

Scoping child mental health workforce capability – State and Territory Snapshots

# Tasmania

## Regional data

**Emerging  
Minds.**

National  
Workforce  
Centre for Child  
Mental Health



# Contents

- [Background](#)
- [Regional data on child population](#)
- [Current need for child mental health workforce support](#)
- [Workforce availability to provide child mental health support](#)
- [Current workforce competency in child mental health](#)
- [Conclusion, method and notes](#)

## 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 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](mailto: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.



# Statistics for Tasmania

## Population need

## Workforce capacity

## Workforce competency



**79,233** children aged 0-12 years



**3,458** High opportunity specialists. **Lower availability** than the national avg. e.g. *Psychiatrist, GP, Psychologist.*



**Low** generalist-level child mental health competency. Avg score 4.93. **Slightly lower** than the national avg (5.11).



**7,646** Aboriginal or Torres Strait Islander children (10%)



**21,165** High Opportunity Generalist/Med Opportunity Specialist. **Lower availability** than the national avg. e.g. *Registered Nurse (Mental Health), AOD Counsellor, School Teacher.*



**Moderate** specialist-level child mental health competency. Avg score 5.17. **Similar** to national avg (5.09).



**14,220** Children 0-12 years estimated to have mental health conditions (18%)



**27,325** Med Opportunity Generalist **Lower availability** than the national avg. e.g. *Health Promotion Officer, Emergency Medicine Specialist, Police Officer.*



**Low** competency working with Aboriginal and Torres Strait Islander families. Avg score 4.13. **Lower** than the national avg (4.78).



**11.9%** Children's mental health at risk due to severe developmental vulnerability



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



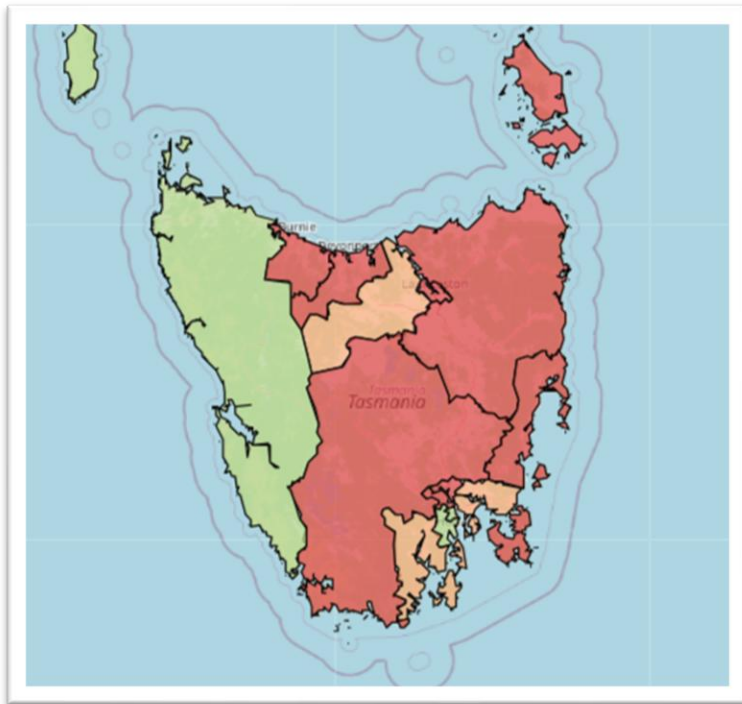
**Low** child mental health competency in disasters. Avg score 4.23. **Lower** than the national avg (4.57).

