Scoping child mental health workforce capability – State and Territory Snapshots

Northern Territory

Regional data

Emerging Minds. National Workforce Centre for Child Mental Health

Contents

Background to the Project

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 to12 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

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This project was funded by the Australian Government Department of Health and Aged Care, see Footnote 1.

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

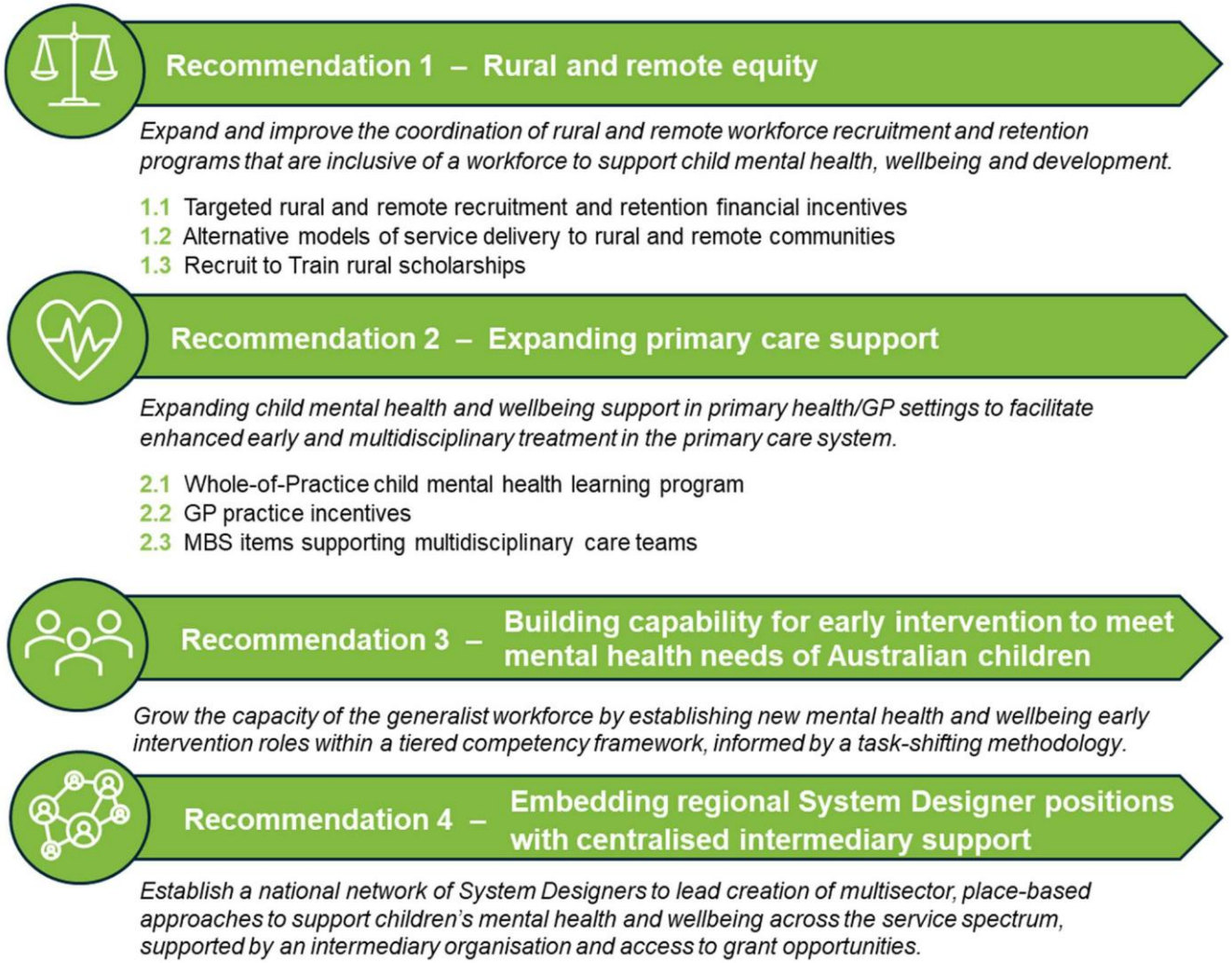
Outcomes of the project in 2024

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).



At a glance

Statistics for Australia

Population need	Workforce availability	Workforce competency*
4,004,812 children aged 0-12 years	1 **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%)	2 **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%)	3 **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.

