The Royal Australian & New Zealand College of Psychiatrists

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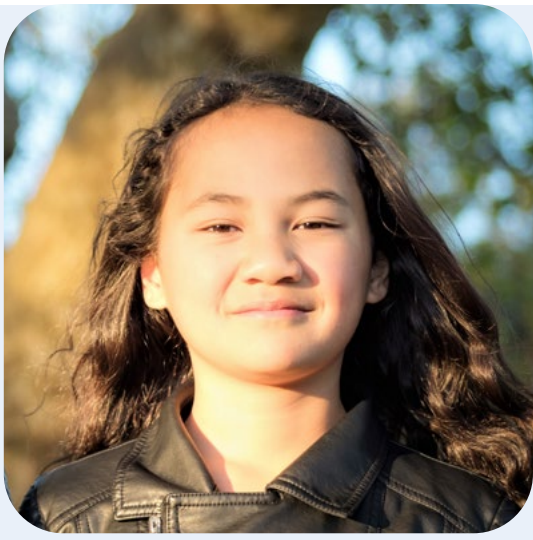
RANZCP Faculty of Child and Adolescent Psychiatry

A Call to Action on the CAP Workforce



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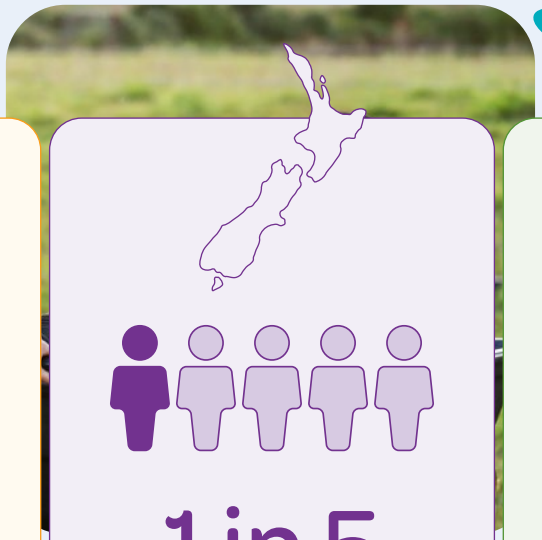


1 in 7

Australian children have a mental health disorder

1 in 5

New Zealand children have a mental health disorder

$13.64

In social and economic benefits returned for every $1 invested in CAP.

Evidence Used to Inform This Report

This report draws on peer-reviewed literature, national databases from the Australian Institute of Health and Welfare (AIHW), the Australian Bureau of Statistics (ABS), the National Mental Health Service Planning Framework (NMHSPF), the Medical Council of New Zealand (MCNZ) and Health New Zealand | Te Whatu Ora; Royal Australian and New Zealand College of Psychiatrists (RANZCP) membership data and Fellow survey results; structured stakeholder consultation with the RANZCP Faculty of Child and Adolescent (FCAP) Committee members and senior child and adolescent psychiatrists (CAPs) across all jurisdictions; and a conservative Social Return on Investment (SROI) analysis using a Benefit-Cost Analysis framework with a benefit transfer approach.

Where precise data is unavailable (particularly for Aotearoa New Zealand where comprehensive CAP-specific national data collection does not exist), conservative estimates are used and clearly identified. Key terms are defined in Appendix A of this report. The SROI result should be interpreted as lower bound estimates of the true economic value of CAP workforce investment. Full methodology for the CAP workforce estimates and SROI are available upon request from policy@ranzcp.org.

Executive Summary

Australia and Aotearoa New Zealand face a deepening child and adolescent mental health crisis. The specialist workforce is critically insufficient, underfunded, poorly distributed, with the gap between supply and demand widening consistently. This report synthesises the findings of the RANZCP Faculty of Child and Adolescent Psychiatry's (FCAP) 2025 bi-national workforce project, making a clinical, economic and social case for urgent action.