At a glance

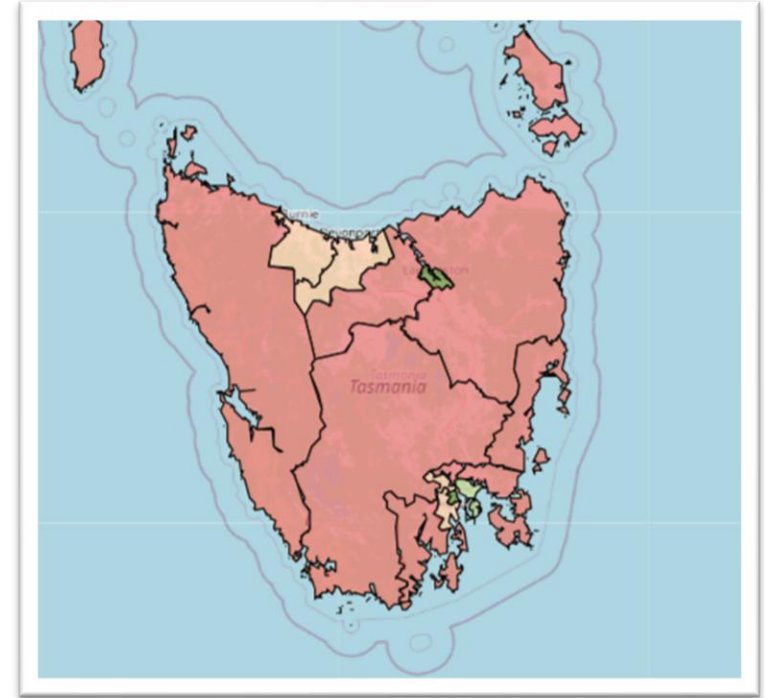
# Tasmania

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**



**Workforce availability: High opportunity specialists per 1000 children**



Significantly Favourable Favourable Unfavourable Significantly Unfavourable

Compared to the national average

Low Priority Moderate Priority High Priority Extreme Priority

Compared to the national average

# In summary

- For Tasmania'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.
  - 18% are currently experiencing a mental health condition
  - 12% of 5-year-olds are currently developmentally vulnerable to develop a mental health condition in later childhood
- The estimated workforce available to support infant and child mental health in Tasmania is lower than other states and territories across Australia.
- The infant and child mental health specialist workforce in Tasmania has below the national average time available to support children aged 0 to 12 years.
- There is a lack of available workforces in Tasmania to meet existing and future child mental health needs.
- 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.

## Population

# Tasmania - PHN601

SA3 Region	Child population					Service considerations	
	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
Brighton	787	922	907	1192	3809	18%	9.1%
Hobart - North East	1936	1973	2040	2831	8775	7%	11.5%
Hobart - North West	1984	1786	1935	2643	8350	10%	20.3%
Hobart - South and West	1137	1270	1371	1960	5739	6%	12.8%
Hobart Inner	1282	1391	1521	2077	6264	2%	21.2%
Sorell - Dodges Ferry	596	644	659	870	2766	7%	10.4%
Launceston	2748	2859	3024	4149	12782	7%	13.9%
Meander Valley - West Tamar	637	727	766	1127	3261	7%	8.1%
North East	1103	1192	1247	1795	5337	8%	7.8%
Central Highlands (Tas.)	354	399	402	605	1753	11%	9.9%
Huon - Bruny Island	609	691	750	1039	3091	16%	10.9%
South East Coast	130	154	138	212	635	10%	12.6%
Burnie - Ulverstone	1498	1537	1742	2401	7178	15%	7.4%
Devonport	1396	1435	1581	2239	6648	13%	8.4%
West Coast	587	617	626	903	2731	19%	11.6%
National (Australia)	865791	912561	951013	1275442	4004812	5%	25.7%

# In summary

- Across fifteen SA3 regions in Tasmania there is some variation in the total number of children aged 0 to 12 years. As expected, regions such as Launceston have a high population of infants and children compared to other less densely populated regions such as South East Coast.
- But there is little variation in the proportion of child age groups across different regions in Tasmania.
- There are differences in the proportion of Aboriginal and Torres Strait Islander children and families speaking a language other than English at home across different regions in Tasmania.
  - Most regions have a very high proportion of Aboriginal and Torres Strait Islander children and families speaking a language other than English, compared to the national average.
- 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

