to have mental health conditions (13%)



1,085,650 Med Opportunity Generalist.
e.g. Health Promotion Officer, Emergency Medicine Specialist, Police Officer.



Low competency working with Aboriginal and Torres Strait Islander families.
Avg score 4.78.



11.4% Children's mental health at risk due to severe developmental vulnerability



6.78 hours average hours per child per year of specialist care available.



Low child mental health competency in disasters.
Avg score 4.57.

* Survey scores out of 7

Population need, see Footnote 3.

Workforce capacity, see Footnote 4.

Workforce competency, see Footnote 5.



Statistics for Australian Capital Territory

Population need



72,523 children aged 0-12 years



2,355 Aboriginal or Torres Strait Islander children (3.2%)



11,127 Children 0-12 years estimated to have mental health conditions (15%)



13.3% Children's mental health at risk due to severe developmental vulnerability

Workforce capacity



2,960 High opportunity specialists. **Slightly higher availability** than the national avg.
e.g. Psychiatrist, GP, Psychologist.



18,712 High Opportunity Generalist/Med Opportunity Specialist. **Higher availability** than the national avg.
e.g. Registered Nurse (Mental Health), AOD Counsellor, School Teacher.



17,361 Med Opportunity Generalist
Lower availability than the national avg.
e.g. Health Promotion Officer, Emergency Medicine Specialist, Police Officer.



8.32 hours average hours per child per year of specialist care available. **Above** the national avg (6.78 hours).

Workforce competency



Low generalist-level child mental health competency. Avg score 4.67.
Lower than the national avg (5.11).



Low specialist-level child mental health competency. Avg score 4.94.
Slightly lower than the national avg (5.09).



Low competency working with Aboriginal and Torres Strait Islander families. Avg score 4.54.
Slightly lower than the national avg (4.78).

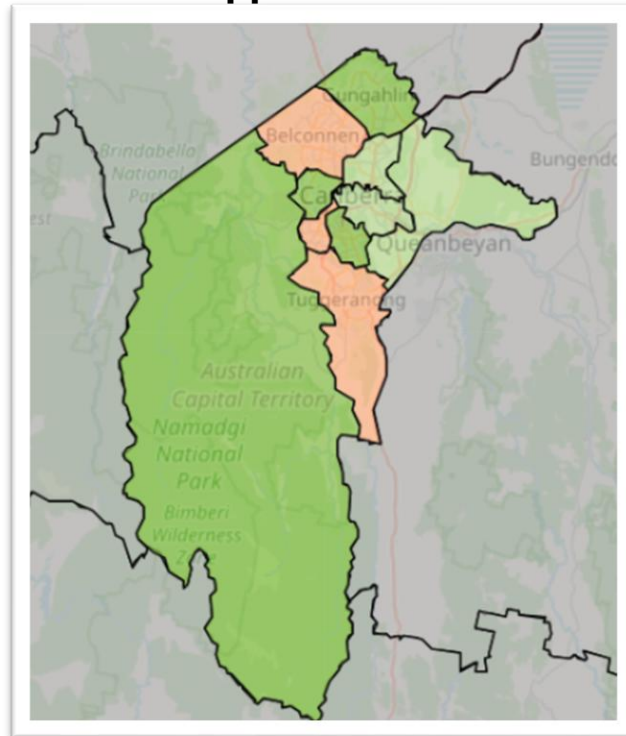


Low child mental health competency in disasters. Avg score 4.33.
Slightly lower than the national avg (4.57).

Australian Capital Territory

All SA3 regions have need for child mental health support, and some regions have greater need compared to the national average. The access to specialist workforce in these regions varies.

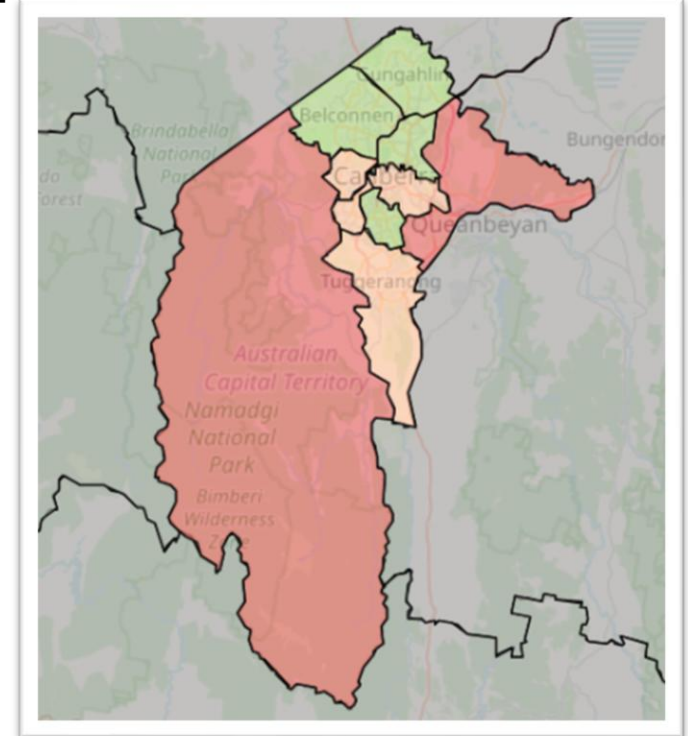
Need for child mental health workforce support: Total need index



Significantly Favourable Favourable Unfavourable Significantly Unfavourable

Compared to the national average

Workforce availability: High opportunity specialists per 1000 children



Low Priority Moderate Priority High Priority Extreme Priority

Compared to the national average

In summary

- For ACT's children aged 0 to 12 years, there is a larger proportion of children estimated to be at risk of or experiencing mental health conditions compared to the national average.
 - 15% are currently experiencing a mental health condition
 - 13.3% of 5-year-olds were developmentally vulnerable in 2021, putting them at risk to develop a mental health condition in later childhood
- While the level of need for child mental health supports seems to be similar to the national average, the availability of workforce to support infant and child mental health in ACT is low in many areas.
- ACT workforce surveyed indicated low levels of knowledge, confidence and skills required to promote and support children's mental health in their work.
- See the following sections for more detail and potential areas for development.

Section 1

Child population

Data in this section

Geographical Classification



Statistical Area Level 3 (SA3)

Statistical Area Level 3 (SA3) is a method of geographically mapping data that fulfills the need to protect the confidentiality of children and families while also providing detailed data for a region. SA3 are Australian Statistical Geography Standard (ASGS) areas, comprising of 359 regions that map the whole of Australia. In large urban areas, SA3s are designed to closely align to local government areas (LGAs). SA3s in outer regional and remote areas represent regions that have similar socio-economic characteristics.

