



The Royal
Australian &
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College of
Psychiatrists



Discussion Paper prepared by the Faculty of Child and Adolescent Psychiatry
Child and adolescent psychiatry: meeting future workforce needs

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working with the community

Purpose

This discussion paper has been developed by the Royal Australia and New Zealand College of Psychiatrists' (RANZCP) Faculty of Child and Adolescent Psychiatry (FCAP) to inform psychiatrists, the medical profession and other health professionals, service providers, governments, and the Australian and New Zealand communities about child and adolescent psychiatry workforce¹. The paper is intended to promote debate and recommend future action to ensure that workforce can adequately meet the mental health needs of young people².

Executive summary

It is well documented that the results of psychological distress and mental illness in young people are considerable and include poor mental health into adulthood, low school engagement and performance, high welfare dependency and involvement with the child protection system, criminal activity, insecure housing, drug and alcohol dependency, and premature death [1]. Failure to address early mental illness effectively could have implications across multiple sectors, highlighting the importance of investing in the mental health of young people. A key part of this is the need to increase numbers of child and adolescent psychiatrists. Key findings from this paper are that:

- There are too few child and adolescent psychiatrists to meet the direct mental health needs of young people. Infants, children and adolescents comprise nearly 25% of the population in Australia and New Zealand whilst child and adolescent psychiatrists represent only 10% of the psychiatry workforce. This long-standing disparity is compounded by maldistribution.
- The scope of child and adolescent psychiatric practice is evolving to encompass a broader age-range, increased complexity, and greater involvement in specialist mental health service provision (e.g. child protection, youth justice) requiring increased workforce numbers with specialist skills.
- The current estimated number of child and adolescent psychiatrists is 1.6 FTE per 100,000 population in Australia and 1.0 FTE per 100,000 population in New Zealand. It is suggested that substantially more child and adolescent psychiatrists are required to meet child and adolescent psychiatry demands, as well as to support youth mental health services and perinatal and infant mental health needs.
- Providing services for populations with higher needs such as children and adolescents with intellectual disability or complex physical health problems, residing in out-home-care, or in youth justice settings will require a yet more child and adolescent psychiatrists.
- Determining the number of child and adolescent psychiatrists required is only one aspect of addressing access delivery to services. There is a need for service model reform, prioritising the most at risk groups, that best use the consultancy skills and expertise of child and adolescent psychiatrists and support other team members, utilising the workforce optimally to reflect the patient population.

¹ Child and adolescent psychiatrists are those who have undertaken specific training leading to the advanced certificate in child and adolescent psychiatry.

² 'Young people' is defined as pre-school children (0–4 years), children (5–11 years), adolescents (12–17 years), youth transitioning to adult health services (18–24 years). It is acknowledged that varying data sources and reports use different definitions of age and where possible this has been taken into account in this paper. It is recognised that meeting the needs of young people includes working with their families.

Key facts

- Infants, children and adolescents (aged 0–19 years) comprise approximately 25% of the population in Australia and New Zealand whilst child and adolescent psychiatrists represent only 10% of the psychiatry workforce.
- In New Zealand the 12 month prevalence rate of mental disorder for people aged 0–19 is estimated to be 15% [2-4].
- In Australia one in seven (approximately 14%) of children and adolescents (aged 4–17 years) experienced a mental disorder in a 12 month period [5].
- In Australia, for youth aged 16–24, the estimated 12 month prevalence rate for any mental disorder is 26.4% [6].
- There are no Australian or New Zealand data on the prevalence of mental disorders in early childhood (aged 0–4 years), however international studies have identified the prevalence of mental disorders in preschool children to be comparable to that of children and adolescents [7, 8].
- Approximately 50% of the Māori, Pacific Islander, and Aboriginal and Torres Strait Islander peoples population are under 25 [9, 10] and these population groups have disproportionately poorer mental health [11-13].
- There is an increase in prevalence of severe disorders [5, 14], and growing ongoing demand for specialist care [13].
- There is a shortage of child and adolescent psychiatrists as well as a shortage of child and adolescent psychiatry training posts in Australia and New Zealand to meet infant, child, adolescent and youth mental health needs [15, 16].
- In Australia, of the approximately 80,000 children with a severe disorder over a 12 month period, only 22,000 had seen a psychiatrist (27%) indicating that access to specialist care remains a persistent problem [5].
- It is estimated that there are approximately 1.6 FTE child and adolescent psychiatrists per 100,000 population in Australia and 1.0 FTE per 100,000 population in New Zealand.
- Nationally and internationally, there are a diverse range of recommendations for child and adolescent psychiatrist workforce coverage ranging from 2.5 FTE to 18.0 FTE per 100,000 population with no agreement on one particular model or methodology.
- Australia and New Zealand fall well short of national and international comparisons for child and adolescent workforce coverage per head of population.