Key Findings

The need is large and growing: Approximately one in seven Australian children and one in five New Zealand children are experiencing a mental health disorder. Prevalence is rising, complexity is increasing, and early intervention capacity has effectively been withdrawn from much of the system.

Child and adolescent psychiatrists (CAPs) are irreplaceable: They are the only medical specialists trained to treat the full range of serious mental health conditions in children: from eating disorders and depression to ADHD and autism with complex needs; and the only profession that can prescribe, authorise involuntary treatment, and lead multidisciplinary teams.

The workforce gap is severe and widening: Australia faces an estimated unmet need of at least 230 CAP FTE (full-time equivalents) by 2028. Aotearoa New Zealand has CAP vacancy rates of 24% in public child and adolescent mental health services (CAMHS).

The consequences fall hardest on those most vulnerable: Children in rural areas, First Nations young people, disabled children, and those in low socioeconomic areas that have the least access to specialist care.

Investment delivers exceptional economic returns: The Social Return on Investment (SROI) of expanding the CAP workforce is estimated at $13.64 for every dollar invested, marking one of the highest return interventions available to government.

Key Recommendations

The following recommendations are directed at governments and health systems across Australia and Aotearoa New Zealand:

- Increase funded CAP FTE in public CAMHS services and ensure competitive remuneration to attract and retain psychiatrists in the public sector, reducing workforce shortages and reliance on locums.
- Fund additional CAP registrar positions and protect the Commonwealth Specialist Training Program (STP) which supports up to one-third of trainee positions in some jurisdictions.
- Request national registration bodies (AHPRA and the Medical Council of New Zealand) publish psychiatry workforce data broken down by patient age group (0–17 years), so the true workforce gap can be accurately measured.
- Close equity gaps in access to services by funding targeted outreach models such as telehealth, culturally responsive service models, and rural workforce incentives.
- Recognise CAP workforce expansion as a high-return public investment, with modelling indicating an estimated $13.64 social return for every dollar invested.
- Introduce health insurer rebate parity for child and adolescent psychiatry services in Aotearoa New Zealand, comparable to paediatric specialist rebates.

1. The Scale of the Need

1.1. Mental health disorders are common and starting earlier

Poor mental health is not a rare occurrence in childhood and adolescence. Approximately 50% of all mental health disorders emerge before the age of 14, and 75% by the age of 25(1,2). The peak age of onset for any mental disorder is 14.5 years, a stark reminder of why early access to specialist care is critical(3).

In Australia, rates of mental health disorders in children and young people increased from 13.9% to 14.9% between 2013-2014 and 2023(4). Moderate and severe disorders, those most likely to require specialist CAP involvement, increased disproportionately. About 9.8% of Australian children aged 4-17 years are estimated to need mental health services(4). CAP services primarily target severe cases and a proportion of moderate, meaning any rise in severity directly increases demand for specialist psychiatrists.

Comparable comprehensive national prevalence data for Aotearoa New Zealand is not currently available. However, the 2024-25 New Zealand Health Survey reports(5) that 12.4% of children 2–14 years are likely to have emotional and/or behavioural problems, with disproportionate rates of 52.3% among children with disability. Between 2011-2012 and 2021-2022, anxiety disorders and emotional/behavioural problems have nearly doubled.

1.2. More young people need care

Demand for CAP services is increasing as mental health issues in children and young people rise globally. This trend began in the early 2010s, before COVID-19, with growing rates of anxiety, depression, psychological distress, self-harm, and suicide(7).

1.3. Suicide and self-harm remain key concerns

Youth suicide rates in both countries remain high, relative to comparable nations. In Australia suicide as a share of all deaths increased for children aged 0-14 years (from 1.3% to 2.1% between 2013 and 2023). Youth self-harm rates are particularly high in Australia, with females 15-19 years having the highest rate for all age groups(9,10).

Both countries have among the highest levels of illness and disability from mental health and substance use disorder in young people under 20 years in comparison to other high income countries(7,11).

