HealthConsult

The Royal Australian & New Zealand College of Psychiatrists

# Rural Psychiatry Roadmap 2021-2031 Mid-term Review

## Final report

19 June 2026

# Contents

## Glossary of Abbreviations

| Abbreviation | Definition |
|---|---|
| AHPRA | Australian Health Practitioner Regulation Agency |
| AIHW | Australian Institute of Health and Welfare |
| BAU | Business as usual |
| CAP | Child and Adolescent Psychiatry |
| C-L | Consultation– Liaison Psychiatry |
| DOT | Director of Training |
| EOI | Expression of interest |
| FATES | Flexible Approaches to Training in Expanded Settings |
| FTE | Full-time equivalent |
| iMIS | RANZCP membership system |
| InTrain | RANZCP training administration system |
| IRTP | Integrated Rural Training Pipeline |
| KEQ | Key Evaluation Question |
| KPI | Key Performance Indicator |
| LHD | Local Health District |
| MEL | Monitoring, Evaluation and Learning |
| MMM | Modified Monash Model |
| MOU | Memorandum of Understanding |
| PWP | Psychiatry Workforce Program |
| RANZCP | Royal Australian and New Zealand College of Psychiatrists |
| RPTP | Rural Psychiatry Training Pathway |
| RRRSTG | Regional, Rural and Remote Training Steering Group |
| SIMG | Specialist International Medical Graduate |
| STP | Specialist Training Program |

# Executive Summary

The Royal Australian and New Zealand RANZCP of Psychiatrists (RANZCP) engaged HealthConsult to undertake a mid-term review of the implementation of the Rural Psychiatry Roadmap 2021–2031 (the Roadmap).

The review assessed progress in implementing the Roadmap, early signals of impact, opportunities for refinement, and alignment with wider medical workforce priorities. As the Roadmap is a 10-year reform and available quantitative data are limited, findings focus on implementation progress, emerging patterns and stakeholder insights rather than definitive attribution of workforce outcomes.

Overall, the Roadmap has made meaningful progress in establishing the foundations for rural psychiatry training. It has strengthened governance arrangements, supported increased rural representation across RANZCP structures, introduced key policy and training reforms, enabled Rural Director of Training roles in all jurisdictions, and improved the visibility of rural psychiatry as a viable and meaningful training and career pathway. However, progress is not consistent and sustainability is challenged by the absence of continued resourcing for the project.

The remainder of the Roadmap is more complex, where further progress will depend on sustained resourcing, stronger integration into RANZCP business-as-usual, and greater alignment between training, workforce planning and service delivery.

## Key findings

### Early implementation has established key system foundations; remaining priorities require more complex changes.

The Roadmap has progressed foundational actions including governance, selection reforms, remote supervision, rural readiness activities, and training system changes. However, many remaining priorities depend on broader system change, including funding, employment arrangements, workforce planning, supervision capacity and jurisdictional service models.

### Rural representation across RANZCP governance has increased, but influence will depend on sustained resourcing

Rural representation has increased in practice across key RANZCP committees and governance structures. However, representation alone is unlikely to sustain Roadmap progress without dedicated coordination, resourcing and mechanisms to ensure rural priorities are progressed between meetings and embedded in RANZCP decision-making.

### Rural Director of Training roles are a key enabler of local implementation and workforce development

Rural Directors of Training (RDOTs) are currently operating in every state, and are crucial, jurisdiction-funded roles. They have supported local coordination, pathway planning, recruitment, trainee support and alignment between training and service needs, and appear particularly impactful in jurisdictions where the Roadmap is being used to support local workforce design and development. However, these roles require sufficient administrative and operational support to sustain their impact. Regional and rural areas would also significantly benefit from extending the RDOT model to operate outside of urban centres.

### Demand for rural training is increasing, but system capacity may limit sustained workforce growth

Stakeholders reported growing interest in rural training pathways, with some regions experiencing increased demand for rural training places. However, this demand cannot be fully converted into workforce growth unless trainees can access supervision, rotations, advanced training, support and clear pathways into post-Fellowship rural roles.

### Supervision capacity has reportedly increased, but remains unevenly distributed and challenging to verify with current data

Stakeholders reported increased supervision capacity in some regional and rural areas, supporting expanded training opportunities. However, available data demonstrating any potential changes are limited, and supervision remains concentrated in metropolitan and larger regional centres. Rural and remote services continue to face constraints where supervision depends on small numbers of consultants, visiting workforce models or limited protected time.