Background

Mental illness in childhood can have enduring consequences and is a strong predictor of morbidity in adult life [17-19]. Consequences of mental health problems include educational and occupational impairment and youth suicide [1, 18]. Considerable capacity is required in child and adolescent mental health services to adequately treat those with mental disorder [20].

Infants, children and adolescents (aged 0–19 years) comprise approximately 25% of the population in Australia and New Zealand. In New Zealand the prevalence rate of mental illness for people aged 0–19 is estimated to be 15% [2-4]. Of note in New Zealand, Māori and Pacific Island populations make up about 40% of the population aged 0–19 years, and these population groups have disproportionately poorer mental health outcomes [13] which is relevant for workforce planning. In Australia one in seven (13.9%) children and adolescents (aged 4–17 years) experienced a mental disorder in a 12 month period [5]. Of these children it is estimated that approximately 60% of children and adolescents have a disorder of mild severity, 25% had a moderate severity disorder, and 15% had a severe disorder [5]. Children and adolescents in low-income families, with parents and carers with lower levels of education and with higher levels of unemployment, have higher rates of mental disorders. There is also a strong relationship with where they live with higher rates of mental disorders in non-metropolitan areas [21]. This is particularly evident in males [5].

For youth aged 16–24, the 12 month prevalence rate for any mental disorder is 26.4% [6], the increased prevalence relating to the incidence of severe mental health disorders and increase in co-morbidity that occurs in this age group. There are no Australian or New Zealand data on the prevalence of mental disorders in early childhood (aged 0–4 years), however international studies have identified the prevalence of mental disorders in preschool children as ranging from 14–26.4% in the US [8] to 7.1% in Norway [7].

Demands on the child and adolescent psychiatry workforce

Access to psychiatry has remained a challenge as demand frequently exceeds the available capacity. Mental and behavioural disorders are the leading cause of disability adjusted life year (DALYs) in Australians aged 5–14 making this a high-priority area yet treatment rates for major childhood mental disorders remain low [22]. In Australia it is reported that only a small percentage of children have enough contact with health professionals to allow provision of minimally adequate treatment, which may be contributing to the unchanging high prevalence of childhood mental disorders [23]. In New Zealand's mental health and addiction system, waiting times for young people (0–19 years) are longer than for all other age groups and do not meet government targets or community expectations [13]. It is acknowledged that there is a shortage of child and adolescent psychiatrists as well as a shortage of child and adolescent psychiatry training posts in Australia and New Zealand to meet infant, child, adolescent and youth mental health needs [15, 16]. Specific strategies are required to address this deficit, which are not yet in place.

It is acknowledged that general psychiatrists', paediatricians' and general practitioners' (GPs) role in delivering child and adolescent mental health services is invaluable, as is the support of other health workers (including but not limited to nurses, psychologists, social workers and occupational therapists). Such support provides a positive impact on the workload and workflow of child and adolescent psychiatrists.