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At a glance

Statistics for Northern Territory

Population need

42,356 children aged 0-12 years

14,827 Aboriginal or Torres Strait Islander children (35%)

2,945 Children 0-12 years estimated to have mental health conditions (7%)

25.7% Children's mental health at risk due to severe developmental vulnerability

Workforce capacity

1

1,925 High opportunity specialists. **Higher availability** than the national avg.
e.g. Psychiatrist, GP, Psychologist.

2

12,743 High Opportunity Generalist/Med Opportunity Specialist. **Higher availability** than the national avg.
e.g. Registered Nurse (Mental Health), AOD Counsellor, School Teacher.

3

11,317 Med Opportunity Generalist
Inline with national avg. availability
e.g. Health Promotion Officer, Emergency Medicine Specialist, Police Officer.

6.00 hours average hours per child per year of specialist care available. **Slightly below** the national avg (6.78 hours).

Workforce competency

Low generalist-level child mental health competency. Avg score 4.88.
Lower than the national avg (5.11).

Low specialist-level child mental health competency. Avg score 4.92.
Slightly lower than the national avg (5.09).

Moderate competency working with Aboriginal and Torres Strait Islander families.
Avg score 5.29.
Higher than the national avg (4.78).

Low child mental health competency in disasters.
Avg score 4.70.
Slightly higher than the national avg (4.57).

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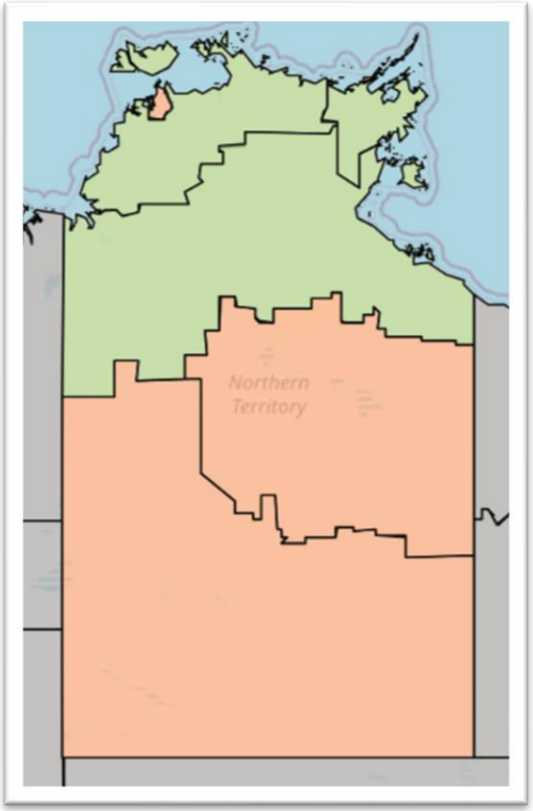
* Survey scores out of 7
Population need, see Footnote 3.
Workforce capacity, see Footnote 4.
Workforce competency, see Footnote 5.

At a glance

Northern Territory

All SA3 regions have need for child mental health support – estimates of need reflect the reported data available. Some regions have greater need compared to the national average. The access to specialist workforce in these regions varies.

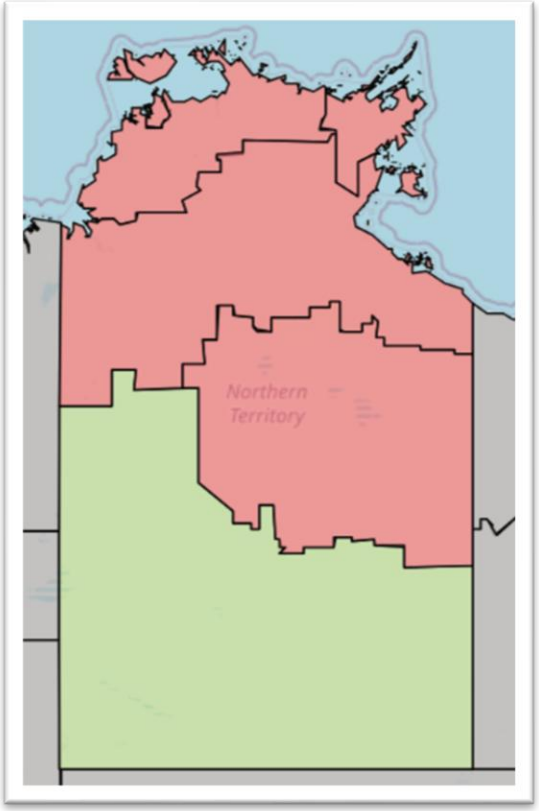


Need for child mental health workforce support:

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 Prioity | Extreme Priority

Compared to the national average

In summary

- In Northern Territory, the proportion of children aged 0 to 12 years estimated to be experiencing mental health conditions appears lower than the national average. However, given these estimate draw upon Census data which relies upon self-report and access to health professionals to provide diagnosis, this data could significantly underestimate child mental health conditions in the Northern Territory .

