Workforce planning for children and young people's mental health care

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Mental health problems and disorders start in childhood and adolescence and can have lifelong effects.[1] Exposure to trauma in childhood might be psychiatry's greatest public health challenge—as Sara and Lappin recently stated in *The Lancet Public Health*.[2] Yet services to adequately address this health problem, and mental disorders in general in young people, are scarce.

In their Article in *The Lancet Public Health*, Leonie Segal and colleagues[3] outline their needs-based workforce model for effective delivery of community mental health care to infants, children, and adolescents in South Australia. This study is timely given that child mental health disorders affect one in seven of the population aged 4–17 years in Australia.[4] The study adds to the group's interest in developing models for workforce planning[5] and in quantifying the population effect of exposure to risk factors in childhood on adult mental health.[6] In a previous study,[7] this group showed that the mental health needs of the youngest age groups (0–4 years) are underserved by a factor of ten compared with those of youth (18–24 years).

Segal and colleagues[3] applied their model to a population aged 0–17 years, which was chosen based on the most common age range for Child and Adolescent Mental Health Services (CAMHS) in the UK and Australia. The model used diverse, high-quality data sources and included the prevalence of mental disorder, as well as cut-points for maternal psychological distress (to derive need in the first 2 years of life) and data from psychological screening instruments. The authors found increased need in late adolescence, which is consistent with epidemiological data.[4]

The systematic approach used by the authors to establish patient complexity and consider its developmental context is novel. The population of children and young people with tertiary-level needs in the study was very large. Policy settings, such as those in the Australian Government Department of Health's Fifth National Mental Health and Suicide Prevention Plan,[8] have assumed a key role for primary-level services in addressing the burden of mental disorders in children and adolescents, but evidence for the effectiveness of this approach is scant.[9] Models of care for this age group have not been well developed or adequately tested, neither across the age range nor across tiers of care.[10] Substantial investment in primary mental health care for youth aged 12–25 years in Australia has resulted in only modest effects.[11] Additionally, despite access of youth to primary care increasing greatly in the country, the population prevalence of mental disorders has not yet decreased.[12] At present, data are insufficient to compare the relative efficacy and cost-effectiveness of different service models, so the fact that the scope of care in this study[3] was referred to as tertiary-level mental health needs is novel. However, as the authors note,[3] the unmet need for this population does not necessarily justify only a tertiary service response, but may require other service responses, providing that high-level workforce competencies are available in the workplace.

Segal and colleagues[3] challenge existing estimates of workforce need, estimating that they should be increased more than five times the current service level. In calculating these estimates, the authors assume 100% coverage of the population, but existing planning frameworks, such as Australia's Draft National Mental Health Services Planning framework,[8] estimate 100% coverage only for those with the most severe disorders, 80% coverage for moderately severe disorders, and 50% coverage for mildly severe disorders, generating smaller workforce estimates. Other commentators have also noted the short-fall in the skilled workforce to address the need in clinical service delivery in the context of escalating demand for services.[13,14]

The study[3] places greater emphasis than usual on the patient journey and clinicians' consensus to delineate clinical pathways and roles. Another approach in Australia, albeit in adults, has taken diagnosis as the cut-point and identified best-practice treatment from published guidelines.[15] Segal and colleagues' case for downplaying practice guidelines in their model is contentious, but has some support in the literature on children and adolescents.[16] As their findings are systematically derived, they will likely spark active debate, some controversy, and further research to inform workforce planning to adequately meet the needs of children and adolescents. It seems quite

possible that meeting these needs will require a much greater investment in the workforce than previously considered.

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