1.4. Inequities drive unmet need

Some groups face greater disadvantages and are less likely to get the care they need:

- **In Australia**: First Nations young people, culturally and linguistically diverse youth, those in rural and remote areas, and young people with complex needs (including disability, juvenile justice, or out-of-home care)(12).
- **In Aotearoa New Zealand**: Māori, Pacific peoples, people with disability, and those in highly deprived areas(5).

Females are also disproportionately affected in both countries(5,9,13).

2. The Workforce Gap

2.1. Current workforce estimates

Using RANZCP membership, CAP estimates are:

- 657 CAPs (586 FTE) working in Australia in 2025, 11.2 per 100,000 children aged 0-17.
- 79 CAPs (70.5 FTE) working in NZ in 2025, 6.7 per 100,000 children aged 0-17.

The absence of national data collection by patient age group means these figures cannot be confirmed with precision. Child and adolescent psychiatrists make up only 13.1% of the psychiatry workforce in Australia and 11.4% in Aotearoa New Zealand, even though children and adolescents are about 20–22% of the population. Both countries' rates are above the OECD average(11).

2.2. The gap is severe and widening

There is a major gap between the need for specialist care and the available workforce. In Australia, National Mental Health Services Planning Framework (NMHSPF) modelling indicates a 19.6% undersupply of psychiatrists overall in 2024(14). Applied to the 0-17 population, this produces a conservative estimate of **at least 230 fewer CAPs than needed by 2028**, and this is likely to underestimate the true gap, as shortfalls are known to be larger for children and older people.

A comparable analysis does not yet exist for Aotearoa New Zealand. However, the 2024 Stocktake of Infant, Child and Adolescent Mental Health Services found that CAPs had the highest vacancy rates of all professions: 21% in 2022, rising to 24% in 2024(15) while psychiatry FTE actually decreased by 5% over that period(15).

A 2021 survey of over 540 psychiatrists and trainees in Aotearoa New Zealand found that 94% judged current resourcing as insufficient, and only 3% believed future planning was on the right track(16).

2.3. Very few children see a specialist

The practical consequences of this workforce gap are stark. In 2023–24, only 1.7% of the 0–17 population who required specialist care saw a child and adolescent psychiatrist in a 12-month period, highlighting the significant gap between need and access. For every 571 Australian children with moderate to severe mental illness, there is just one CAP. Research has found that in the 18 months after being identified with a mental disorder, only 11.6% of Australian children had enough contact with health professionals to receive minimally adequate treatment(17).

In Aotearoa New Zealand, 1 in 15 children reported an unmet need for mental health support in the past 12 months(18). Many young people in rural areas cannot access CAPs at all.

2.4. Access is inequitably distributed

The workforce that does exist is heavily concentrated in metropolitan areas(19,20).

Intake criteria in public CAMHS has narrowed dramatically to manage surging acute demand, meaning younger children are routinely turned away as services prioritise adolescents in crisis.

> *"We can no longer see children under 12 years as we've had to prioritise adolescents with more acute and complex issues."* - *FCAP Committee Member*

> *"We see far fewer under 12s than other CAMHS services, few primary school kids, very few pre-school kids ... 85% are 12 and over. More younger kids are seen in private practice."*
> *- FCAP Committee Member*

Early intervention, where clinical and economic returns are highest, has effectively been withdrawn from large parts of the system.

> *"We are so consumed by the urgent and acute that we never get to participate in early intervention, research or quality improvement for our region."*
> *- FCAP Committee Member*

3. The Unique and Irreplaceable Role of the Child and Adolescent Psychiatrist

3.1. Medical expertise and clinical leadership

CAPs are unique in the mental health workforce because they are first and foremost medical doctors. After completing medical training (5–8 years), they undertake specialist training in psychiatry (minimum 5 years) and advanced training in child and adolescent psychiatry (a further 1–2 years). Only CAPS can(22,23):