### Current child mental health prevalence

### Child mental health risk

### Total need Index



#### 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



#### 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.



#### 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.



#### 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.



#### 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.



#### 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).



#### 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.

## Child mental health need

# Tasmania - PHN601

SA3 Region	Region characteristics		Current child mental health prevalence			Child mental health risk		TOTAL NEED INDEX (low 7 – high 29)
	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	
South East Coast	Outer Regional Australia	941	23.38%	7.73%	0.88%	20.93%	1.49	27
Central Highlands (Tas.)	Outer Regional Australia	941	16.94%	9.85%	0.57%	13.95%	1.28	25
Brighton	Inner Regional Australia	891	18.19%	8.37%	0.40%	19.87%	1.37	24
Burnie - Ulverstone	Outer Regional Australia	930	19.31%	7.00%	0.41%	12.28%	1.34	23
North East	Outer Regional Australia	938	21.95%	8.31%	0.29%	13.50%	1.24	23
Hobart - North West	Inner Regional Australia	924	19.46%	8.77%	0.28%	14.16%	1.45	23
Launceston	Inner Regional Australia	955	21.62%	9.21%	0.28%	12.33%	1.30	22
Devonport	Outer Regional Australia	937	17.62%	6.28%	0.30%	14.73%	1.37	22
Sorell - Dodges Ferry	Inner Regional Australia	996	17.59%	8.41%	0.36%	9.80%	1.31	21
Huon - Bruny Island	Outer Regional Australia	983	16.28%	6.47%	0.39%	11.33%	1.21	21
Meander Valley - West Tamar	Outer Regional Australia	967	18.46%	7.77%	0.30%	5.50%	1.24	20
Hobart - North East	Inner Regional Australia	1007	17.20%	7.90%	0.36%	9.95%	1.28	19
West Coast	Outer Regional Australia	934	11.18%	4.54%	0.00%	15.59%	0.98	17
Hobart - South and West	Inner Regional Australia	1039	16.24%	7.27%	0.33%	7.05%	1.20	16
Hobart Inner	Inner Regional Australia	1046	10.01%	7.39%	0.42%	7.46%	1.08	14
National Average (Australia)			12.52%	6.32%	0.53%	10.83%	1.02	

# In summary

- Tasmania 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.
- The Total Need Index shows the specific regions of highest child need. In Tasmania most regions score very highly on this index with scores ranging from 14 to 27, significantly higher than the national average.
- 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 is urgently needed in Tasmania, focusing on 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 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 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 availability

# Tasmania - 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 (low 6 – high 24)
Brighton	38	10	43	590	155	557	848	223	864	8
Burnie - Ulverstone	285	40	153	1862	259	857	2519	351	1176	19
Central Highlands (Tas.)	18	10	9	329	188	452	456	260	699	7
Devonport	202	30	102	1740	262	876	2237	336	1114	16
Hobart - North East	386	44	143	2689	306	1167	3149	359	1331	21
Hobart - North West	189	23	78	1833	220	734	3121	374	1381	15
Hobart - South and West	282	49	190	1774	309	1102	1792	312	1065	19
Hobart Inner	909	145	481	2703	432	1158	3310	528	1423	23
Huon - Bruny Island	99	32	79	730	236	602	750	243	594	11
Launceston	710	56	243	3678	288	1116	5214	408	1585	23
Meander Valley - West Tamar	91	28	43	679	208	531	969	297	737	9
North East	134	25	49	1138	213	626	1484	278	770	9
Sorell - Dodges Ferry	67	24	71	657	238	626	790	286	800	11
South East Coast	19	30	0	159	250	337	175	276	174	10
West Coast	29	11	6	604	221	786	511	187	395	7
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

- Only a small number of Tasmanian regions such as Launceston and Hobart (Inner), show high availability of **child mental health specialists** compared to the national average, which is similar to other capital and highly populated cities across Australia. Many Tasmanian regions have low access to specialists however.
- 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 Tasmania, where specialists have higher availability, the generalist child mental health workforce (Groups 2 and 3) also tends to have higher availability. Similarly, if an area has low specialist availability, Groups 2 and 3 are likely to also have low availability.
- The geography of Tasmania consists of inner and outer regional areas. In these regions there is mixed availability of generalists, where some have high availability of generalists who 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 Launceston and inner Hobart with other regions of Tasmania, 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.**