### Remote supervision is an effective enabler, but is not a standalone solution

Remote supervision is supporting access to training in some settings and has generally been positively viewed as structured and high quality. However, its effectiveness depends on local workforce stability, clinical governance and service readiness. It should complement, rather than replace, local supervision capacity.

### Limited availability of advanced and specialised training remains a barrier to trainee progression and retention in rural areas.

Access to advanced and specialised training opportunities remains constrained in many regional and rural settings due to case mix, infrastructure, specialist supervision and funded position availability. This can require trainees to leave rural settings to complete training, disrupting continuity and reducing the likelihood of long-term rural retention.

### The ability to complete training rurally has improved, especially where training and workforce planning are aligned

In some rural regions, trainees can now complete most or all their training in the one location. The strongest examples of improved access are where training pathways are actively designed around local workforce needs, with coordinated rotations, supervision, support and planning for consultant roles after Fellowship.

### The Roadmap aligns with wider medical workforce priorities, but its continuing value will depend on embedding, measuring and sustaining impact.

The Roadmap is well aligned with priorities relating to rural workforce distribution, specialist training pipelines, supervision flexibility, Specialist International Medical Graduate (SIMG) workforce contribution, Fellowship program reform, and integrated rural models of care. Its ongoing relevance will depend on demonstrating contribution to trainee progression, workforce sustainability and retention.

## Priorities for the next phase

The central risk for the next phase is loss of momentum if Roadmap activities are not clearly owned, resourced and embedded. Several initiatives have been developed or commenced but remain dependent on dedicated project capacity, individual champions or time-limited funding. If dedicated Rural Psychiatry Training Pathway (RPTP) resourcing is not continued, the RANZCP will need clear arrangements to ensure Roadmap actions continue to be a priority and are carried forward across by relevant business areas.

Assuming the RPTP Team continues, nine recommendations have been identified to guide the next phase of implementation. These are summarised in Table 1 and set out in full, with supporting conclusions, in Chapter 8.

**Table 1: Summary of recommendations**

| # | Recommendation | Responsible party |
|---|---|---|
| **R1** | Develop a transition plan before the current RPTP funding period concludes to maintain dedicated oversight of Roadmap priorities (remote supervision, selection reforms, rural communications, rural readiness, reporting) while embedding completed actions into core RANZCP processes. | RANZCP leadership |
| **R2** | Clarify ownership, accountability and priority for remaining Roadmap actions (identifying which require RANZCP delivery, advocacy, external partnership or monitoring) and update the implementation plan. | RPTP team / RANZCP leadership |

| # | Recommendation | Responsible party |
|---|---|---|
| **R3** | Ensure rural psychiatry training priorities are explicitly and structurally considered in relevant governance, accreditation, training policy and resource allocation decisions. | Relevant Committees |
| **R4** | Review gaps in RDOT coverage, document the roles' value, and work with health services and jurisdictions to expand or adapt locally embedded coordination models in regions without dedicated rural training support, with adequate administrative and operational support. | RPTP team / jurisdictions |
| **R5** | Prioritise strengthening data collection, linkage and reporting capability, including a data health check well in advance of the 2031 evaluation. | RANZCP data / RPTP team |
| **R6** | Strengthen rural supervision capacity and sustainability, including advocating for protected supervision time and expanding supervisor development pathways. | RANZCP / health services |
| **R7** | Review remote supervision eligibility criteria to better account for service catchment context, workforce availability and training need. | RANZCP |
| **R8** | Strengthen alignment between rural training pathway planning and jurisdictional workforce planning, including proactive planning for post-Fellowship consultant roles. | RPTP team / health services |
| **R9** | Develop a comprehensive and coordinated support model for rural trainees, supervisors, rural psychiatrists and SIMGs across the full training and workforce pathway. | RANZCP / RPTP team |

# Conclusion

The Roadmap remains highly relevant and well aligned with broader medical workforce reform. Its value lies in strengthening the conditions that make rural psychiatry training viable, high quality and connected to long term workforce outcomes. The remaining years of the Roadmap are an opportunity to consolidate early gains, embed successful initiatives into core RANZCP processes, and focus effort on the system changes needed to sustain progress. Full conclusions and recommendations are set out in Chapter 8.

# 1. Introduction

The Royal Australian and New Zealand RANZCP of Psychiatrists (RANZCP) engaged HealthConsult to undertake a mid-term review of the implementation of the Rural Psychiatry Roadmap 2021–2031. This report presents findings from the review, including assessment of implementation progress, early workforce and training impacts, and opportunities to refine the Roadmap over the remaining implementation period.