- Proportion of children in Northern Territory experiencing severe developmental vulnerability is much higher than the national average and gives an indication of current and future need for child mental health supports in the regions of the territory.

- The availability of workforce to support infant and child mental health in Northern Territory is lower than other states and territories and mismatched with the level of need.

- The infant and child mental health specialist workforce in Northern Territory has a slightly less time available to support children aged 0 to 12 years than the national average specialist hours per child per year.

- Workforce capability in a range of infant and child mental health domains is low. Northern Territory workforces are more confident working with Aboriginal and Torres Strait Islander families than those in other state and territories, however there is still need to develop this to ensure culturally responsive practice, given the high proportion of Aboriginal and Torres Strait Islander children in Northern Territory .

- 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.

Geographical Classification, see Footnote 6.
Child Population, see Footnote 7.
Service Considerations, see Footnote 8.

Northern Territory – PHN701

	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**
Alice Springs	1581	1612	1579	2073	6846	46.2%	45.3%
Barkly	272	267	249	342	1125	80.8%	52.8%
Daly - Tiwi - West Arnhem	557	681	771	1030	3044	81.4%	76.7%
Darwin City	844	772	730	909	3253	7.7%	34.7%
Darwin Suburbs	2280	2226	2390	3059	9947	13.6%	34.1%
East Arnhem	525	670	666	916	2785	62.0%	69.0%
Katherine	855	871	866	1255	3850	62.3%	56.9%
Litchfield	651	709	812	1076	3245	12.4%	14.9%
Palmerston	1968	2022	1938	2334	8261	16.5%	22.3%
National (Australia)	865791	912561	951013	1275442	4004812	5%	25.7%

In summary

- Across the nine SA3 regions in Northern Territory, there is some variation in the total number of children aged 0-12 years. Areas such as Darwin suburbs and Palmerston have higher populations of children, while other more remote regions have smaller populations.

- Northern Territory regions have very high proportions of Aboriginal and Torres Strait Islander children compared to other parts of Australia, especially in remote communities, highlighting the importance of culturally responsive services.

- Northern Territory regions also have high proportions of children who speak a language other than English at home. As many as half of the children who speak a language other than English at home could be representing children speak an Aboriginal or Torres Strait Islander language. It is therefore difficult to estimate the multicultural child population using only this indicator, although it does indicate the high level of need for language appropriate services.

- These results have implications for the design of appropriate services to meet these 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.

Region Characteristics, see Footnote 9.
Current child mental health prevalence, see Footnote 10.
Child mental health risk, see Footnote 11.
Total need index, see Footnote 12.

Child mental health need

Northern Territory – PHN701

	Region characteristics		Current child mental health prevalence			Child mental health risk		
SA3 Region	**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**	**TOTAL NEED INDEX**
Alice Springs	Remote Australia	883	4.58%	3.42%	2.05%	32.39%	0.83	19
Barkly	Very Remote Australia	717	-	2.52%	0.76%	61.33%	0.89	20
Daly - Tiwi - West Arnhem	Remote Australia	609	4.34%	2.30%	0.18%	-	0.99	14
Darwin City	Outer Regional Australia	1062	4.56%	5.30%	0.62%	14.34%	0.68	15
Darwin Suburbs	Outer Regional Australia	1010	7.79%	4.97%	0.34%	17.37%	0.78	15
East Arnhem	Very Remote Australia	679	4.74%	2.89%	0.23%	-	0.92	15
Katherine	Remote Australia	755	6.00%	3.03%	0.51%	32.16%	0.87	17
Litchfield	Outer Regional Australia	1030	10.93%	8.34%	0.57%	20.08%	0.81	19
Palmerston	Outer Regional Australia	1010	9.79%	5.97%	0.57%	23.36%	0.78	17
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

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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Note: some data not available for Barkly, Day – Tiwi – West Arnhem, and East Arnhem

In summary

- Northern Territory includes outer regional and remote areas some with high levels of socioeconomic disadvantage.