Child Population



Child population (grouped)

A child's needs are influenced by many factors, including their age. Key to understanding the needs of this population is knowing how many infants, children and adolescents live in Australia and in what regions they live.

Population data have been age-grouped as follows:

- 0 to 2 years
- 3 to 5 years
- 6 to 8 years
- 9 to 12 years



Child population (total)

Total population data for Australian children (0 to 12 years) gives essential context for understanding the needs of a population.

All population data have been obtained from the Australian Bureau of Statistics (ABS) 2021 Census of Population and Housing.

Service Considerations



Aboriginal and Torres Strait Islander Children

Supporting the health and wellbeing of Aboriginal and Torres Strait Islander children requires acknowledging their unique strengths and being aware of the considerations that need to be present in the support services available. Services must take a holistic approach that encompasses physical, mental, cultural and spiritual health when supporting Aboriginal and Torres Strait Islander children and families.



Language other than English spoken at home

Language spoken at home provides an understanding of ethnicity and cultural diversity across Australia. Cultural considerations are key to providing appropriate and effective support to children and families.

Australian Capital Territory – PHN801

	Child population					Service considerations	
SA3 Region	0-2 years	3-5 years	6-8 years	9-12 years	Total children 0-12 years	% 0-12s Aboriginal and/or Torres Strait Islander	% 0-12s language other than English spoken at home
Belconnen	3731	3889	4049	5166	16831	3.5%	23.8%
Canberra East	32	32	40	39	142	2.8%	41.5%
Gungahlin	3958	4375	4396	5318	18045	2.3%	37.4%
Molonglo	601	611	631	600	2432	1.4%	42.4%
North Canberra	1444	1458	1486	1966	6355	2.2%	23.9%
South Canberra	728	770	895	1259	3653	2.2%	29.0%
Tuggeranong	3203	3389	3645	4710	14951	5.2%	17.5%
Uriarra - Namadgi	28	32	36	34	134	7.5%	9.7%
Weston Creek	829	938	1028	1328	4123	2.7%	18.1%
Woden Valley	1192	1234	1441	1975	5845	2.0%	28.5%
National (Australia)	865791	912561	951013	1275442	4004812	5%	25.7%

In summary

- Across eleven SA3 regions that overlap with ACT PHN catchment, there is some variation in the total number of children aged 0 to 12 years. The largest populations of children are in Gungahlin, Belconnen and Tuggeranong.
- There is little variation in the proportion of child age groups across different regions in ACT.
- There are fewer Aboriginal Torres Strait Islander children in ACT proportionally to national levels and compared to other states and territories. This may make it difficult for Aboriginal and Torres Strait Islander families to find culturally responsive services.
- Many regions in ACT have a higher than average proportion of children who speak a language other than English at home.
- These results have important implications for the design of appropriate services to meet the needs in each region.

Section 2

Child mental health need

Data in this section

Region Characteristics



Remoteness Areas

Remoteness Areas are a geographical classification consisting of five levels that provide a measure of relative geographic access to services.

- Major cities of Australia
- Inner regional Australia
- Outer regional Australia
- Remote Australia
- Very remote Australia



SEIFA IRSD score

The Socio-Economic Indexes for Areas (SEIFA) Index of Relative Socio-economic Disadvantage (IRSD) considers the social and economic conditions of a population within a specified geographical area. The national average SEIFA IRSD score is 1000, with scores below this indicating relative disadvantage.

Current child mental health prevalence



Child and infant mental health

Children and infants may experience a range of mental health conditions that require both specialist and generalist support. Child and infant mental health estimates are not readily available by SA3s for children aged 0 to 12 years. As such, we modelled estimates based on scaled up ABS Census 2021 prevalence.



Mental health service and prescription use

Use of prescriptions for mental health medications and access to community mental health services among children are indicators of the current prevalence of child mental health in Australia.

Data relating to prescription and service use have been sourced from the Australian Institute of Health and Welfare (AIHW).

Child mental health risk



AEDC vulnerability domains

Australian Early Development Census (AEDC) shows the proportion of children who in their first year of school are developmentally vulnerable on two or more of the five domains measured. The domains are physical health and wellbeing, social competence, emotional maturity, language and cognitive skills (school-based), and communication skills and general knowledge.



Risk factors

Identifying and addressing risk factors that may contribute to mental health difficulties is key to supporting children. The average number of risk factors per child in an SA3 region has been calculated as an indicator of child mental health risk.

Total need Index



Total Need Index

The Total Need Index provides a measure of need for infant and child mental health support in an SA3 area. The Index uses data from seven indicators to generate a score ranging from 7 to 29. Higher scores indicate that children aged 0 to 12 years in that region have greater need for support.

Australian Capital Territory – PHN801

SA3 Region	Region characteristics		Current child mental health prevalence			Child mental health risk		TOTAL NEED INDEX
	Remoteness Area	SEIFA IRSD Score	EM Scaled Census estimates of Mental Health Conditions in 0-12s	Service Use - % 0-17s children with a MH prescription	Service Use - % 0-11s children with a Community MH service contact	% AEDC Vulnerability on 2+ domains	Average number of risk factors per child in region	
Belconnen	Major Cities of Australia	1058	18.72%	7.46%	0.99%	16.65%	1.12	21
Canberra East	Major Cities of Australia	891	-	13.54%	10.24%	-	0.78	16
Gungahlin	Major Cities of Australia	1078	13.07%	5.56%	0.35%	13.12%	0.80	13
Molonglo	Major Cities of Australia	1100	6.44%	2.71%	0.65%	13.64%	0.62	11
North Canberra	Major Cities of Australia	1082	15.58%	7.72%	0.49%	8.45%	1.01	15
South Canberra	Major Cities of Australia	1103	8.81%	7.31%	0.48%	11.33%	0.97	14
Tuggeranong	Major Cities of Australia	1054	18.26%	7.14%	1.28%	14.91%	1.24	21
Uriarra - Namadgi	Inner Regional Australia	1096	24.62%	5.62%	0.00%	-	0.83	12
Weston Creek	Major Cities of Australia	1076	17.21%	7.03%	0.95%	11.26%	1.08	18
Woden Valley	Major Cities of Australia	1080	11.01%	6.78%	0.30%	8.86%	0.93	12
National Average (Australia)			12.52%	6.32%	0.53%	10.83%	1.02	

Remote or Very Remote	Outer Regional Australia	Inner Regional Australia	Major Cities of Australia
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Sig. less favourable than the national avg.	Less favourable than the national avg.	Equal to or more favourable than the national avg.	Sig. more favourable than the national avg.
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In summary

- ACT regions are mostly metropolitan and higher socioeconomic status areas.
- The level of child mental health need is mixed among regions with large population areas such as Tuggeranong and Belconnen, as well as Weston Creek showing high rates of estimated child mental health conditions. The Total Need Index shows these as specific regions of highest child need.
- Uriarra – Namadgi has a small population of children aged 0-12 but a concerning high proportion estimated to be already experiencing mental health concerns.
- Higher than average rates of developmental vulnerability also highlight need for current and future support for children, especially in areas such as Tuggeranong, Belconnen, Gungahlin and Molonglo.
- Region characteristics, child mental health prevalence and child mental health risk all interact to influence the mental health and wellbeing of the infants and children in a region. A dual focus needed, one that centers mental health treatment of children under 12 and addressing development signs and family risk factors influencing these children's mental health outcomes in the future. An investment in early intervention may assist in preventing and reducing later increases in child mental health support.