Whilst optimal use of the available workforce and service improvement is essential to improving outcomes for young people [24], this can only be achieved by accompanying increase in the reach, availability and access to the child and adolescent psychiatry workforce. This is important as demand is only likely to increase owing to a range of developments in child and adolescent psychiatry including:

- high community prevalence of mental illness in children and adolescents, with an increase in prevalence of severe disorders [5, 14], and growing ongoing demand for specialist care [13]
- increasing recognition of the role of child abuse and neglect and its impact on development and mental health
- significant unmet need within the population [23] and, with this, greater community expectation of mental health care quality and access as awareness and expectations of treatment increases [25]
- greater focus on youth mental health, particularly the expansion of some child and adolescent mental health services up to age 25, and the expansion of services delivered to the 0–12 year age group to improve access and meet the increased demand for mental health intervention for this age group
- recognition that the developmental and family systems focus of child and adolescent psychiatry is well suited to work in early childhood or infant mental health services with perinatal and infant psychiatry services being established and expanded throughout Australia and New Zealand³, delivering prevention and early intervention and better integration with maternity and early parenting service and workforce
- emerging service models (for example community assertive outreach teams) that are resource intensive and require child and adolescent psychiatry leadership
- improved monitoring, early intervention, and prevention of physical health and mental health comorbidity [26, 27]
- population characteristics, particularly given that in New Zealand approximately 50% of the Māori population is under 25, and nearly half (46.1%) of the Pacific Islander population are less than 20 years old [9, 10], and that in Australia more than half (53%) of Aboriginal and Torres Strait Islander peoples are aged under 25 years in comparison with almost one in three (31%) non-Indigenous people [28]. This has major implications for how services are configured given the higher prevalence of mental health problems [11-13] and access to them is poor
- community and policy priorities concerning measures to address the high rates of deliberate self-harm in young people and prevent suicide [5, 29], noting that in New Zealand the suicide rate for youth, particularly Māori, is one of the highest within Organisation for Economic Co-operation and Development (OECD) countries [30]
- increased service provision and engagement with particular patient groups including:
 - child protection, those affected by family violence and those in out of home care
 - juvenile justice
 - consultation–liaison psychiatry
 - neuropsychiatric and neurodevelopmental disorders and disability
 - substance use and addiction including alcohol related problems

³ Whilst the youth and infant and perinatal psychiatry may be seen as areas of specialty in their own right, the developmental training of child and adolescent psychiatry is well suited to both sectors and frequently child and adolescent psychiatrists are involved in these services. However only part of the workforce required for these groups will be child and adolescent psychiatrists, acknowledging that working collaboratively in partnership with adult psychiatrists who have specialised in perinatal psychiatry is valuable.

- refugees and asylum seeker populations.
- development of collaborative practice models including:
 - the need for access to support, consultation and advice from psychiatrists in the management of patients with mental health issues which is particularly valued by general practitioners [31], paediatricians [32], psychologists, mental health nurses, and other health professionals
 - education and training including working with other medical practitioners to promote optimal psychotropic drug prescription practices for young people [33]
 - expectation and demand from patients and families for more access to their psychiatrist, with time to be spent ensuring that the relationship is one of family-centred partnership [34].
- active specialist contribution to inform implementation of prevention and early intervention programs, including development, clinical oversight, capacity building and consultation
- the expansion of online interventions, e-health and telehealth, that are frequently relevant to young people
- increased need for research into treatment effectiveness, given that the evidence-base for treatment of child mental health problems is limited [35]
- implementation of the National Disability Insurance Scheme (Australia)
- recommended reforms in the youth justice, child protection or family support services
- teaching and mentoring junior colleagues to ensure succession planning
- leadership and administrative roles requiring complex clinical systems of care knowledge.

Further information is available in [Professional Practice Guideline 15: The role of the child and adolescent psychiatrist](#).

The current child and adolescent psychiatry workforce in Australia and New Zealand

Whilst no report in isolation provides a complete picture of the current child and adolescent psychiatry workforce, there are a number of data sources which when presented together provide an overview. A summary of these data are provided in table 1 below.