- Assess, diagnosing and treating the full range of mental health conditions across the spectrum of severity
- Conduct differential diagnosis, including ordering and interpreting medical investigations to exclude organic causes of mental health presentations
- Prescribe medications including Schedule 8 (controlled) medications for ADHD and other conditions
- Authorise involuntary treatment under mental health legislation
- Admit children and adolescents to hospital for voluntary or involuntary care
- Provide legally recognised forensic and medico-legal assessments
- Provide clinical governance and leadership for multidisciplinary teams

3.2. System-level impact

Beyond just direct clinical care, one additional CAP FTE materially influences the care of approximately 250 children and adolescents per year; through consultation, diagnostic clarification, medication review, crisis management, and leadership of multidisciplinary teams(24,25). This is not the number of children receiving ongoing treatment from a psychiatrist; it is the number whose care quality is materially improved by having a CAP in the system.

When CAPs are absent, the consequences extend beyond individual patients. Multidisciplinary teams lose clinical leadership, trainees lose supervision, risk escalates, and the system is forced to substitute costly crisis responses for the early interventions where CAPs add the most value(22,23).

> *"Child and adolescent psychiatrists bring a unique combination of psychopharmacological, psychological, and developmental expertise — whole-system thinking and high-stakes decision-making. We hold biological, psychological, social, and family factors together, and we work across acute, community, and private settings. Because of that, we understand the whole system and the risks within it."*
>
> *- FCAP Committee Members*

4. The Economic Case for Investment

4.1. Overview

A conservative Social Return on Investment (SROI) analysis was conducted to understand the financial value of investing in additional CAP workforce capacity. The analysis found that each additional CAP FTE generates an estimated **$5.85 million in lifetime social and economic benefits**, equivalent to a **social return of $13.64 for every dollar invested**.

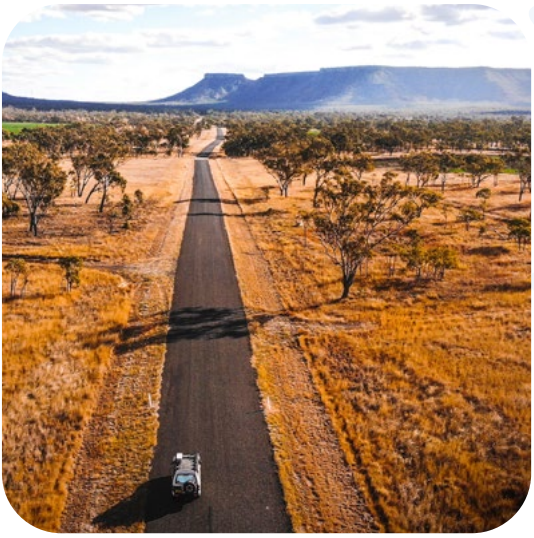
The modelling identified three key sources of benefit:

- Reduced use of high-cost health services, including emergency department presentations, inpatient admissions and severe self-harm.
- Improved parental workforce participation through reduced caring responsibilities.
- Improved educational attainment and lifetime productivity through better mental health outcomes for children and young people.

Benefit Category	Estimated lifetime benefit per CAP FTE ($AUD)
Reduced mental health system use *(250 young people influenced per year)*	$501,400
Increased parental workforce participation *(Reduced care burden on families)*	$1,648,700
Improved education and lifetime productivity *(Improved Year 12 completion rates)*	$3,704,160
Total:	**$5,854,260**

These estimates are intentionally conservative and exclude several potential benefits, including physical health improvements, reduced National Disability Insurance Scheme (NDIS) expenditure and justice system savings. As a result, the true value of investment is likely to be higher.

Mental illness emerging in childhood and adolescence creates lifelong impacts on health, education, employment and wellbeing. Investing in the CAP workforce is therefore not only clinically necessary but also represents a high-value long-term investment in future generations.