Section 3

Workforce availability

Data in this section

Workforce Classifications



Group 1: High opportunity specialists

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, e.g. psychiatrist, GP, psychologist.



Group 2: High opportunity generalist/Medium opportunity specialist

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, e.g. registered nurse (mental health), AOD counsellor, school teacher.



Group 3: Medium opportunity generalist

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, e.g. health promotion officer, emergency medicine specialist, police officer.

Measures



Workforce population (n)

Population data for the specialist and generalist child and infant mental health workforce provides essential context for understanding the support available in Australia. All population data have been obtained from the 2021 Census of Population and Housing.



Workforce population (standardised per 1,000 children)

The workforce population was standardised per 1,000 children to assist in the comparison and analysis of workforce availability across SA3 regions. Standardising shows how many children (0 to 12 years) are located in a SA3 region per specialist or generalist professional.



Weekly workforce hours available (standardised per 1,000 children)

Weekly workforce hours are a key indicator of infant and child mental health workforce availability. Standardising indicates how many hours specialist and generalist professionals have available each week to distribute across 1,000 children in a SA3 region.

Total Workforce Availability Index



Total Workforce Availability Index

The Total Workforce Availability Index provides a measure of availability of the workforce who can provide mental health and wellbeing support to infants and children in an SA3 region.

The index uses data from six indicators to generate a score ranging from 6 to 24. Lower scores indicate that the workforce in that region has lower availability to provide support.

Workforce classifications, see Footnote 13.

Measures, see Footnote 14.

Total workforce availability index, see Footnote 15.

Australian Capital Territory - PHN601

	Group 1: High opportunity specialists			Group 2: High Opportunity Generalist/Med Opportunity Specialist			Group 3: Med Opportunity Generalist			
SA3 Region	n	per 1000 children	hours per week per 1000 children	n	per 1000 children	hours per week per 1000 children	n	per 1000 children	hours per week per 1000 children	TOTAL WORKFORCE AVAILABILITY INDEX
Belconnen	530	31	149	4864	289	1235	4028	239	986	18
Canberra East	0	0	0	10	70	103	22	155	28	6
Gungahlin	453	25	143	3836	213	1236	3251	180	954	13
Molonglo	143	59	261	476	196	926	685	282	1310	18
North Canberra	435	68	171	2281	359	825	1609	253	573	16
South Canberra	371	102	325	1016	278	714	1194	327	880	18
Tuggeranong	366	24	102	3740	250	1164	3559	238	1052	14
Uriarra - Namadgi	0	0	0	24	179	320	11	82	0	6
Weston Creek	163	40	198	951	231	835	891	216	775	12
Woden Valley	499	85	376	1514	259	998	2111	361	1364	21
National (Australia)	157,906 (n)	32 (mdn)	130 (mdn)	980,672 (n)	259 (mdn)	1004 (mdn)	1,085,650 (n)	275 (mdn)	984 (mdn)	

In summary

- The existing workforce available to support infant and child mental health in ACT is small
- Regions clustered around Canberra show high availability of workforce positioned to provide **child mental health specialist services** (Group 1) – per 1,000 children - compared to the national average. This is similar to other capital and highly populated cities across Australia. However, some other regions in ACT regions have lower access to specialists.
- Stakeholder consultations indicate the national average level of accessibility of specialists is not optimal (even in capital cities), and so we also look to the availability of the **generalist workforce** to provide support. In ACT, the availability of generalists per 1,000 children (Group 2 and 3) is highly variable and lacking in many regions of the territory.
- Because of the geography in ACT, there is mixed availability of specialists and generalists across regions. As such, neighboring workforces could be drawn upon to fill service gaps and others with low generalist supply may present opportunities for targeted recruitment.
- **There is a need in regional planning to connect access to specialists in Canberra with other regions of ACT, as well as build the capacity and reach of generalist workforce to apply early intervention approaches in child mental health.**

Section 4

Workforce competency

National Workforce Survey overview

In 2023, Emerging Minds conducted its biennial National Workforce Survey for Child, Parent and Family Mental Health, where the Australian health, social and community services workforce is invited to rate their capabilities across a range of workforce competencies essential for supporting children's mental health. Generalist competencies are those that any worker in these sectors can enhance to improve outcomes for children. Specialist-level competencies include more advanced skills for those with opportunity to respond directly to children's mental health concerns.

Key findings overall



- Two thirds of the survey said that supporting child mental health was an expectation of their job, but even those where it wasn't part of their job found themselves regularly supporting child mental health at work (57% said sometimes, often or always).



- Rural and remote areas need extra support, but show strength in adapting practice to their local context and working with Aboriginal and Torres Strait Islander families.



- Child mental health competency is moderate in some areas and low in others, and there is need for improvement across the workforce **especially in child mental health practice**.