Table 1: Current child and adolescent psychiatry workforce provision in Australia and New Zealand

<p>Total number of child and adolescent psychiatrists</p>	<p>In 2017 there were 432 accredited members of the Faculty of Child and Adolescent Psychiatry (386 in Australia, 46 in New Zealand). This represents approximately 10% of the psychiatry workforce [36]. Approximately a further 80 trainees are undertaking advanced training in child and adolescent psychiatry.</p> <p>Using this information as a proxy for total child and adolescent psychiatry numbers there are approximately 1.6 FTE child and adolescent psychiatrists per 100,000 population in Australia and 1.0 FTE per 100,000 population in New Zealand. It is noted that in New Zealand especially there are a significant number</p>
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	<p>of overseas trained child and adolescent psychiatrists who are not Fellows of the College. However, many psychiatrists work part-time and spend time in leadership, research and other roles further complicating the calculation of clinical FTE. Hence these calculations are likely to be overestimates.</p>
<p>Child and adolescent psychiatrists and adult psychiatry cross over</p>	<p>It is estimated that approximately 800 psychiatrists see children and adolescents with 30% of these also undertaking general adult psychiatry work [37]. This suggests that many general psychiatrists provide care to young people as part of their work. Reasons for this may include access bottlenecks for child and adolescent psychiatrist review, including limited access to child and adolescent psychiatrists. Though data to confirm this are not available, it is likely that many will restrict this to seeing older adolescents.</p> <p>Only 8% of psychiatrists report practising exclusively in child and adolescent psychiatry [38]. Further, a third of psychiatrists, for whom child and adolescent psychiatry is a primary area of practice, report working across child and adolescent psychiatry and adult psychiatry [38]. Hence it can be assumed that many child and adolescent psychiatrists also work in non-child and adolescent psychiatrist practice.</p>
<p>Child and adolescent psychiatrist and perinatal/youth psychiatry cross over</p>	<p>Approximately 460 psychiatrists in Australia and 85 in New Zealand report working with young adults and close to 200 psychiatrists in Australia and 25 in New Zealand report working in perinatal and infant psychiatry [36, 38]. There is overlap in this population of psychiatrists as many will see more than one age group. For example a quarter of psychiatrists report working across youth and child and adolescent mental health. Overall approximately 15% of the psychiatry workforce population works in child and adolescent, perinatal and youth⁴ [38].</p>
<p>Child and adolescent psychiatrists in private and public practice</p>	<p>The impact of private practice is significant in Australia where approximately one third of child and adolescent psychiatrists work exclusively in private practice, and a quarter work in a mix of public and private settings [38]. In New Zealand, fewer than 10% of child and adolescent psychiatrists do any work in private settings [38]. It is necessary to improve understanding of and promote the role of child and adolescent psychiatry private practice, including the impact of how private psychiatry services may impact on the needs of the community and or</p>

⁴ All child and adolescent psychiatrists are recognised general psychiatrists and general psychiatrists are recognised as having some competence in providing psychiatry services to all age groups, including young people. Therefore it is expected that many psychiatrists will work across various age groups.

	public child and adolescent mental health services, including psychiatry workforce numbers.
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Shortfall of child and adolescent psychiatrists to meet mental health needs of the population

There is a confirmed shortage of child and adolescent psychiatrists as well as a shortage of child and adolescent psychiatry training posts [15] with coverage particularly poor in New Zealand and the Northern Territory and in all rural and remote areas. In Australia child and adolescent psychiatry has been identified as a specialty where there are/will be barriers to training sufficient numbers [15].

The skills shortage is not unique to child and adolescent psychiatry but exists across the entire mental health sector in both Australia and New Zealand. A number of reports have identified the key issues including an ageing workforce and reliance on overseas trained specialists to meet psychiatry workforce needs [15, 39-41]. In addition shortage of child and adolescent psychiatrists, like in all areas of psychiatry, is compounded by maldistribution in rural and metropolitan areas. Psychiatrists aggregate in major cities [15, 42] and access to psychiatrists in rural areas is particularly poor. Initiatives to address rural workforce shortage, for example telehealth, exist and continue to try to address access issues across all areas of psychiatry.