The review has been undertaken at the mid-point of a 10-year reform. As such, the evaluation focuses on the extent to which the Roadmap has established the foundations required to support rural psychiatry training, the early signals of change that are emerging, and the conditions required to sustain progress. It does not seek to provide a definitive assessment of long term workforce outcomes, which will require a longer timeframe to observe and measure.

## 1.1. Context

Australia faces a severe and worsening shortage of psychiatrists, with demand predicted to substantially outstrip supply over the coming decades. The Psychiatry Supply and Demand Study by the Department of Health, Disability and Ageing projects a baseline undersupply of psychiatrists of approximately 2.7% in 2024, rising to 7.4% in 2033 and remaining at 4.3% by 2048. When unmet need is included in the modelling, the projected undersupply increases to 19.6% in 2024 and 20.7% by 2048.[1]

This shortfall is not evenly distributed. Shortages are most acute in rural, regional and remote areas with many funded specialist positions in public mental health services remaining unfilled in these areas, while the proportion of psychiatrists working in metropolitan centres remains very high.[2]

The workforce undersupply and resulting pressures are already impacting clinical care. A high proportion (>90% of those recently surveyed by RANZCP) of psychiatrists reported that workforce shortages are already negatively impacting patient care, with high levels of burnout and concerns about retention compounding the challenges of expanding the workforce.[3]

[1] Australian Government Department of Health, Disability and Ageing. (2025). *Psychiatry Supply and Demand Study: Compendium report*. Australian Government

[2] Padley, J. (2025). The future of rural medical education in Australia. *Australian Journal of Rural Health, 33*(2), 112–118. https://doi.org/10.1111/ajrh.13256

[1] Royal Australian and New Zealand College of Psychiatrists. (2024). *The RANZCP Workforce Report: Action is needed, now*. RANZCP.

A growing body of evidence on rural medical education indicates that training in rural settings is a significant predictor of subsequent rural practice. Evaluations of Rural Clinical Schools[4] and end-to-end rural medical programs[5] show that students exposed to longer-term, community-embedded placements in rural areas are more likely to report intentions to practise in rural communities and to be located rurally in the early stages of their careers. This is especially the case when selection criteria and support structures are explicitly aligned with rural workforce objectives.

Similarly, national evaluations of the Rural Health Multidisciplinary Training program demonstrate that Rural Clinical Schools and University Departments of Rural Health contribute to improved recruitment and retention of medical, dental, nursing and allied health professionals in rural and remote Australia, although effects vary by discipline and placement intensity.[6]

For psychiatry, structured rural training pathways (particularly when these extend beyond undergraduate medical training) have the potential to reduce existing workforce shortages by strengthening the pipeline of psychiatrists who are not only willing to work in a non-metro setting but actively prefer to work in a regional/rural setting. Research indicates that the impact of rural training on workforce outcomes depends on the quality and continuity of supervision, the availability of sufficiently diverse clinical experience, and the integration of training into supportive local service environments.[7] These principles are all reflected in the Rural Psychiatry Roadmap 2021-2031.

## 1.2. Challenges for rural psychiatry training

There are a range of challenges facing the rural psychiatry workforce that directly impact trainees seeking to complete their psychiatry training in regional and rural settings. While rural training can offer broad clinical exposure, close relationships with communities and opportunities to develop strong generalist capability, trainees in rural and regional areas often face additional barriers compared with those training in metropolitan settings.

A key challenge is access to the full range of training experiences required for progression. Rural trainees may have more limited access to subspecialty rotations, advanced training opportunities, research and quality improvement projects, and some mandatory training experiences. This can mean that trainees need to travel or relocate to metropolitan centres to

[4] Greenhill, J., et al. (2015). Outcomes of Australian Rural Clinical Schools: A decade of development and evaluation. *Rural and Remote Health, 15*(3), 2991.

[5] Looi, J. C. L., Allison, S., Bastiampillai, T., Hensher, M., Kisely, S., & Robson, S. J. (2024). Australian specialised mental healthcare labour shortages: Potential interventions for consideration and further research. *Australian & New Zealand Journal of Psychiatry, 58*(11), 1121–1134. https://doi.org/10.1177/10398562241267138

[6] Australian Government Department of Health. (2020). *Evaluation of the Rural Health Multidisciplinary Training (RHMT) Program*. Australian Government Department of Health.

[7] Mansfield, K. J., et al. (2024). Regional, rural and remote medicine attracts students with higher rural career intentions. *Teaching in Higher Education, 29*(7), 1050–1065. https://doi.org/10.1080/22423982.2024.2404274

complete parts of their training, disrupting continuity and potentially weakening their connection to rural practice and the communities that they have been based in.