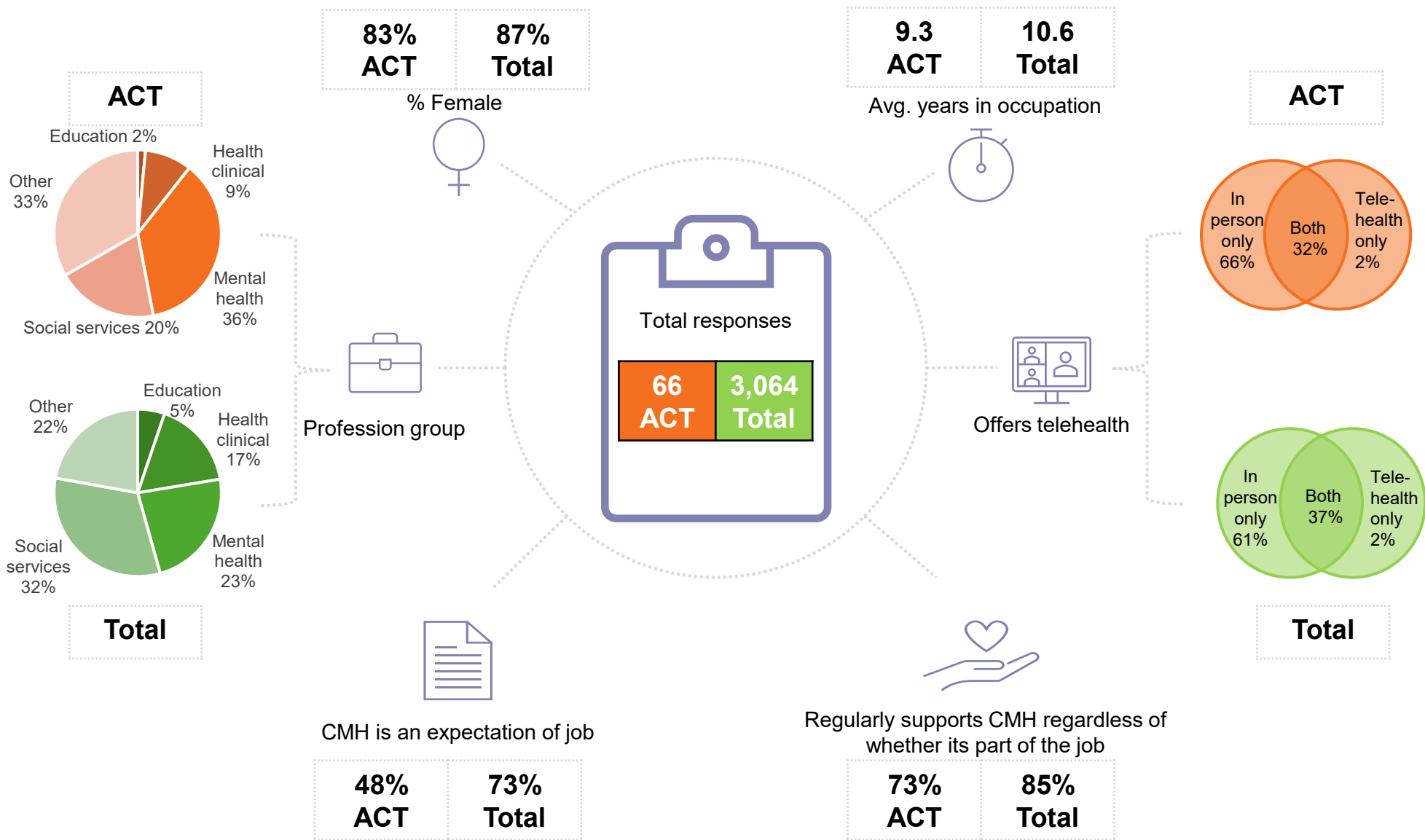


- Engagement in workforce development makes a significant difference in the level of competency in child mental health. Those who had completed training or used resources reported higher competence in all areas we measured.



- Most of the workforce has very low confidence in:
 - Working with Aboriginal and Torres Strait Islander families
 - Infant mental health
 - Understanding child mental health in the context of disaster.

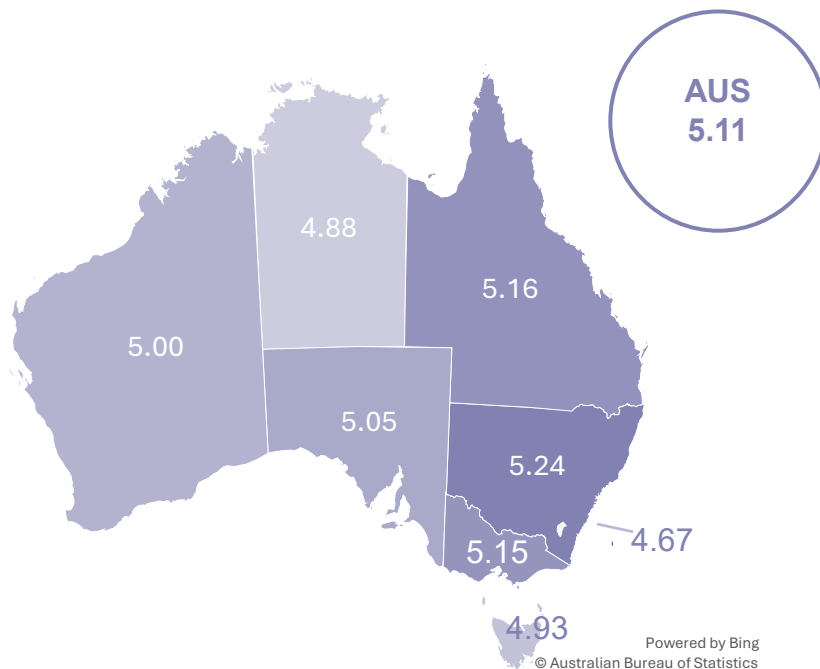
2023 National workforce survey sample



National Workforce Survey overview

In Australian Capital Territory

Generalist child mental health competency scores in ACT are lower than the national average



The clinical health professionals rated their generalist and specialist child mental health competence very low, and lower than other profession groups. However, this must be interpreted with caution as the health professional group was very small among the ACT sample



Social services professionals in ACT rated their capabilities low on average, although showed some moderate confidence in Facilitating support, Trauma and some specialist child mental health skills. The social services group indicated struggles with Child focused practice, Infant mental health and specialist responses to disasters.



The mental health profession group showed the higher confidence than other profession groups, with moderate confidence across many generalist and specialist child mental health competencies. Child focused practice in general, as well as working with Aboriginal and Torres Strait Islander families are areas where this workforce needs additional support.

Competencies in child mental health

Generalist competencies for all practitioners

Survey questions offered to all respondents

Child-focused practice	Working in ways where child mental health is front of mind and is reflected in practices.
Assessment	Knowledge and confidence to identify children at risk of developing or who are displaying signs of emerging mental health concerns.
Workplace support	The work environment positively influences the chances of providing child mental health-promoting and family-focused practice.
Infant mental health	Understanding theory, infant mental health, the parent-child relationship, and providing support in the perinatal period.
Facilitating support	Knowing when and how to connect children and families with mental health support outside the immediate scope of practice, including external providers.
Working with Aboriginal and Torres Strait Islander families	Knowledge, confidence, skills and structures to adapt practice to better support Aboriginal and Torres Strait Islander families in ways that are culturally safe, centres culture and promotes healing.
Family resilience	Practices that reflect key components of the Family Resilience Model, including engaging family members to identify and draw upon strengths and collaboration.
Child mental health in the context of disasters	Understanding how disasters can impact on children's mental health and confidence to provide early intervention support to children and families affected by disaster.
Engaging parents	Skills focused on talking to parents about children's mental health, helping equip parents and examining the relationships between parents and children.
Trauma and adversity	Understanding theory of trauma responses and the impact of adversity on child development and mental health, working in trauma informed ways with children and families.