Estimated requirements to meet mental health needs of young people

- In Australia, in 2014, just over half of children and adolescents with mental disorders saw a health professional, with 7.1% of those seeing a psychiatrist [5]. Whilst there has been a significant increase in service use by children and adolescents with mental disorders between 1998 and 2014 [5], a large proportion of children with mental disorder are still not seen by a psychiatrist even when clinical need indicates this as optimal care. Of the over 80,000 children with a severe disorder over a 12 month period, only 22,000 had seen a psychiatrist (27%) indicating that access to specialist care remains a persistent problem. It is suggested that at least 70% of children with a severe mental disorder should be able to see a psychiatrist, even if their care may be being managed primarily by other mental health professionals⁵.
- The New Zealand Werry Centre for Child and Adolescent Mental Health's most recent biennial stocktake indicated a current shortfall of nearly 400 FTE clinicians to meet community infant, child and adolescent mental health needs as recommended in the *Blueprint for mental health services in New Zealand* [16, 43]. 7% of this shortfall is in psychiatry. This accounts for approximately 30 child and adolescent psychiatrists, which is a significant shortage. This does not take into account child and adolescent psychiatrists working in inpatient settings.
- There are a diverse range of comparisons for child and adolescent FTE that can be applied across Australia and New Zealand either within these countries or internationally, but no agreement of one particular model or methodology. Table 2 illustrates recommendations that do exist. It is however important to recognise the funding differences between Australia, New Zealand, Europe, the UK and the USA that will impact on models. In the UK all services are publicly funded and provided through multidisciplinary teams, and services are largely driven by public funding availability. In the USA almost all services are private with the vast majority of psychiatrists working in sole practice, with the

⁵ See endnote for assumptions and methodology.

numbers essentially driven by the market. Australia has a mixed model, while in New Zealand services are primarily publicly funded.

Table 2: National and international FTE recommendations

Country	Psychiatry FTE recommendations
New Zealand	2.0 psychiatry FTE per 100,000 is for community CAMHS [16, 43] – does not include inpatient services
UK	3.6 – 4.8 FTE child and adolescent psychiatrists per 100,000 population [44, 45]. These recommendations are made for community CAMHS aged up to 18 which, whilst including young people with complex mental health needs, does not include services specialised in residential, day-patient or out-patient settings for young people with severe and/or complex mental illness.
USA	12.0 FTE child and adolescent psychiatrists per 100,000 population [46, 47] for comprehensive care across the spectrum of need. However currently every State in the US but one falls well short of this recommendation with availability of child and adolescent psychiatrists variable between 1.5 FTE and 6.0 FTE per 100,000 population.
	Child and Adolescent Mental Health Services (CAMHS) FTE recommendations
Australia (New South Wales)	18.2 FTE for a CAMHS service includes all mental health clinicians, interpreted from estimates that the resources required for comprehensive CAMHS service provision, including prevention and early intervention, are 65 FTE per 100,000 <18 year-olds, which is estimated as 18.2 FTE per 100,000 total population ⁶ [48].
Australia (South Australia)	947 FTE for tertiary-level mental health services for the 365,000 people aged 0–17 [1]. This equates to 260 FTE per 100,000 population aged 0–17, which is estimated as 72.8 FTE per 100,000 population ⁷ . This estimates that FTE should be increased more than five times the current service level [49]. <i>[note this study was a needs-based workforce model assuming 100% coverage for the population]</i>

- Whilst it is acknowledged that there are differences between health care and training systems, these recommendations provide a useful comparison and identify clearly that currently available child and

⁶ If based on the UK model of 15–25% psychiatrist input for each CAMHS service, this would require approximately 2.5 – 4.5 psychiatry FTE per 100,000 population

⁷ If based on the UK model of 15–25% psychiatrist input for each CAMHS service, this would require approximately 10.0 – 18.0 psychiatry FTE per 100,000 total population

adolescent psychiatrist FTE for both Australia and New Zealand are significantly lower than targets recommended for other developed nations.

- Switzerland currently has the highest ratio of child and adolescent psychiatrists per 100,000 individuals in the population aged <14 years at 48.3 [50]. Assuming this equates to between 15–20% of the population, it is equivalent to approximately 7.0–9.5 FTE child and adolescent psychiatrists per 100,000 population.