- Estimates of apparent low prevalence of child mental health conditions in Northern Territory likely represent significant under reporting of child mental health need due to the limitations of the data collection. The 2021 ABS Census question on long term health conditions that formed the basis of our modelling, relies upon self-report and access to health professionals to have provided diagnosis. There may be many reasons why this method could not appropriately collect accurate information for some populations. Caution is similarly advised around the apparent low rate of family and socioeconomic risk factors we sought to analyses from the Census data.
- However, the Australia Early Development Census (AEDC) shows very high proportions of young children are severely developmentally vulnerable across the regions in Northern Territory and this perhaps provided a more reliable picture of children's current mental health needs and risks of future mental health concerns.

- The AIHW service use data suggests low rate of mental health prescriptions for children in Northern Territory, and community mental health services utilisation that is similar to, or lower than the national average.
- Northern Territory has many SA3 regions of high child mental health needs or presentation of vulnerability that requires an immediate workforce response. Across the state, there is an urgent need to address the mental health treatment needs of children under 12 years of age, as well as address emerging issues and vulnerabilities in young children.

- A dual focus on mental health treatment of children under 12 years and addressing development signs and family risk factors influencing these children's mental health outcomes in the future. An investment in early intervention may address 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 to12 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.

Workforce availability

Northern Territory – PHN701

	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**
Alice Springs	423	62	319	2462	360	1850	2297	336	1765	24
Barkly	24	21	96	359	319	1424	244	217	1059	16
Daly - Tiwi - West Arnhem	75	25	73	869	285	1242	349	115	439	12
Darwin City	320	98	291	1484	456	1350	1560	480	1418	24
Darwin Suburbs	681	68	385	3002	302	1479	3348	337	1623	24
East Arnhem	53	19	117	737	265	1377	290	104	491	12
Katherine	103	27	115	1199	311	1521	829	215	978	15
Litchfield	88	27	92	842	259	801	696	214	600	10
Palmerston	158	19	104	1789	217	1319	1704	206	1296	13
National (Australia)	157,906 (*n*)	32 (*mdn*)	130 (*mdn*)	980,672 (*n*)	259 (*mdn*)	1004 (*mdn*)	1,085,650 (*n*)	275 (*mdn*)	984 (*mdn*)	

Sig. below the national avg. (<25%)	Below the national avg.	Equal to or above the national avg.	Sig. above the national avg. (>75%)

In summary

- In major centres in Northern Territory – around Darwin and Alice Springs - the availability of workforces who can provide specialist child mental health support (Group 1) is higher than the national average rate of workers per 1000 children , which is similar to other capital and highly populated cities across Australia. While in other more **remote SA3 regions the availability of the specialist workforce is very low**. It is likely that workforces servicing remote areas are based in the cities.

- 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. There seems also to be higher than average availability of Group 2 generalist workforces which could be drawn upon to fill service gaps and provide early intervention and prevention supports. However, it is interesting to note that in nearly all Northern Territory regions, these generalist workforces are working much higher than average hours, suggesting a workforce that is potentially stretched and overworked attempting to meet the local need.

- **There is a need for regional planning to connect access to specialists in Darwin and Alice Springs with other regions of Northern Territory and explore creative solutions that best utilise the local workforce. It is important to also build the capacity and reach of generalist workforce to apply early intervention approaches in child mental health.**

Section 4

Workforce competency

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).

- 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.**

- 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.

- 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.

- 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.