Specialist-level competencies for child mental health workforce

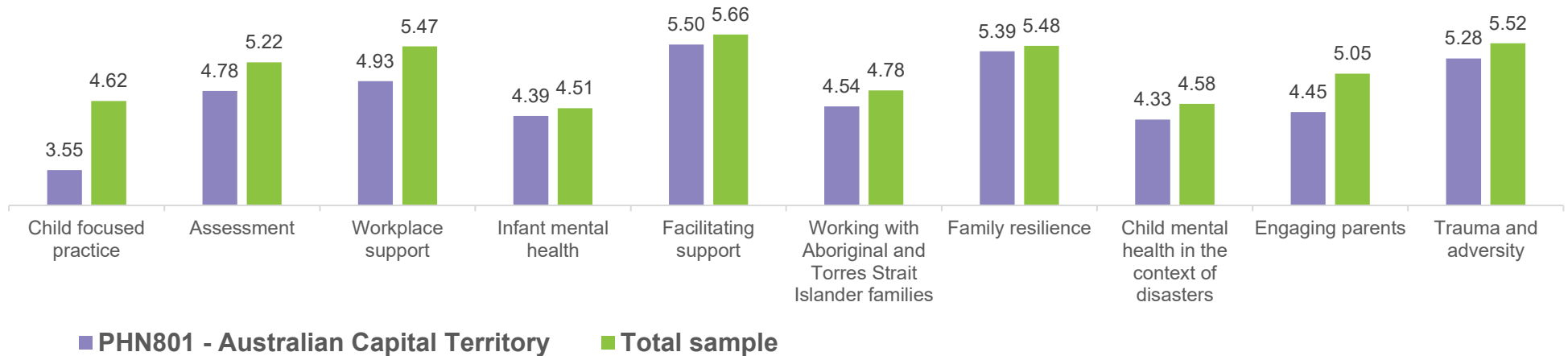
Survey questions offered to respondents who said child mental health was part of their job or that they find themselves regularly supporting child mental health.

Child mental health practice capability	High level knowledge and confidence to adapt mental health practice for children across a range of ages, stages and developmental needs.
Advanced child mental health practice	Skills to use professional discretion to employ components of evidence-based interventions and strategies for effective responses to children's mental health.
Specialist practice in disaster	Advanced practices that directly respond to mental health impacts of disasters in children.
Contextually driven practice	Skills and confidence to adapt practice to the environment and context in which the child's mental health develops, including the rural families and families with various cultural backgrounds.

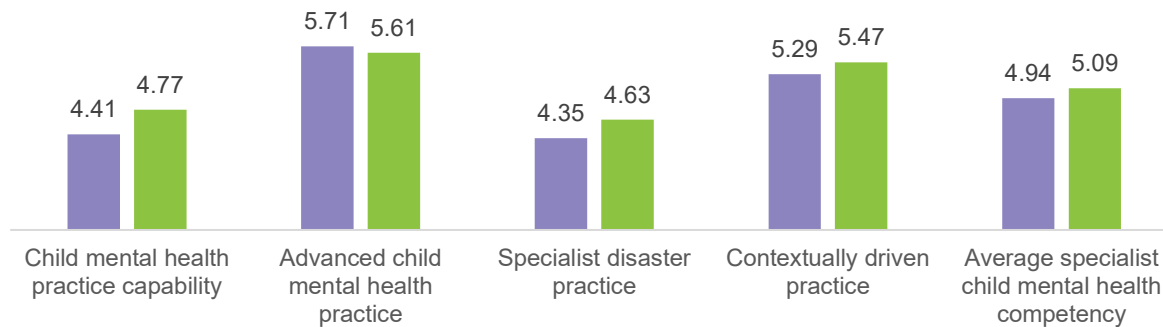
Australian Capital Territory – PHN801

66 total responses

Generalist competencies for all practitioners



Specialist-level child mental health competency average scores



Respondents rated their agreement with a range of competency statements using a 7-point scale from 'strongly disagree' – 'strongly agree'.

Scores are interpreted as follows:

1-4: lack of agreement indicating low competence

5-6: Moderate competence

6-7: High level of competence

Generalist child mental health competencies

For all practitioners

Average competency scores out of 7, by Australian Capital Territory PHN

		Child focused practice	Assessment	Workplace support	Infant mental health	Facilitating support	Working with Aboriginal and Torres Strait Islander families	Family resilience	Child mental health in the context of disasters	Engaging parents	Trauma and adversity
Australian Capital Territory – PHN801	N	49	54	42	41	56	39	28	39	55	44
	Mean	3.55	4.78	4.93	4.39	5.50	4.54	5.39	4.33	4.45	5.28
	Std. Dev.	2.00	1.45	1.69	1.79	1.11	1.31	1.20	1.51	1.55	1.63

Low competence	Moderate competence	High competence
1–4	5–6	6–7

Specialist child mental health competencies

For child mental health workforce

Average competency scores out of 7, by Australian Capital Territory PHN

		Child mental health practice capability	Advanced child mental health practice	Specialist disaster practice	Contextually driven practice
Australian Capital Territory – PHN801	N	17	17	17	17
	Mean	4.41	5.71	4.35	5.29
	Std. Dev.	1.66	1.21	1.84	0.77