Making FTE child and adolescent psychiatrist recommendations for Australia and New Zealand

- The Faculty of Child and Adolescent Psychiatry (FCAP) has not made definitive recommendations about the number of child and adolescent psychiatrists required to meet the mental health needs of young people in Australia and New Zealand at this point. It is acknowledged that making such recommendations is complex owing to a number of variations and assumptions within the population and prevalence data (see endnote)¹. The RANZCP will however, in collaboration with relevant partners, continue to develop this work, for example through seeking engagement with the National Mental Health Services Planning Framework [51].
- Given the issues raised in this paper, it is clear that there is a need for a substantial increase in the number of child and adolescent psychiatrists in Australia and New Zealand.
- In making FTE recommendations it is important to note that consideration of the number of child and adolescent psychiatrists required is only one aspect of addressing the workforce shortfall. Other important factors include: sharing the workload (with adult psychiatrists, general practitioners, paediatricians and other mental health professionals); models of care that exist in different jurisdictions, workload distribution and specialist services (e.g. inpatient services, intensive outreach teams, and specific services associated with child protection and youth justice). There is also need to consider the changing face of the workforce acknowledging adjustments needed for flexible and part-time working arrangements.
- Local and regional variation must be considered with figures adjusted higher to account for:
 - rural, socio-economically disadvantaged, Aboriginal and Torres Strait Islander, Māori, Pacific Islander, and culturally and linguistically diverse (CALD) populations
 - specialty services for young people with intellectual disability, forensic difficulties, substance use, children in out-of-home care or detention, consultation-liaison, and intensive community care or hospital avoidance programs.

There are limited data available on the required FTE to meet the needs of these populations, and further work is required to make specific recommendations for the Australian and New Zealand context. Data that are available from the UK include a recommendation for an additional 0.5 FTE per 100,000 population for intellectual and developmental disability community service (not including training and administration). The UK also recognises the need for further provision in areas where there are in-patient services, with recommendations for a further 2.0 FTE for a 12 bedded in-patient (Royal College of Psychiatrists, 2013).

- Consideration of recommendations for child and adolescent psychiatrists should also consider the needs for their involvement in:

- perinatal and infant psychiatry, acknowledging that both child and adolescent psychiatrists and adult psychiatrists are involved in perinatal psychiatry. This demand requires ongoing review given the rapidly emerging evidence of the importance of early in life interventions and the need to invest further in services for this age group [52].
- youth psychiatry (aged 18–24 year olds), noting again the involvement of child and adolescent psychiatrists and adult psychiatrists in this field. The prevalence of mental disorders in this age group [6] is nearly double that of the 4–17 age group, and there is an increase of incidence of severe mental health disorders as well as co-morbidity of disorders in this age group (Royal College of Psychiatrists, 2013).
- It is acknowledged that to achieve a substantially increased FTE per 100,000 population for child and adolescent psychiatrists would require a significant input of resources, and that shortages also exist in other areas of psychiatry and maldistribution is an issue for all subspecialties. It is further recognised that current training pathways may provide insufficient opportunities to meet with FTE need. This paper is intended to contribute to the discussion to inform RANZCP advocacy for training priorities and workforce capacity development. Efforts to increase the supply of child and adolescent psychiatrists in rural areas should be coordinated with the overall strategy to increase the rural workforce, to avoid simply drawing resources away from other underserved areas [53].

Conclusion

Addressing the workforce shortage for child and adolescent psychiatry requires specific workforce planning including targets, priorities, timelines and strategies, together with greater investment. Whilst changes in mental health care delivery and shifts in government policy may change such projections, such as through implementation of the National Disability Insurance Scheme and activity based funding (in Australia), and the increasing emphasis on children's health in New Zealand [13, 54], currently available projections predict a significant shortfall in the foreseeable future.

Collaboration with, and changing practices in primary care and paediatrics will also have an impact on the demand for child and adolescent psychiatry; most likely increasing demand further [55, 56]. It is clear that a shortage of child and adolescent psychiatrists is likely to remain a key issue particularly as demands increase due to greater need in areas relating to child protection, family violence, out of home care, juvenile justice and family disturbance (including family separation, substance use and parental mental illness). The growing needs of Aboriginal and Torres Strait Islander peoples, and increasing populations of Māori and Pacific Islander young people, with a disproportionate levels of poor mental health outcomes also has relevance and will require consideration of how to expand the child and adolescent psychiatrist workforce from these population groups. Whilst the need for greater investment has been acknowledged and a range of workforce initiatives are being implemented [57], further work in this area is required.