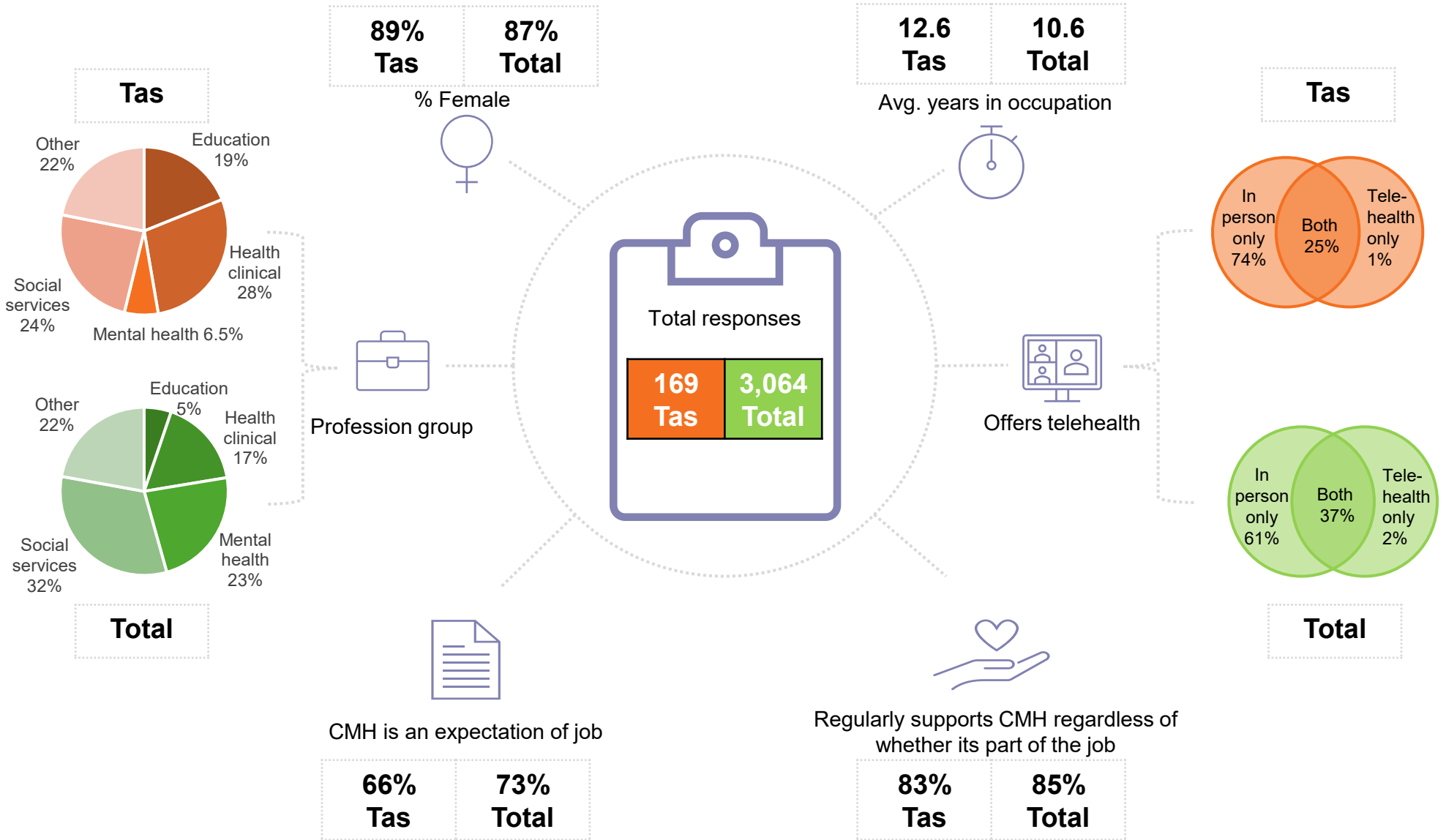


- Engagement in workforce development makes a significant difference in the level of competency in child mental health. Those who had completed training or used resources reported higher competence in all areas we measured.



- 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.