2023 National workforce survey sample

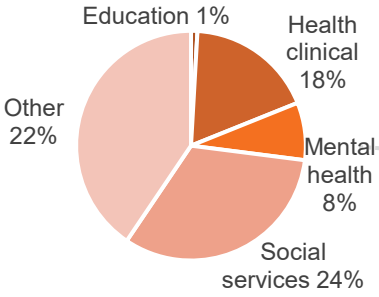
84% NT	87% Total

% Female

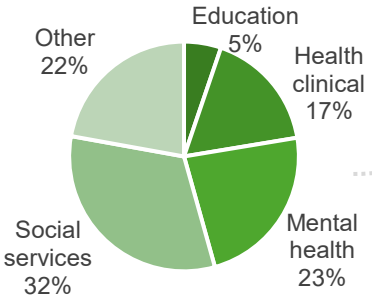
8.6 NT	10.6 Total

Avg. years in occupation

NT



Total

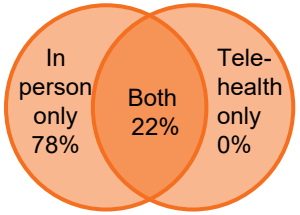


Profession group

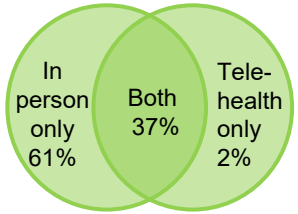
Total responses

121 NT	3,064 Total

NT



Total



Offers telehealth

CMH is an expectation of job

66% NT	73% Total

Regularly supports CMH regardless of whether its part of the job

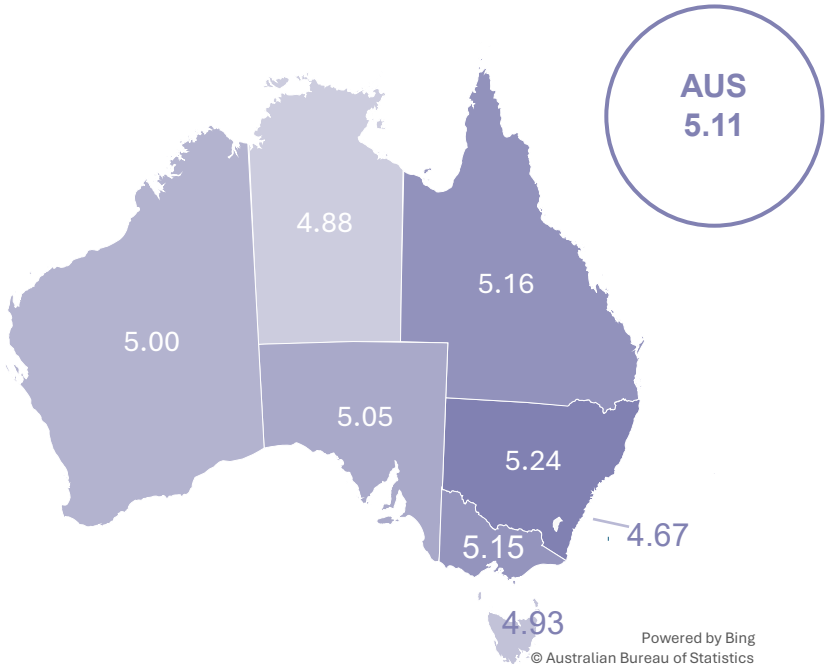
77% NT	85% Total

Workforce competency

National Workforce Survey overview

In Northern Territory

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



Clinical health professionals in Northern Territory rated their generalist and specialist child mental health competence very low and lower than other profession groups. Although showed moderate strengths in contextually driven practice adapting to the environment of the child.

Social services professionals in Northern Territory showed moderate confidence across many generalist and specialist competencies, although there is room for improvement. Social services group indicated struggles with child focused practice, infant mental health and some specialist responses to disasters.

The mental health profession group was very small but showed high levels of confidence. Especially in working with Aboriginal and Torres Strait Islander families and specialist practices. Although need support in child focused practice and infant mental health.

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.

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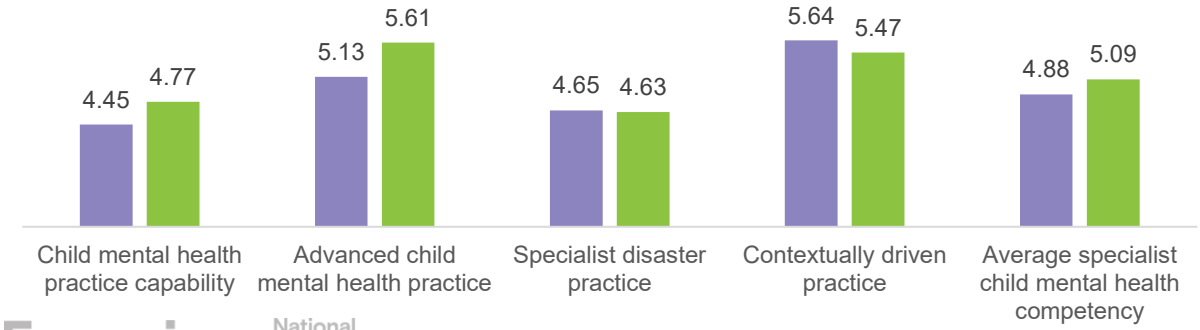
121 total responses