5. Challenges Facing the CAP Workforce

Consultations with CAPs across all Australian jurisdictions and in Aotearoa New Zealand found consistent themes of chronic under-resourcing. The following challenges were commonly reported:

5.1. Inadequate resourcing

All jurisdictions reported that public CAMHS resourcing has not grown in line with population growth, or rising demand for mental health care. As a result, many services are operating with significant workforce shortages, leading to longer wait times, reduced access to specialist care, and increasing pressure on existing staff.

In some jurisdictions, 10-50% of funded psychiatry positions are vacant and must be filled by locums or visiting medical officers. While these arrangements help maintain services, they can reduce continuity of care, disrupt multidisciplinary teams and increase costs.

> *"I have to say no to 5-10 new clients every week in my private practice."*
> *- FCAP Committee Member*

> *"We haven't had an increase in FTE for decades but we have had to stretch our resources to provide CAP services to more settings and more target groups."*
> *- FCAP Committee Member*

These challenges are occurring within a broader mental health workforce shortage. The National Mental Health Workforce Strategy 2022–2032 estimated a 32% shortfall in the mental health workforce shortage against projected need, rising to 42% by 2030 if no action is taken(31).

5.2. A constrained training pipeline

Despite child and adolescent psychiatry remaining the most popular RANZCP subspecialty, structural barriers are limiting graduation rates:

- **Too few funded registrar positions:** Supervision capacity exists in many jurisdictions, but funded positions, particularly in community and rural settings, do not.
- **Geographic barriers to completion:** Mandatory metropolitan inpatient rotations have contributed to high attrition among rural trainees, highlighting the need for more flexible training pathways.
- **Specialist Training Program funding at risk:** In some jurisdictions, up to one-third of registrar positions are STP-funded. The 2026 STP review has generated concern that changes could further reduce pipeline capacity, particularly in regional and rural areas.

5.3. Loss of early intervention capacity

Opportunities to identify and support children early are being lost. Many services that previously provided early intervention have been reduced or withdrawn, meaning children are often referred for specialist care only after their needs have become more complex and acute(12).

Initiatives such as the Thriving Kids program represent an important effort to address this gap, providing earlier access to assessment and support for children before their needs escalate to the specialist level.

5.4. Fragmentation between specialist and primary care

Demand for child and adolescent psychiatry services has grown, particularly for ADHD assessment and medication management, without a corresponding increase in specialist workforce capacity. As a result, families often face long waits and must navigate multiple services before reaching a child and adolescent psychiatrist, by which time mental health needs may have become more severe and complex(12,17).

6. Recommendations

The following recommendations are directed at governments and health systems across Australia and Aotearoa New Zealand. They are grounded in the evidence presented in this report and reflect priorities identified by CAPs across all jurisdictions.

6.1. Increase public sector CAMHS funding and CAP resourcing

- Increase funded CAP FTE in public CAMHS services across all jurisdictions to align with population growth and rising mental health prevalence.
- Ensure competitive and consistent remuneration for salaried CAPs to reduce reliance on locum and visiting medical officer cover and improve care continuity(33).
- Protect and expand non-clinical time for CAPs to enable supervision, training, research and quality improvement.

6.2. Strengthen the CAP training pipeline

- Fund additional CAP registrar positions, particularly in regional and rural areas, and protect the Specialist Training Program (STP) which supports up to one third of trainee positions in some jurisdictions(34).
- Develop flexible alternatives to compulsory CAMHS inpatient unit rotations to enable rural trainees to complete training without relocating.

6.3. Improve workforce data and planning infrastructure

- Request AHPRA, AIHW and the Medical Council of New Zealand to collect and publish disaggregated psychiatry workforce data by patient age group (0–17 years). At present, the truth size of the CAP workforce cannot be confirmed, and this makes evidence-based planning difficult.
- Expand access to the NMHSPF to support CAP-specific workforce planning at national, state and local levels.
- Develop equivalent national workforce planning infrastructure for Aotearoa New Zealand, where no CAP-specific gap analysis currently exists(15).

