Background

Rural psychiatry is an important and distinctive context for psychiatric practice. In addition to implementing strategies that address the challenges of rural psychiatry, the RANZCP advocates the promotion of the potential benefits of rural practice including: lifestyle and leisure factors; sense of community; sense of altruism; and the opportunity for better patient relations and more diverse work experiences.

- Rural psychiatrists often operate as generalists, working with patients across all age ranges and treating a wider array of issues than psychiatrists in the city.
- Management of patients is more likely to involve the psychiatrist working more closely with primary carers and the community to cover large geographical areas and a dispersed population. This occurs particularly in rural and remote areas, where the psychiatrist carries increased clinical responsibility for patients, particularly where there are fewer clinical supports.
- Rural psychiatrists may be involved in travelling out to remote areas, and/or transferring patients to larger centres for treatments unavailable in the local region, which can give the perception of reduced work efficiency.
- Māori, Aboriginal and Torres Strait Islander mental health is a significant issue, as a higher proportion of Indigenous people live in socially and/or geographically disadvantaged areas. They often have complex needs and multi generational abuse and loss issues.
- Telepsychiatry can be an important aspect of practice, with communication technology being used to work with patients and their carers from a distance (RANZCP 2014).
- The rural environment can affect the aetiology or manifestation of an illness (e.g. the effects of isolation in remote areas, the impact of drought, or the social pressure in a small town environment). People living in rural, remote and often dispersed localities are often presented with unique challenges in arranging access to appropriate mental health care and treatment.
- At times of severe stress and economic hardship in rural communities there will continue to be an increased demand for psychiatric services.

Evidence

There is a severe shortage of consultant psychiatrists in rural Australia and in provincial areas of New Zealand, due to most people exercising a strong preference to live and work in major cities. Trainee psychiatrists also report a clear inclination to practice in capital cities or urban centres (ABS 2007).

The most recent data on the issue showed that major cities have approximately 22 FTE employed psychiatrists and psychiatrists-in-training per 100,000 population, while for inner regional areas that figure was six per 100,000 population, and three per 100,000 in outer regional and remote areas (MHWAC 2008). The more remote the location, the worse the access is to psychiatric services (Hilton et al 2010; Kulkarni 2010). In New Zealand, 85% of the available psychiatrists are servicing 69% of the population, leaving 15% of psychiatrists to service 31% of the population living in rural New Zealand.
Challenges of rural practice include: professional isolation; social and family factors (including difficulties with spouses obtaining employment); career opportunities; size of patient base; burden of travel to outreach services; lack of specialist positions at regional hospitals; and remuneration (HWA 2012; DoHA 2008; Levitt 2003).

Factors contributing to professional isolation may relate to deficits in after hours and sickness cover, peer support and review, access to ongoing educational and professional development, opportunities to train registrars and to have junior medical staff backup, collegiality, and the impact of chronic shortages on sustainable workloads.

For the reasons stated, rural and remote settings are almost inevitably areas of unmet need, leading to a situation where a significant number of International Medical Graduates (IMGs) are employed. This can introduce additional cultural and language issues, which can accentuate problems of professional and social isolation for practitioners.

The extent of the effect this has on service provision to the local population does vary between the different States and Jurisdictions in Australia, as well as between different areas in New Zealand, as does the model of service delivery. One pertinent example is the New South Wales Rural Psychiatry Project, whose outcomes demonstrated that, with the commitment of government funding and support, better access to psychiatry can be delivered in rural areas (RANZCP 2010).

**Recommendations**

While psychiatrists have the right to choose where they live and work, the profession has a responsibility to strongly advocate for equitable community access to well-trained psychiatrists across Australia and New Zealand. Therefore the RANZCP recommends a range of strategies relating to training, workforce, and innovative models of service delivery that are aimed at enabling rural communities to access a full range of mental health services as near to their place of residence as possible.

**Training:**

The RANZCP has identified a number of strategies to promote rural, regional and remote psychiatry through training which include:

- Increasing the numbers of medical students with a rural background in proportion to the population by establishing enrolment targets and weighting of enrolment criteria in favour of regional/rural students.
- Investing in integrated rural psychiatry training centres, such as the Hunter New England Training Network, to facilitate more trainees undertaking their psychiatry training entirely in a rural area, increasing the likelihood that they will continue with rural psychiatric practice.
- Increasing the availability of longer rural clinical placements for trainees and improving the capability of rural mental health services to accept psychiatry trainees.
- Improving the support provided to trainees working in rural and remote settings including information and orientation, internet access, peer support via the internet, good supervision, mentoring, access to CPD and educational material, adequate accommodation, travel assistance, promotion of telepsychiatry training opportunities, increased opportunities for advanced training in rural and remote settings and financial assistance to cover additional costs that are often involved in re-locating.

**Recruitment and retention:**

The RANZCP recommends further government funding and grants aimed at improving the recruitment and retention of rural psychiatrists such as:
Increasing the level of support to psychiatrists who reside and practice in rural areas, specifically in relation to providing access to continuing professional development and access to locum support. This is particularly relevant to IMGs who may require further support in terms of academic requirements and supervision.

Increasing financial incentives to psychiatrists who reside and practice in rural areas.

Supporting employers to offer competitive salary packages (and relocation costs) to attract psychiatrists to rural areas.

Encouragement of health services to develop policies and procedures to assist in finding employment for a psychiatrist’s partner. These are to be developed to enable couples to be recruited and once recruited to be retained in rural and remote locations.

**Continuing Professional Development:**

A range of CPD resources and supports for rural psychiatrists is needed to meet mandatory CPD requirements and minimize the risk of professional isolation. It is therefore recommended that extra financial and practical support is required to improve access to all components of CPD for rural practitioners and promote sustainable lifelong learning and clinical practice improvement, including:

- Regular contact with peers and supervisors is a core component of CPD. Whilst Telepsychiatry can improve access; regular face to face contact is also required, particularly for peer review groups, practice visits and supervision.

- Development of specific ongoing learning resources for rural psychiatrists in generalist mental health and rural and remote mental health practice. This may include online modules and lectures, interactive web based or videoconference workshops, and postgraduate courses.

- Access to locum support to promote attendance at CPD events, postgraduate programs and congress and conferences.

**Service delivery:**

Innovative models of service delivery are required to meet the needs of rural communities and provide access to quality mental health care.

- In communities without adequate numbers of resident or local psychiatrists, or where sub-specialist services are unavailable, flexible models of psychiatric service provision should be supported to ensure equitable access in all communities. Flexible models may include the use of telepsychiatry and fly-in, fly-out services.

- Financial assistance and practical travel arrangements (which minimise fatigue) should be available for psychiatrists visiting rural areas via outreach programs, in communities where there is an unmet need and an inability to employ a resident psychiatrist within the area. Outreach services should focus on fitting in with local services and up-skilling to improve the sustainability of local medical services.

- Telepsychiatry has the potential to deliver significant benefits to rural psychiatry, particularly in relation to sub-specialist and consultation-liaison services (RANZCP 2014).

- It is important that the Government work with stakeholders to promote access to relevant community infrastructure. Telepsychiatry is also a useful tool for training, delivery of clinical services to rural areas, as well as supervision opportunities for rural psychiatrists.
REFERENCES


Disclaimer

This information is intended to provide general guide 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 College endeavours to ensure that information is accurate and current at the time of preparation, but takes no responsibility for matters arising from changed circumstances or information or material that may have become subsequently available.

REVISION RECORD

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