Low competence	Moderate competence	High competence
1–4	5–6	6–7

Competencies by profession groups

Average competency scores out of 7, by Australian Capital Territory PHN

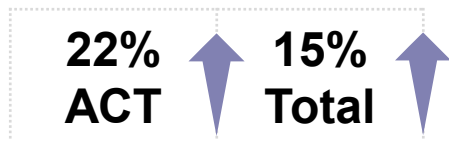
ACT respondents by profession group		Generalist competencies For all practitioners										Specialist competencies For child mental health workforce			
		Child focused practice	Assessment	Workplace support	Infant mental health	Facilitating support	Working with Aboriginal and Torres Strait Islander families	Family resilience	Child mental health in the context of disasters	Engaging parents	Trauma and adversity	Child mental health practice capability	Advanced child mental health practice	Specialist disaster practice	Contextually driven practice
Education (n=1) 1 EC educators	N	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	Mean	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	Std. Dev.	-	-	-	-	-	-	-	-	-	-	-	-	-	-
		-	-	-	-	-	-	-	-	-	-	-	-	-	-
Health – clinical (n=6) 3 allied health professionals, 2 midwives, 1 nurse	N	5	5	4	4	5	4	3	4	5	4	-	-	-	-
	Mean	3.40	3.60	2.25	4.00	4.40	3.00	4.33	3.25	3.25	4.25	-	-	-	-
	Std. Dev.	1.52	1.14	1.50	2.58	1.14	0.00	1.53	1.25831	1.57	1.85	-	-	-	-
		-	-	-	-	-	-	-	-	-	-	-	-	-	-
Mental health (n=24) 13 psychologists, 7 MH nurses, 2 MH social workers, 2 counsellors	N	20	22	15	14	22	16	13	15	22	16	10	10	10	10
	Mean	4.80	5.36	5.87	5.00	5.77	4.88	5.69	4.80	5.22	5.94	5.20	6.20	4.70	5.40
	Std. Dev.	2.09	1.50	1.13	1.96	0.97	1.15	1.11	1.37321	1.27	1.43	1.40	0.79	1.77	0.84
		-	-	-	-	-	-	-	-	-	-	-	-	-	-
Social services (n=13) 7 social workers, 3 child protection, 2 community workers, 1 FDV worker	N	11	11	10	10	11	10	8	10	11	10	4	4	4	4
	Mean	3.18	4.82	5.10	4.60	5.73	5.10	5.38	4.10	4.42	5.50	3.25	4.25	3.00	5.25
	Std. Dev.	1.47	0.87	1.10	1.65	0.90	1.20	1.19	1.66333	1.35	0.96	1.50	1.50	1.83	0.96
		-	-	-	-	-	-	-	-	-	-	-	-	-	-
Other (n=22) 8 program mgr/admin, 4 police/fire/paramedic, 1 exec, 1 policy/advocacy, 1 legal, 7 others	N	12	15	12	12	17	9	4	10	16	13	3	3	3	3
	Mean	2.08	4.27	4.42	3.67	5.41	4.00	5.25	4.3	3.88	4.63	3.33	6.00	5.00	5.00
	Std. Dev.	1.08	1.53	1.78	1.37	1.23	1.41	1.26	1.56702	1.64	1.99	1.53	0.00	1.73	0.00
		-	-	-	-	-	-	-	-	-	-	-	-	-	-

Impact of workforce development

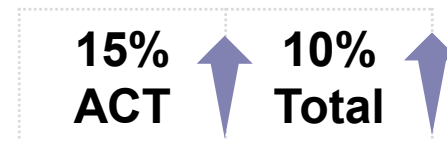
Survey findings indicate a relationship between engagement with Emerging Minds and improved child mental health workforce competency. Among the survey sample, 50% had actively engaged with Emerging Minds resources (called the *Exposed* group), a further 9% were just aware of Emerging Minds or had only used passive resources of the website and e-news (*Aware* group). The remaining 41% had not heard of Emerging Minds prior to taking the survey (*Control* group). Respondents in the *Aware* or *Exposed* group were statistically significantly more competent than those in the *Control* group across all the competency subscales we measured. Those in the *Exposed* group also showed higher levels of competency scores overall.



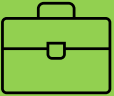
% Change in generalist
competency with
engagement with
Emerging Minds



% Change in specialist
competency with
engagement with
Emerging Minds



Impact of workforce development

	 % Had actively used Emerging Minds before	 % Found Emerging Minds resources highly relevant to their work	 % Learned something new from the Emerging Minds resources	 % Contact with Emerging Minds improved confidence discussing child mental health with families	 % Have been able to apply learning from Emerging Minds in their work
Australian Capital Territory – PHN801	46.3% (n=19)	77.3%	86.4%	68.2%	61.9%
Australian Capital Territory	46.3% (n=19)	77.3%	86.4%	68.2%	61.9%
Total sample	50%	88.4%	92.2%	76.4%	79.8%

Summary for Australian Capital Territory

- A total of 66 ACT workers completed the survey. Although the specialist questions are only answered by those who regularly do, or are supposed to, support child mental health at work, the group answering those items is smaller.
- Only 48% of the ACT sample indicated supporting child mental health is part of their job, much lower than other states and territories' samples within the survey. Yet, three quarters of the ACT sample said they regularly end up supporting child mental health in their work, regardless of whether it is not part of their job. It is therefore vitally important to support this workforce in the work they are already doing.
- The ACT group also included a larger proportion of mental health professionals than other states and territories and most of these were psychologists and mental health nurses. The low number of responses to specialist questions by mental health professionals suggests many of these do not see child mental health as part of their job.
- Respondents from ACT rated their own capabilities as lower than the national average across all nearly all of the infant and child mental health domains. They showed moderate strengths in facilitating support, family resilience and the small child mental health specialist group showed confidence in utilising components of evidence-based interventions or assessing risk (Advanced child mental health practice).
- There is an opportunity to build capability in the ACT workforce, especially in areas such as child focused practice, disasters and engaging parents. This may be especially relevant in supporting adult-focused practitioners to understand how they can play a role to influence the wellbeing of children.

Summary for Australian Capital Territory

- ACT users found Emerging Minds learning and practice resources effective and useful, with respondents who had actively engaged with resources demonstrating drastically improved competence and confidence. The higher-than-average increase among engaged respondents could be related to large proportion of non-child focused practitioners in the ACT or may indicate the level of need for workforce development in the regions.
- ACT respondents were less likely to have applied their learnings to practice and also reported lower levels of Workplace support. This suggests a need for targeted engagement with the region to support implementation of child focused practices and systems that support them.

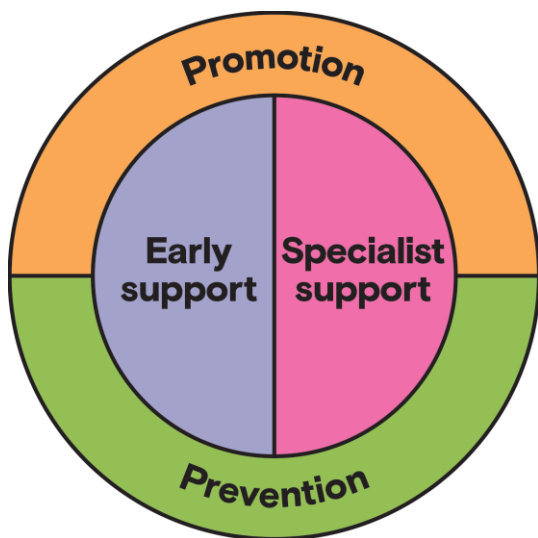
Section 5

Conclusion

Conclusion

Creating a comprehensive child mental health system

Workforce development and training is part of the broader solution for creating a system of care which promotes and responds to children's mental health. There are opportunities to enhance the system by embedding promotion and prevention across all levels influencing changes in practice specific to workforce groups. Sector consultations highlighted the need for supportive funding models and dedicated focus on early intervention and prevention. As with other findings in this report there is a call among stakeholders for system level responses, beyond a focus on practitioner change, that allow for adaptation in local contexts.