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

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Generalist child mental health competencies

For all practitioners

Average competency scores out of 7, by Northern 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
Northern Territory – PHN701	N	89	94	85	82	96	75	50	71	93	86
	Mean	4.34	5.09	5.35	4.27	5.35	5.29	5.36	4.66	4.64	5.21
	Std. Dev.	1.71	1.29	1.40	1.50	1.44	1.29	1.01	1.48	1.42	1.48

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 Northern Territory PHN

		Child mental health practice capability	Advanced child mental health practice	Specialist disaster practice	Contextually driven practice
Northern Territory – PHN701	N	40	40	40	39
	Mean	4.45	5.13	4.65	5.64
	Std. Dev.	1.74	1.49	1.73	1.29

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

Competencies by profession groups

Average competency scores out of 7, by Northern Territory PHN

		Generalist competencies For all practitioners										Specialist competencies For child mental health workforce			
Northern Territory respondents by profession group		**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**	**Context-ually driven practice**
Education (*n*=1) 1 childcare	N	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	Mean	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	Std. Dev.	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Health – clinical (*n*=20) 12 nurses, 3 midwives, 2 GPs, 1 paed, 1 speech path, 1 ATSI health worker	N	17	17	15	16	17	16	13	16	17	16	8	8	9	8
	Mean	3.47	4.35	4.33	4.06	4.47	4.38	4.92	3.94	3.93	4.50	3.50	4.50	4.22	5.38
	Std. Dev.	1.55	1.27	1.45	1.65	1.50	1.67	1.04	1.29	1.37	1.51	1.69	1.77	1.56	1.41
Mental health (*n*=9) 4 ATSI SEWB, 4 counsellors, 1 psychologist	N	8	8	8	8	8	7	6	7	8	8	4	4	3	4
	Mean	4.38	5.50	5.63	4.13	5.63	6.14	5.67	5.14	5.25	5.71	4.50	5.75	6.33	6.25
	Std. Dev.	2.07	0.93	1.69	1.25	0.92	1.21	1.03	0.90	1.20	0.81	1.91	0.50	1.15	0.96
Social services (*n*=36) 9 support workers, 8 social workers, 5 child/family practitioners, 5 child protection, 4 AOD, 2 ATSI consultants, 1 FDV, 1 Disability, 1 youth worker	N	33	33	29	28	34	25	18	23	33	29	16	16	15	16
	Mean	4.94	5.45	5.55	4.39	5.79	5.56	5.67	5.00	5.07	5.71	5.19	5.44	4.73	5.63
	Std. Dev.	1.56	1.06	1.38	1.52	1.20	1.08	0.77	1.28	1.15	1.30	1.56	1.55	1.62	1.41
Other (*n*=45) 13 program mgr/admin, 7 execs, 3 health promotion, 2 policy/advocacy, 20 others	N	23	28	25	22	29	20	7	18	27	25	10	10	11	9
	Mean	3.70	4.89	5.56	4.27	5.24	5.40	5.14	4.83	4.34	4.81	4.30	5.10	4.55	5.78
	Std. Dev.	1.66	1.47	1.16	1.52	1.62	1.05	1.21	1.65	1.53	1.70	1.77	1.37	1.97	1.20

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

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Insufficient responses from Education profession group to provide results. Sample groups with less than 20 respondents should be interpreted with caution.

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

10% NT ↑ **15% Total** ↑

% Change in specialist competency with engagement with Emerging Minds

3% NT ↑ **10% Total** ↑

Workforce competency

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
Northern Territory – PHN701	**33.3%** (n=25)	**76.6%**	**83.3%**	**65.5%**	**60.0%**
Northern Territory	**33.3%** (n=25)	**76.6%**	**83.3%**	**65.5%**	**60.0%**
Total sample	**50%**	**88.4%**	**92.2%**	**76.4%**	**79.8%**

See footnote 2.

Summary for Northern Territory

- Among the Northern Territory sample, 66% indicated supporting child mental health is part of their job, a smaller proportion than other states and territories' samples within the survey. However, three quarters of Northern Territory respondents regularly find themselves supporting child mental health at work regardless of whether its part of their job. It is therefore **vitally important to support this workforce in the work they are already doing**. There is also opportunity to increase child focused practice by supporting broader workforces to see their role in supporting children's mental health.