This discussion paper is based on best available data and it is acknowledged that many assumptions have been made. Future work required will include determining the workforce available within the private sector, the impact of part-time working patterns, how much higher the needs are in particularly vulnerable populations, and determining how child and adolescent psychiatrists interact with other psychiatrists, doctors and health professionals

The RANZCP will use this document to advocate for measures that address the shortages in child and adolescent psychiatry in Australia and New Zealand, to promote government and other relevant groups' initiatives to meet the mental health needs of young people.

Points for consideration

To help address increasing the child and adolescent psychiatry workforce to better meet the needs of the community in Australia and New Zealand the RANZCP' Faculty of Child and Adolescent Psychiatry (FCAP) will consider:

- Advocacy to substantially increase the number of child and adolescent psychiatrists in Australia and New Zealand.
- Working collaboratively with relevant bodies to improve the data availability and quality so that more definitive workforce recommendations can be made which take into account private practice, part-time working arrangements, administrative demands and time spent undertaking research.
- Advocacy for child and adolescent psychiatrists to be involved in strategic planning in relation to child and adolescent mental health policy and workforce planning. This includes advocating for the need for a representation from infant, child and youth psychiatry with the Chief Psychiatrist's office in all states in Australia and New Zealand, with appointment of a Deputy Chief Psychiatrist where possible.
- Advocacy to propose that all governments develop jurisdictional modeling in relation to the child and adolescent psychiatry workforce that take account of rural, remote and metropolitan unmet needs using measures such as rurality and deprivation indices and that governments identify appropriate models of care for high risk child and adolescent populations including those who:
 - are clients of child protection
 - are clients of youth justice
 - have intellectual disability and neurodevelopmental disorders
 - have alcohol and substance use disorders
 - have comorbid severe physical illness including those who require consultation–liaison psychiatry input in a paediatric setting
 - are the child of parents with mental illness and/or substance use disorder
 - have experienced trauma or family violence
 - live in a rural or remote settings
 - are from CALD populations, including refugees and asylum seekers and
 - are Indigenous or from a Pacific Island population.
- Identifying incentives and barriers to recruitment, training and retention at undergraduate, postgraduate and mid-career levels to promote recruitment and retention of the child and adolescent psychiatry workforce. Specific strategies should be targeted for medical students and junior doctors who are Aboriginal and Torres Strait Islander, Māori or Pacific Islander.
- Delivering projections for the child and adolescent psychiatry workforce to meet the needs of Aboriginal and Torres Strait Islander, Māori and Pacific Islander populations.
- Improving understanding of and promote the role of child and adolescent psychiatry in private practice, including the impact of how private psychiatry services may impact on the needs of the community and or public child and adolescent mental health services, including psychiatry workforce numbers.

- Supporting and encouraging the recruitment, training and retention of mental health workers into other disciplines working in child and adolescent mental health services including, but not limited to, nurses, psychologists, social workers and occupational therapists, paediatricians and GPs in partnership with other Colleges and professional associations.
- Working collaboratively with carer and consumer organisations to optimise the child and adolescent mental health workforce to improve outcomes for young people with mental illness.
- Promoting efforts to increase the provision of child and adolescent psychiatrists in rural areas in keeping with overall strategies to increase rural workforce.