For service providers delivering universal and targeted guidance and support on health, child development and parenting.

- Increase access for families to information about children's mental health development
- Normalise conversations about children's mental health and wellbeing
- Create shared language about child mental health
- Increase partnerships with children and families using [Emerging Minds Families](#)



For service providers providing support to adults, families and children who are experiencing health, relationship, social and financial stressors.

- Address known child mental health risk factors
- Consider and provide support around the impact of parent and family adversity on child mental health and wellbeing
- Build family agency using [PERCS](#) and [Getting through tough times](#) resources.



Professionals delivering early intervention support for emerging mental health difficulties.

- Deliver multidisciplinary care to address emerging mental health difficulties
- Improve identification and low intensity support using [Emerging Minds Learning](#)
- Provide anticipatory guidance
- Provide support before/while referring



Professionals delivering specialised mental health support for infants and children experiencing severe and/or persistent mental health difficulties.

- Enhance infant and child mental health practice using [Practice strategies courses](#) and [Practice strategies suite for infants and toddlers](#).
- Support family agency
- Improve competency in disaster practice using [Supporting infants and children in disasters: A practice guide](#).
- Increase access to specialist secondary consultation
- Embed health promotion and prevention activities in practice.

Australian Capital Territory – PHN801

Current situation for child mental health workforce support

There were **72,551 children** aged 0-12 years resident in ACT in the 2021 Census. Our analysis estimates availability of *High opportunity specialists* (workforce classification Group 1) available per 1000 children in inner city regions such as North Canberra, South Canberra and Molonglo, (and other regions such as Weston Creek and Woden Valley) is in line with or more favorable than the national average which is consistent with other regions around capital and highly populated cities in Australia. However, the actual number of practitioners in the PHN region is small and there are areas with high levels of need such as Belconnen, Tuggeranong and Uriarra – Namadgi where low availability of generalist workforces (workforce classification group 1 and group 2) presents **significant barriers to children accessing early and specialist support**.

Key opportunities for development

Half of SA3s located in ACT PHN had higher child need than what the estimated workforce availability across our three workforce classification groups could meet. **Tuggeranong, Weston Creek and Belconnen** showed the greatest disparity between child need and workforce availability. **Uriarra – Namadgi and Canberra East** are very small populations where local workforce is lacking within the region. Woden Valley, Molonglo and South Canberra show workforce availability that is higher than the local level of child mental health need. National workforce survey respondents from ACT ($n=66$) rated their child mental health competence lower than the national average. Respondents showed **strengths in Facilitating support, Family resilience and specialist practices including Advanced child mental health practice**. The ACT workforce could benefit from workforce development activities targeted at areas of **low competence such as Child focused practice, Infant mental health, Engaging parents and responding to Child mental health in disasters**, but also **strengthening generalist child mental health competency more broadly**. Emerging Minds' learning and practice resources were highly effective, relevant and applicable to the work of ACT users. ACT practitioners could be supported to apply learnings in child mental health and have their role in supporting children and families recognised in job expectations.

Comments made in this report are based on available data and represent estimates of child mental health need as compared to estimates of workforce availability that have been adjusted to the child population in that region. These data come with limitations and cannot describe the nuanced context of every region. It is important to also understand the competence of the local workforce to support children and families, and their capacity to do so within the systems they work in. This indicative data can form part of broader workforce and systems development strategies which recognise local context and needs.

Get involved

Emerging Minds is working with sectors and organisations around Australia to improve the capacity of systems to support children and families. We can advise on workforce development strategies, support regional planning and offer learning and practice resources to help build capacity in your region. We would love to talk with you about improving child mental health services and support in your region. **Email us info@emergingminds.com.au and sign up to [e-news](#) for the latest updates. Download the [Scoping child mental health workforce capability report](#).**

Methodology

Data collection and analysis

Data sources that could answer the research questions were identified and accessed where possible. Data available at a regional level was required to be able to inform policy responses that enhance workforce competency in supporting children's mental health, with a particular focus on addressing the needs of rural and remote communities. SA3 regions were selected as the base boundary for reporting to support consideration of local context, while maintaining confidentiality of children and families.

Population level data sources including Australian Census of Population and Housing and Australian Early Development Census were key sources for the population need and workforce availability streams due to their coverage of the population and recency of completion (2021). Emerging Minds' National Workforce Survey was the primary data source for workforce competency (see box). Due to a lack of benchmarks, the national average was used to allow for comparison among regions.

Prevalence of child mental health conditions in regions was modelled by Emerging Minds by scaling up underestimation prevalence data from the 2021 ABS Census to align with a national child mental health conditions prevalence of 13% found in research literature.

Total Need Index and **Total Workforce Availability Index** were calculated for each region by assigning a score of 1 to 4 for each included indicator, based on that indicator's quartile relative to all other regions. The scores for the included indicators were then totalled for that region to create an overall Index score.

Evidence review

Desktop research of grey and peer reviewed publications (including citations and secondary sources) was conducted using broad search strategy, identified risk and protective factors as well as international workforce models for relevance to Australian context and the project research questions.

Review of evidence-based frameworks informed development of a competency framework for child mental health competencies. This framework acknowledges the continuum of mental health, transdiagnostic lens and children's development.

Stakeholder consultation

National and state-level stakeholders were identified who could provide systems-level insights into the child mental health workforce. Over 60 individuals from government, non-government and industry sectors participated in interviews and focus groups discussing barriers and enablers of good child mental health practice and opportunities for innovation. Lived experience insights were gathered from Emerging Minds' Family Forum.

Recommendations and engagement

Broad system-level recommendations were developed from analysis of findings and implications from data; literature review; review of government policies and workforce development strategies; and stakeholder consultation. Findings and recommendations were reported to the Department of Health and Aged Care.

Data and findings are being disseminated to sector stakeholders to help inform local and regional level responses.

