Child and adolescent psychiatry: meeting future workforce needs*

The Royal Australian & New Zealand College of Psychiatrists

Your Health in Mind

Overview of child and adolescent psychiatry workforce

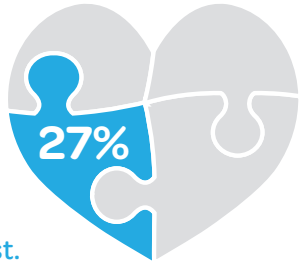
Access to child and adolescent psychiatrist care remains a persistent problem in Australia and New Zealand. There is a shortage of child and adolescent psychiatrists as well as a shortage of child and adolescent psychiatry training posts. Coverage is particularly poor in rural and remote areas.

How many children are affected?

People **under 20** comprise nearly **25%** of the population, whilst child and adolescent psychiatrists represent **only 10%** of the psychiatry workforce.

In Australia and New Zealand, **approximately 15% of children and adolescents experience a mental disorder in a 12-month period;** these figures are internationally comparable.

Of approximately **80,000** **children with a severe disorder** over a 12-month period in Australia, **only 22,000** (27%) had seen a psychiatrist.



Child and adolescent psychiatry workforce gap

In Australia there are approximately 450 child and adolescent psychiatrists, around **35% work exclusively in private practice**, **25% work in a public-private mixed settings**, **40% work exclusively in public practice.**

In New Zealand there are approximately 50 child and adolescent psychiatrists, around **10% work in public-private mix**, **90% work exclusively in public practice.**

It is estimated that there are

1.6 FTE per 100,000 total population in Australia and **1.0 FTE** per 100,000 total population in New Zealand

National and international recommendations range from **2.5 FTE to 18.0 FTE per 100,000 total population**

Working collaboratively

Working alongside other psychiatrists and other medical/health professionals provides a positive impact on the workload and workflow.

- Many children and adolescents are seen by general psychiatrists
- Frequently child and adolescent psychiatrists are involved in perinatal and infant and youth psychiatry services working alongside adult psychiatrists. Approximately 15% of the total psychiatry workforce provides child and adolescent, perinatal and infant, and youth services
- A collaborative approach to child and adolescent psychiatrists' provision of mental healthcare requires engagement with:
  - » other doctors: general psychiatrists, paediatricians, general practitioners
  - » nurses
  - » allied health professionals: psychologists, social workers, speech therapists, occupational therapists
  - » other professionals: education workers, Māori and Aboriginal and Torres Strait Islander health workers
- Child and adolescent psychiatrists actively engage with family, whānau and carers.

Why more child and adolescent psychiatrists are needed

Many more child and adolescent psychiatrists are needed to meet the basic psychiatry needs of young people, and even more are required to meet specialty needs of high-risk groups. Increasing needs include:

Greater role in service provision and engagement in high-risk groups:

- child protection, trauma and family violence
- Māori, Pacific Island and Aboriginal and Torres Strait Islander populations, who have disproportionately poorer mental health and growing youth populations.
- youth justice
- intellectual disability and neurodevelopmental disorders
- alcohol and substance use disorders
- comorbid severe physical illness including consultation–liaison psychiatry in a paediatric setting
- children of parents with mental illness and/or substance use disorder
- children with suicidal behaviours
- culturally and linguistically diverse (CALD) populations, including refugees and asylum seekers
- intensive community care

Changing policy and service models to meet community priorities:

- increased complexity and growing demand for specialist family-centred care
- expansion of child and adolescent mental health services to include youth to age 25 and clinical services for infants and toddlers
- prevention, early intervention and stepped care provision
- holistic care including physical health needs
- expansion of online interventions, e-health and telehealth
- collaborative practice models requiring complex clinical systems of care knowledge and psychiatry leadership
- addressing high rates of deliberate self-harm and suicide prevention
- increased recognition of the impact of child abuse and neglect on development and mental health
- academic research into treatment effectiveness, implementation, and teaching

Top priorities to increase the child and adolescent psychiatry workforce

- Involve child and adolescent psychiatrists in strategic and workforce planning
- Explore ways to expand the number of child and adolescent psychiatry training posts
- Identify incentives and barriers to recruitment, training and retention
- Encourage trainees to undertake dual certificate training
- Promote training and posts for child and adolescent academic careers
- Improve clarity of the role of child and adolescent psychiatry in private and public practice
- Improve data availability and quality to inform workforce planning
- Strengthen links between training in child and adolescent psychiatry and perinatal and infant, youth, intellectual and developmental disability, and forensic psychiatry.
- Develop local modelling including for high-risk populations
- Develop specific strategies for Aboriginal and Torres Strait Islander, Māori, Pacific Island, and rural populations
- Advocate for resources for child and adolescent physical health
- Work in collaboration with other organisations and national mental health workforce strategies being developed in Australia and New Zealand

*Adapted from the Discussion Paper prepared by the Faculty of Child and Adolescent Psychiatry - Child and adolescent psychiatry: meeting future workforce needs (June 2019)