6.4. Close equity gaps in access to services

- Fund targeted outreach models, telehealth infrastructure and rural workforce incentives to improve CAP service access for children and adolescents in rural, remote and low socioeconomic areas(35,36).
- Develop culturally responsive service models in partnership with First Nations communities (Aboriginal and Torres Strait Islander peoples and Māori) and Pacific communities.
- Support and scale early intervention programs such as the Thriving Kids program, which targets children before they reach crisis point, reducing downstream demand on specialist CAMHS services.
- Ensure that expansion of Medicare Mental Health items is matched with commensurate investment in comprehensive assessment and multidisciplinary treatment capacity.

6.5. Invest in the CAP workforce as high-return public investment

- Recognise CAP workforce expansion as a high-value investment, with modelling indicating an estimated social return of $13.64 for every dollar invested, improving outcomes across health, education, employment, and social services.
- Introduce health insurer rebate parity for child and adolescent psychiatry services in Aotearoa New Zealand, comparable to paediatric specialist rebates, to improve access to care and support private sector capacity(16).
- Recognise and fund CAP workforce expansion as a long-term investment in human capital, with benefits flowing to health, education, employment and social support services.

Conclusion

The evidence presented in this report demonstrates a substantial and growing gap between the need for specialist child and adolescent mental health care and the capacity of the current workforce to provide it. Across Australia and Aotearoa New Zealand, demand for services is increasing, presentations are becoming more complex, and workforce shortages are limiting access to timely specialist care.

The current workforce gap is the result of longstanding underinvestment in a specialist workforce that takes many years to train. Without action, workforce shortages are likely to worsen, placing further pressure on services, reducing opportunities for early intervention, and increasing reliance on more intensive and costly forms of care.

The economic analysis reinforces the clinical case for investment. With an estimated Social Return on Investment of $13.64 for every dollar invested, expanding the child and adolescent psychiatry workforce has the potential to deliver significant benefits across health, education, employment and social services.

The recommendations outlined in this report provide practical actions for governments and health systems to strengthen workforce capacity, improve access to specialist care, and support better outcomes for children, young people and their families. Timely and sustained investment will be critical to ensuring that future service demand can be met and that children and young people receive the care they need, when they need it.

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Appendices

Term	Definition/description
Adolescent	For the purposes of this paper, an adolescent is a person aged 12-17 years.
Affiliate member of RANZCP	Members of the College who are not Fellows, but can access peak body benefits such as training and education, membership of Faculties, Sections, Networks and Special Interest Groups, and participate in mentoring programs, access journals and discounted Congress rates, and so on. In Australia, to apply for Affiliate membership, the person must: • hold either an overseas specialist qualification in psychiatry that allows them to practice as a psychiatrist in the country where they trained, or an Australian Diploma of Psychological Medicine (DPM) qualification granted up until 1994, and • be currently employed as a specialist psychiatrist in Australia (whether as a RANZCP Substantial Comparability candidate on the Specialist Pathway, or otherwise) OR be enrolled with the RANZCP as a Partial Comparability candidate on the Specialist Pathway. In Aotearoa NZ, the person must: • be either provisionally vocationally registered or vocationally registered in psychiatry, and • be currently employed as a psychiatrist, with a current practising certificate.
Advanced Certificate in Child and Adolescent Psychiatry	Qualification with the Royal Australian and New Zealand College of Psychiatrists (RANZCP) to specialise in child and adolescent psychiatry with children and young people aged 0-17 years inclusive (up to 18th birthday) and their families and kin. Takes at least 2 years to complete and participants have up to 6 years to finalise all requirements.
Actual FTE	A filled permanent or fixed term full time equivalent position (excluding casual employees)
Certificates of Advanced Training in psychiatry	These courses allow medical doctors to specialise in an area of psychiatry. Across all certificate programs Trainees and Fellows complete a mix of supervised training, formal education via a course or self-directed learning, and workplace-based assessments. Stage 3 RANZCP Trainees (i.e. those in year 4 or 5 of the 5 year [minimum] course) and Fellows can apply. Specialist International Medical Graduates (SMIGs) on the Specialist comparability pathway need to achieve Fellowship before they can enrol in an advanced certificate.
CAMHS	Child and Adolescent Mental Health Services: publicly funded specialist services providing assessment and treatment to young people with moderate to severe mental health disorders.
CGAS (Children's Global Assessment Scale)	A clinician-rated scale (0–100) measuring overall functioning in children and adolescents, used in this report to anchor estimates of clinical improvement attributable to CAP care.
Child	For the purposes of this paper, a child is an overarching term that includes infants (0 and up to 1 year), toddlers (1-2 years), preschoolers (3-4 years) and children (5-11 years inclusive)[1].
Child and adolescent psychiatrist (CAP)	A medical doctor who specialises in the assessment and treatment of mental health problems in infants, children and young people. In addition to the primary medical degree and mandated experiences in general medicine, child and adolescent psychiatrists have undertaken a minimum of five years of specialty training prescribed by the RANZCP. Child and adolescent psychiatrists undertake specific training leading to the Advanced Certificate in Child and Adolescent Psychiatry(23).