Training considerations

- Exploring ways to expand the number of child and adolescent psychiatry training posts
- Encouraging trainees to undertake dual certificate training i.e. child and adolescent psychiatry and forensic psychiatry, or child and adolescent psychiatry and consultation–liaison psychiatry to meet the expanding needs in those areas.
- Considering opportunities for improved collaboration and training with other relevant health and medical practitioners and organisations, including the RACP to support the Paediatric and Child and Adolescent Psychiatry Dual Fellowships Training Program.
- Partnering with the Section of Youth Psychiatry to develop a plan for enhancing and promoting appropriate training in youth mental health.
- Partnering with the Section of Perinatal and Infant Psychiatry to develop a plan for enhancing and promoting appropriate training in perinatal and infant mental health.
- Partnering with the Section of Psychiatry of Intellectual and Developmental Disabilities to Develop plans to strengthen training in intellectual and developmental mental health.
- Partnering with the Section of Child and Adolescent Forensic Psychiatry and the Faculty of Forensic Psychiatry to strengthen training in and child and adolescent forensic mental health.
- Promoting training posts that support child and adolescent academic opportunities for training in academic psychiatry to improve research in infant, child, adolescent and youth mental health.
- Aligning child and adolescent psychiatry training and workforce development with wider efforts to address maldistribution and inequity in healthcare.
- Supporting training through local service developers (e.g. Primary Health Networks in Australia and Primary Health Organisations in New Zealand) and how to best participate in comprehensive child and adolescent psychiatry service delivery.

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This information is intended to provide general guidance to practitioners, and should not be relied on as a substitute for proper assessment with respect to the merits of each case and the needs of the patient. The RANZCP endeavours to ensure that information is accurate and current at the time of preparation, but takes no responsibility for matters arising from changed circumstances, information or material that may have become subsequently available.

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ⁱ Methodology and assumptions

The paper was developed by experienced Australian and New Zealand child and adolescent psychiatrists within the RANZCP FCAP based on their broad experience with clinical, administrative and academic child and adolescent psychiatry. It is not intended to be a comprehensive study of supply and use of mental health services and the related workforce. There are a number of assumptions and limitations (including the availability and quality of data). It is argued that, at this time, the information provided is the best available to facilitate planning and decisions about future workforce and that it can be refined over time with further data and consultation.

The number of child and adolescent psychiatrists available in Australia and New Zealand is based on accredited members of the FCAP, e.g. those who have undertaken RANZCP Advanced Training in child and adolescent psychiatry, or who are recognised as having eminence or special expertise in this field

The 2014 RANZCP Workforce Survey was used to determine working patterns of child and adolescent psychiatrists (including public–private mix), as well as proportion of psychiatrists working across age groups. This was completed by 1,228 Fellows and Affiliates in Australia and New Zealand, about 35% of the total number eligible to respond so caution needs to be used in interpreting these figures.

The estimated number of current FTE per 100,000 is based on accredited members of the FCAP divided by population data. Population data is based on Australian Bureau of Statistics data and Statistics New Zealand data, correct as at February 2017. This methodology has several limitations. It is assumed that each accredited member of the FCAP represents a FTE (e.g. it has taken no account for part–time working) and the figures take further no account of geographical location or distribution of psychiatrists. It also does not take into account child and adolescent psychiatrists who are not accredited members of the FCAP, which includes overseas trained psychiatrists. These figures are therefore approximate, but probably overestimate the availability of the workforce. FTE per 100,000 population was chosen as this figure appears to be the most utilised for comparisons internationally. It is however acknowledged that international figures also refer to FTE per 100,000 young people. Where this is the case, these figures have been aggregated to FTE per 100,000 population.

Utilising the Commonwealth of Australia report on the second Australian child and adolescent survey of mental health and wellbeing (2015) the FCAP calculated that of the over 80,000 children with a severe disorder over a 12 month period, only 22,000 had seen a psychiatrist (27%). The FCAP suggests that at least 70% of children with a severe mental disorder should be able to see a psychiatrist, even if their care may be being managed primarily by other mental health professionals. This is based partly on clinical experience but also the Fifth National Mental Health and Suicide Prevention Plan (2017) that acknowledges that many people with severe and complex mental illness still do not receive the supports they need. In addition, the National Mental Health Service Planning Framework (2019) acknowledges a greater proportion of people with moderate and complex disorders require specialist psychiatric care, with 75% requiring a comprehensive mental health assessment by a psychiatrist. Acknowledging this is for adults aged 18–64, the FCAP suggests that comparable figures could be applied for children and adolescents, and suggests further work on this service need be considered as part of future planning.