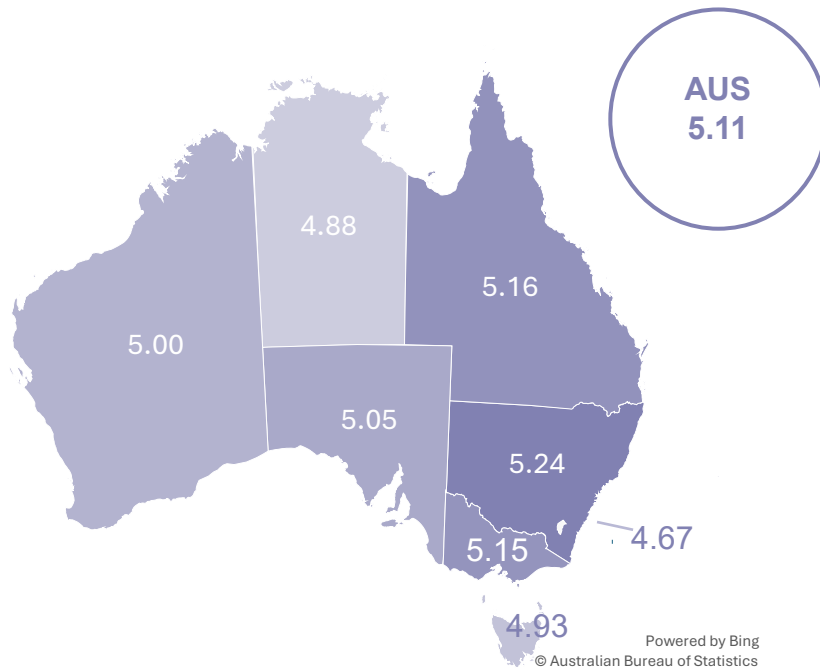
# 2023 National workforce survey sample



# National Workforce Survey overview

### In Tasmania

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



Clinical health professionals in Tasmania rated their generalist and specialist child mental health competence lower than other profession groups.



Educators showed moderate confidence in generalist and specialist child mental health competencies, but low confidence in working with Aboriginal and Torres Strait Islander children and families, and disaster contexts.



The mental health profession group showed the highest level of confidence. Although average scores for both mental health and social services professionals indicate moderate to high competency with room for improvement.

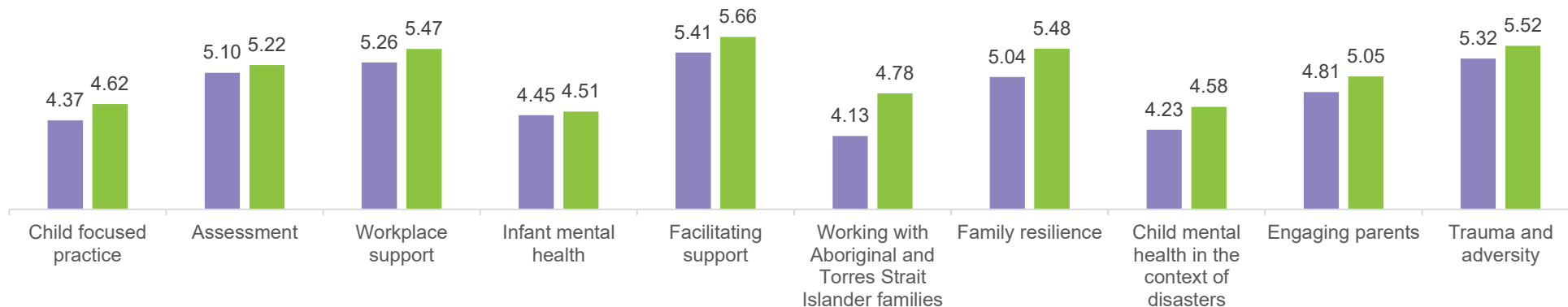
# Competencies in child mental health

<b>Generalist competencies for all practitioners</b>	
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.
<b>Specialist-level competencies for child mental health workforce</b>	
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.

## Tasmania – PHN601

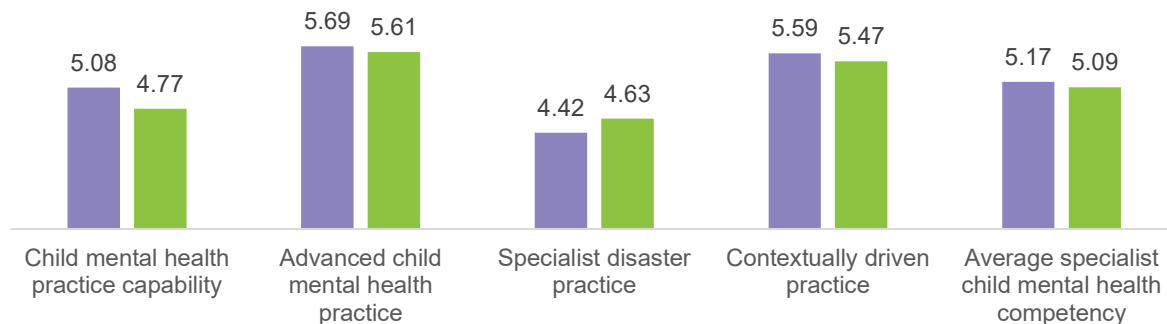
169 total responses

Generalist competencies for all practitioners



■ PHN601 - Tasmania ■ Total sample

### 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

## Workforce competency

# Generalist child mental health competencies

For all practitioners

Average competency scores out of 7, by Tasmania 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
PHN601 - Tasmania	N	132	144	129	126	145	122	78	115	146	133
	Mean	4.37	5.10	5.26	4.45	5.41	4.13	5.04	4.23	4.81	5.32
	Std. Dev.	1.76	1.39	1.50	1.66	1.43	1.43	1.66	1.70	1.49	1.54