Ethics

Human research ethics approval for this project has been received from the Monash University Human Research Ethics Committee as an amendment to the National Workforce Centre for Child Mental Health evaluation (Project ID 30181).

National Workforce Survey for Child, Parent and Family Mental Health.

The second National Workforce Survey for Child, Parent and Family Mental Health (the Survey) was released on 15 August 2023 and closed on 17 November 2023.

A total of 3,064 responses were received from client-facing and non-client facing workers in over 50 professions from health, social and community service sectors in Australia.

The Survey comprises several sections in which respondents are questioned about their work role, modes of delivering services and work locations, engagement with Emerging Minds, and demographics. Several sections of competency statements asked respondents to self-rate their competence by indicating their agreement with the statement on a scale of 1–7 (where 1 = strongly disagree and 7 = strongly agree). High levels of agreement with statements, i.e. scores of 6 or 7 were interpreted as high workforce competency.

Questions on generalist competencies were available for any respondent to answer, while questions on specialist competency were only visible to those who indicated that supporting child mental health was a regular or intended part of their work.

Dissemination of the survey was supported by promotion through Emerging Minds e-news, social media, and website, and in presentations, as well as through engagement with key organisations and stakeholders. Around 100 stakeholders helped disseminate the survey to their networks.

Participation in the Survey was incentivised by the opportunity to win one of five iPads over two draws. Survey responses were anonymous.

Survey questions were informed by workforce competency research and were co-designed with internal and external subject matter experts including Emerging Minds' National Aboriginal and Torres Strait Islander Consultancy Group

Quantitative data was analysed with IBM SPSS Statistics 27. Exploratory factor analysis identified competency subscales as presented in this report.

Footnotes

1. The National Workforce Centre for Child Mental Health (NWC) is funded by the Australian Government Department of Health and Aged Care under the National Support for Child and Youth Mental Health Program. The NWC was additionally contracted by the Department of Health and Aged Care to undertake the Scoping the child mental health workforce project.
2. National workforce survey respondents were considered actively engaged with Emerging Minds if they had accessed one or more of online course, short article or research paper, webinar, podcast or toolkit. Percent of respondents refers to respondents who answered 5, 6, or 7 out of 7 for the impact questions included in this report.
3. Population need sources.
 - i. Australian Bureau of Statistics (ABS). (2021). *Population: Census*. ABS.
 - ii. Australian Early Development Census. (2021). *Australian Early Development Census national report 2021*. Australian Government Department of Education.
 - iii. Emerging Minds modelled child mental health estimates based on scaled up ABS Census 2021 prevalence.
4. Workforce availability sources.
 - i. Australian Bureau of Statistics (ABS). (2021). *Hours worked (HRSP)*. ABS.
 - ii. Australian Bureau of Statistics (ABS). (2021). *Occupation (OCCP)*. ABS.
 - iii. Emerging Minds developed the Workforce Classification Framework to conceptualise the child mental health and wellbeing workforce for the Workforce Stocktake project.
5. Workforce competency sources.
 - i. National Workforce Survey 2023.
6. Geographical classification sources.
 - i. Australian Bureau of Statistics (ABS). (2021). *Statistical Area Level 3*. ABS.
7. Child population sources.
 - i. Australian Bureau of Statistics (ABS). (2021). *Population: Census*. ABS.
8. Data consideration.
 - i. A notable limitation to using place-based data is that those who selected 'No Usual Address' in their census response are not captured in PHN data. Place of enumeration and place of usual residence census datasets have been used to ensure as many people as possible are represented in this report. We acknowledge that workforce may provide services outside their SA3 of residence. We also acknowledge that housing insecurity has a significant impact on child and family mental health and wellbeing. We can all play a role in supporting families who are navigating housing insecurity. Data within this report should be interpreted with caution.
9. Service considerations sources.
 - i. Australian Bureau of Statistics (ABS) (2022). *Cultural diversity of Australia*. ABS.
 - ii. Australian Bureau of Statistics (ABS). (2021). *Language used at home (LANP)*. ABS.
 - iii. Australian Bureau of Statistics (ABS). (2021). *Population: Census*. ABS.
 - iv. Commonwealth of Australia. (2017). *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017-2023*. Canberra: Department of the Prime Minister and Cabinet. Retrieved from https://www.niaa.gov.au/sites/default/files/publications/mhsewb-framework_0.pdf
 - v. Emerging Minds. (2020). *Working with Aboriginal and Torres Strait Islander families and children toolkit*. Emerging Minds. Retrieved from <https://emergingminds.com.au/resources/toolkits/working-with-aboriginal-and-torres-strait-islander-families-and-children/>
10. Region characteristics sources.
 - i. Australian Bureau of Statistics (ABS). (2023) *Remoteness Areas*. ABS.
 - ii. Australian Bureau of Statistics (ABS). (2023) *Socio-Economic Indexes for Areas (SEIFA), Australia*. ABS.
11. Current child mental health prevalence sources.
 - i. Emerging Minds modelled child mental health estimates based on scaled up ABS Census 2021 prevalence.
 - ii. Australian Institute of Health and Welfare (AIHW). (2023). *Medicare-subsidised mental health specific services 2021-22, Data tables, Table MBS1.1*. AIHW.
 - iii. Australian Institute of Health and Welfare (AIHW). (2023). *Mental health-related prescriptions data tables*. AIHW.
12. Child mental health risk sources.
 - i. Australian Early Development Census. (2021). *Australian Early Development Census national report 2021*. Australian Government Department of Education.
 - ii. To calculate the average rate of risks per child the sum of instances of each risk factor is divided by the number of children aged 0-12 years in the region.
13. Total need index.
 - i. Calculated by Emerging Minds to summarise the extent to which each included indicator deviates from the national average.
14. Workforce classifications.
 - i. Emerging Minds developed the Workforce Classification Framework to conceptualise the child mental health and wellbeing workforce for the Workforce Stocktake project.
15. Measures.
 - i. Australian Bureau of Statistics (ABS). (2021). *Occupation (OCCP)*. ABS.
 - ii. Australian Bureau of Statistics (ABS). (2021). *Hours worked (HRSP)*. ABS.
 - iii. Australian Bureau of Statistics (ABS). (2021) *Population: Census*. ABS.
16. Total workforce availability index.
 - i. Calculated by Emerging Minds to summarise the extent to which each included indicator deviates from the national average.

Emerging Minds.

National
Workforce
Centre for Child
Mental Health

Get started

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The National Workforce Centre for Child Mental Health (NWC) is funded by the Australian Government Department of Health and Aged Care under the National Support for Child and Youth Mental Health Program.

For further information contact info@emergingminds.com.au or visit emergingminds.com.au