1 A child is generally defined in legal terms as person under the age of 18 years, although some legislation makes a distinction between a child (a person under 16) and a young person (aged 16 to 17 years). Some Acts make special provision for young people up to the age of 21.

Term	Definition/description
Demand	The expressed need for mental health care measured by people seeking services. Demand is impacted by factors such as access, affordability, awareness, help-seeking behaviour and service availability.
Fellow	A medical practitioner who has successfully completed the full specialist training program in psychiatry approved by RANZCP or has met an equivalent standard through an approved pathway. Fellows are fully qualified psychiatrists recognized by the College.
Full-time equivalent (FTE)	One FTE is defined as 40 weekly average hours worked.
National Mental Health Services Planning Framework (NMHSPF)	The NMHSPF investigates the population's need for mental health services and resources required to meet that need. It brings together the best available evidence and expert advice on the: • prevalence of mental illness • need for mental health services • types and levels of mental health care required for different need groups • efficient standards of health service operation to deliver this care. The model classifies the Australian average population into 'need groups' which are based on severity of mental health diagnosis or other identified mental health need, along with functioning. The epidemiology estimates the number of people within each need group who may require mental health services in a year, by age and level of severity. It sets service demand targets for those who require intervention.
Need	The level of mental health services that people or populations must receive to achieve or maintain good mental health. NMHSPF modelling is based on estimated need (see also definition of NMHSPF).
Psychiatrist	A medical practitioner who has completed specialist training in the diagnosis and treatment of mental illness and emotional problems. Treatment may include prescribing medication, brain stimulation therapies and psychological treatment. To practice as a psychiatrist in Australia or Aotearoa New Zealand, an individual must be admitted as a Fellow of the Royal Australian & New Zealand College of Psychiatrists (RANZCP). They may be accredited through the RANZCP Fellowship Program or International Specialist Pathway for Specialist International Medical Graduates (SIMG). They must also be registered in Australia with the Australian Health Practitioner Regulation Agency (AHPRA) or with the Medical Council of New Zealand in Aotearoa NZ.
Royal Australian and New Zealand College of Psychiatrists (RANZCP)	RANZCP (sometimes referred to in this document as 'the College') is responsible for training, educating and representing psychiatrists in Australia and Aotearoa New Zealand. The College is accredited by the Australian Medical Council (AMC) and the Medical Council of New Zealand (MCNZ) to deliver specialist medical education and training, and professional development programs.
Specialist workforce	The AIHW refers to 'Specialist workers' as those providing mental health services directly and may include professionals with tertiary training in a mental health-related field. AIHW reporting referred to in this paper includes psychiatrists, mental health nurses, psychologists, mental health occupational therapists and accredited mental health social workers as specialist workers.

The Royal Australian & New Zealand College of Psychiatrists

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