- **Fewer Northern Territory respondents offer telehealth** than in other states and territories, presenting a possible strategy to increase access to care.

- Respondents from Northern Territory rated their generalist and specialist child mental health workforce **competencies below the national average in many of the domains that we measured**. Although, in contrast to other states and territories they showed **greater confidence in Working with Aboriginal and Torres Strait Islander families**. This is a moderate level competency that can be continued to be strengthened through workforce development and support. Northern Territory respondents also showed **strength in adapting practices to suit the local, rural and cultural needs of children and families (Contextually driven practice**).

- Northern Territory users found **Emerging Minds learning and practice resources effective and useful**, with respondents who had actively engaged with resources demonstrating improved competence and confidence. Northern Territory respondents were less likely to have used Emerging Minds, and less likely to have applied learnings to their work, suggesting **a need for targeted engagement with the region**. Workforce development support may be **particularly helpful among health professionals** who demonstrated lower capabilities in children's mental health.

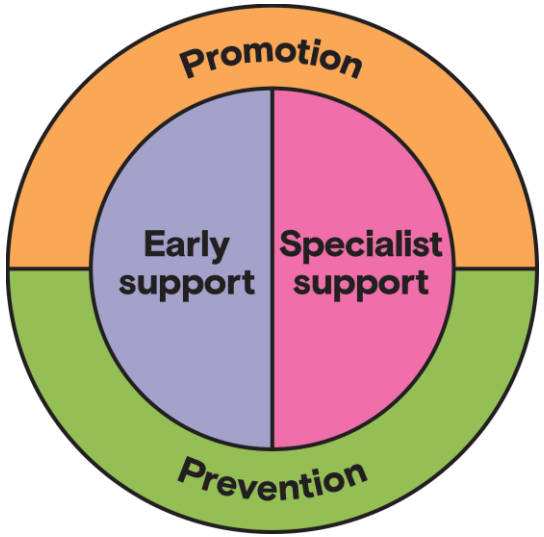
Section 5

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.

Northern Territory – PHN701

Current situation for child mental health workforce support

There were **42,356 children** aged 0-12 years resident in Northern Territory in the 2021 Census. Our analysis estimates availability of *High opportunity specialists* (workforce classification group 1) available per 1000 children in regional centres such as Darwin City, Darwin Suburbs and Alice Springs 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, high developmental risk for child mental health combined with low availability across Northern Territory regions for specialist workforces (workforce classification Group 1) and generalist workforces that are already working extra hours (Group 2) or low in availability (Group 3) presents **significant barriers to children accessing early and specialist support**.

Key opportunities for development

Two thirds of SA3s located in Northern Territory had higher child need than what the estimated workforce availability across our three workforce classification groups could meet. Among the most notable were the SA3 regions of **Litchfield,** but also **Barkly, Palmerston and East Arnhem showed a mismatch between need and workforce availability**. Darwin City, Darwin Suburbs and Alice Springs appeared to have higher workforce availability than the level of need in those SA3s dictated, however it is expected these **higher availability workforces likely also service surrounding areas**. One strategy to improve access may be to increase the capacity of the workforce to offer telehealth. National workforce survey respondents from Northern Territory (*n*=169) rated their child mental health competence lower than the national average. Respondents showed **strengths in specialist practices including *Advanced child mental health practice and Contextually driven practice.*** The Northern Territory workforce could benefit from capacity building in areas of **low competence such as *Child focused practice*, *Engaging with parents*** but also **strengthening capacity to provide specialist practices more broadly**. Emerging Minds' learning and practice resources were effective and relevant for Northern Territory respondents and implementation support can help improve translation of learnings to practice. Northern Territory workers should be supported to increase uptake of free resources.

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*.**

Appendix

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.

For more information on the methods email us

Appendix

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.

Suggested citation: Goodyear, M., Taylor, E., Marsh, C., Scharling-Gamba, K., Mclean, S., Burn, M., & Morgan, B. (2025). *Scoping child mental health workforce capability: Northern Territory regional data snapshot*. Emerging Minds.

Emerging Minds.

National Workforce Centre for Child Mental Health

Get started

Support change in your practice, organisation or region with key resources

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