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

## Workforce competency

# Specialist child mental health competencies

For child mental health workforce

Average competency scores out of 7, by Tasmania PHN

		Child mental health practice capability	Advanced child mental health practice	Specialist disaster practice	Contextually driven practice
PHN601 - Tasmania	N	72	75	69	76
	Mean	5.08	5.69	4.42	5.59
	Std. Dev.	1.50	1.15	1.92	1.26

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

## Workforce competency

# Competencies by profession groups

Average competency scores out of 7, by Tasmania PHN

Tasmanian 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=32) <small>16 EC educators, 9 teachers, 5 childcare, 1 principal, 1 teacher's aid</small>	N	28	31	30	28	31	26	12	25	31	30	20	21	18	21
	Mean	5.14	5.61	5.53	4.43	5.48	4.69	5.00	4.84	5.12	5.71	5.35	5.95	4.78	5.24
	Std. Dev.	1.35	0.92	1.25	1.40	1.34	1.16	1.35	1.46	1.14	1.02	0.99	0.92	1.86	1.41
Health – clinical (n=48) <small>36 nurses, 6 GPs, 3 midwives, 2 speech path, 1 OT</small>	N	36	38	31	33	38	32	26	31	39	34	20	20	21	21
	Mean	3.72	4.37	4.71	4.70	4.87	3.38	4.50	3.52	4.33	4.53	4.20	4.85	3.33	5.19
	Std. Dev.	1.49	1.34	1.01	1.74	1.46	1.21	1.56	1.65	1.52	1.56	1.36	0.67	1.74	1.12
Mental health (n=11) <small>5 MH nurses, 3 counsellors, 2 psychologists, 1 MH social worker</small>	N	10	10	9	9	10	9	7	9	10	9	7	8	8	8
	Mean	5.70	6.10	5.44	5.33	6.30	5.00	6.00	5.56	5.85	6.26	6.29	6.50	5.75	6.63
	Std. Dev.	1.64	1.37	1.74	1.58	0.67	1.50	1.41	1.74	1.32	1.32	0.95	0.76	2.05	0.74
Social services (n=41) <small>15 social workers, 12 support workers, 8 child/family practitioners, 2 peer worker, 2 FDV, 1 ATSI consultant, 1 child protection</small>	N	33	37	33	33	38	32	24	30	38	36	16	17	15	17
	Mean	4.33	5.24	5.61	4.39	5.76	4.22	5.38	4.10	5.06	5.72	5.06	5.65	4.40	5.76
	Std. Dev.	1.99	1.59	1.75	1.77	1.42	1.41	1.69	1.58	1.56	1.50	2.05	1.62	1.88	1.30
Other (n=37) <small>12 program mgr/admin, 2 health promotion, 2 execs, 1 creative therapist, 1 researcher, 19 others</small>	N	25	28	26	23	28	23	9	20	28	24	9	9	7	9
	Mean	3.96	5.00	5.12	3.87	5.29	4.09	5.00	4.15	4.40	5.02	5.56	6.33	5.29	6.11
	Std. Dev.	1.74	1.19	1.70	1.60	1.49	1.59	2.18	1.76	1.51	1.71	1.01	0.50	0.95	0.78

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

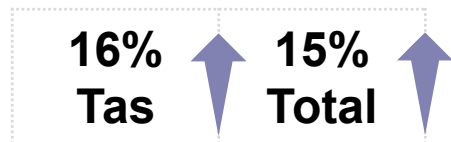
## Workforce competency

# Impact of workforce development

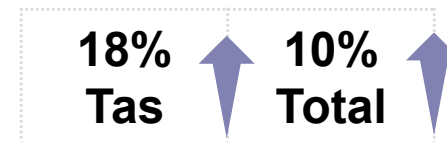
Survey findings indicate a relationship between engagement with Emerging Minds and improved child mental health workforce competency. Among the survey sample, 50% had actively engaged with Emerging Minds resources (called the *Exposed* group), a further 9% were just aware of Emerging Minds or had only 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
PHN601 - Tasmania	33%	87.2%	93.6%	82.3%	89.3%
<b>Tasmania</b>	33%	87.2%	93.6%	82.3%	89.3%
<b>Total sample</b>	50%	88.4%	92.2%	76.4%	79.8%

# Summary for Tasmania

- A large proportion of Tasmanian respondents regularly find themselves supporting child mental health at work regardless of whether its part of their job. Fewer Tasmanian respondents offer telehealth than in other states and territories, presenting a possible strategy to increase access to care.
- Respondents from Tasmania rated their generalist child mental health workforce competencies below the national average in all domains that we measured.
  - Respondents felt the least competent and were well below the national average were *Working with Aboriginal and Torres Strait Islander families* and generalist and specialist responses to children in the context of *Disasters*. This indicates these may be key areas for future workforce development strategies, particularly given the high proportion of Aboriginal and Torres Strait Islander children in Tasmania.
  - Other areas for practice development included child focused practice, working with parents and working in the context of childhood trauma.
- However, child mental health specialists showed higher than average competence in *Specialist practices*. Similarly, the capacity to adapt practice to the child's local environment (*Contextually driven practice*) was higher than average, which is consistent with respondents from other rural and remote areas in Australia.

# Summary for Tasmania

- Tasmanian 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 clinical health practitioners in the Tasmanian sample who tend to show greater improvement from learning and practice development than social services, mental health and education professionals.
- Tasmanian respondents were less likely to have used Emerging Minds suggesting a need for targeted engagement with the region, but those who had indicated resources had high levels of relevance and applicability to their work.

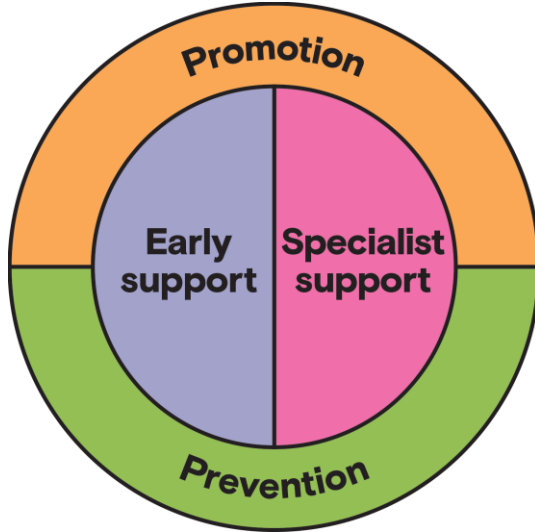
## Section 5

# 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.

# Tasmania – PHN601

### Current situation for child mental health workforce support

There were **79,233 children** aged 0-12 years resident in Tasmania in the 2021 Census. Our analysis estimates availability of *High opportunity specialists* (workforce classification group 1) available per 1000 children in regions such as Launceston and Hobart (Inner, North East, South and West) 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, low availability across Tasmania for specialist and generalist workforces (workforce classification group 1 and group 2) presents **significant barriers to children accessing early and specialist support**.

### Key opportunities for development

Over 70% of SA3s located in Tasmania PHN had higher child need than what the estimated workforce availability could meet. Among the most notable were the SA3 regions of **South East Coast** and **Central Highlands (Tas.)**, which had **extreme levels of disparity of workforce availability and child need**. Only four regions had workforce availability that was estimated to be at similar levels to child need – Launceston and Hobart (Inner, North East, South and West) – however the estimated need in some of these areas was very high. One strategy to improve access may be to increase the capacity of the workforce to offer telehealth. National workforce survey respondents from Tasmania ( $n=169$ ) 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 Tasmanian workforce could benefit from workforce development activities targeted at areas of **low competence such as *Working with Aboriginal and Torres Strait Islander families, responding to Child mental health in disasters and Infant mental health***, 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 Tasmanian users. Tasmanian workers should be supported to increase uptake of 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](mailto: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](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

[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](mailto:info@emergingminds.com.au) or visit [emergingminds.com.au](http://emergingminds.com.au)