Supervision is another major constraint. Rural services may have fewer supervisors, higher consultant turnover, greater reliance on locum or visiting psychiatrists, and less flexibility to provide consistent mentorship and protected teaching time. This can affect both the quality and continuity of training. In smaller or more isolated services, the loss of a single supervisor can have a substantial impact on local training capacity.[8]

Rural trainees may also experience practical and professional barriers that shape their training experience. These include long travel distances to attend education sessions, workshops or assessments; smaller peer cohorts; fewer networking opportunities; and greater professional isolation. These factors can affect wellbeing, training satisfaction and perceived viability of remaining in a rural pathway.

There are also cultural and structural barriers. Some stakeholders reported that rural training can be perceived as less prestigious or less comprehensive than metropolitan training, despite the complexity and breadth of clinical experience available in rural settings. This perception may deter some trainees from pursuing rural placements or contribute to concerns about whether rural training will support their longer-term career goals.[9]

These barriers highlight why rural psychiatry workforce development requires more than just increasing the number of training places. It requires coordinated training pathways, reliable supervision, access to required clinical experiences, peer and professional supports, appropriate infrastructure, and clear links between training and future rural employment.

## 1.3. The Rural Psychiatry Roadmap 2021-2031

The Rural Psychiatry Roadmap 2021–2031 sets out a 10-year reform agenda to strengthen rural psychiatry training and workforce development. The Roadmap includes 45 deliverables across 5 action areas:

- governance
- selection and onboarding
- education programs
- clinical rotations
- support.

[8] Commonwealth Department of Health, Australia's Future Health Workforce – Psychiatry (Canberra: Department of Health, 2016).

[9] Albert van Wyk et al., 'The experience of stage one psychiatry trainees in rural Australia: A qualitative study of a national sample', *Australasian Psychiatry* (2026): 1–8.

Together, these deliverables are intended to establish and sustain rural psychiatry training pathways that enable aspiring psychiatrists to live, train and practise in regional, rural and remote locations.

The RPTP is designed to strengthen the rural psychiatry workforce by expanding access to high quality rural training placements, improving access to specialist rotations and supervision, and supporting trainees to maintain a connection with a rural home base. Importantly, the Roadmap is not intended to create a separate rural psychiatry qualification or training stream. Rather, it seeks to enable trainees to complete high quality psychiatry training in rural settings, supported by appropriate supervision, education, infrastructure and support.

Delivery of the Roadmap relies on coordinated action across multiple actors and systems. While RANZCP has direct influence over areas such as RANZCP governance, selection settings, training requirements, accreditation standards and supervision guidelines, many factors that shape rural training are outside the RANZCP's direct control. These include jurisdictional employment arrangements, health service funding, workforce supply, service configuration, housing, local infrastructure and availability of specialist services. For this reason, the Roadmap is best understood as a system reform requiring partnership between the RANZCP, governments, health services, regional training hubs, universities, workforce agencies and other medical RANZCPs.

## 1.4. Evaluation overview

This mid-term review is a formative evaluation undertaken halfway through the Roadmap's implementation period. It assesses progress to date, examines early impacts, and considers how the Roadmap is operating in practice across RANZCP, training and service settings.

The findings from the evaluation are intended to support accountability to the Australian Government under the Psychiatry Workforce Program and inform continuous improvement at the RANZCP over the remaining years of Roadmap implementation.

### 1.4.1. Evaluation questions

The review was guided by 4 Key Evaluation Questions as defined by the Monitoring, Evaluation and Learning Framework developed for the Roadmap:

1. **KEQ1 – Progress and performance**

Assess progress and performance against the RPTP Action Plan and the Roadmap's intended outcomes and key performance indicators.

2. **KEQ2 – Early impact**

Analyse the Roadmap's early impact in advancing the Psychiatry Workforce Program's funding objectives and outcomes.

### 3. KEQ3 – Continuous improvement

Identify opportunities to refine implementation and support continuous improvement, including future directions for the Roadmap.

### 4. KEQ4 – Strategic alignment

Assess the Roadmap's continuing alignment with RANZCP and government strategies and priorities for mental health and medical workforce development in rural locations.

Given the Roadmap's 10-year timeframe, the mid-point evaluation focuses on implementation progress, early signals of change and perceived impacts rather than definitive long term outcomes. Where possible, findings draw on multiple sources of evidence, including document review, administrative data and stakeholder consultation. Where evidence remains limited or emerging, this is noted in the report.

## 1.4.2. Data sources and analysis

The evaluation drew on multiple data sources to assess Roadmap implementation and emerging outcomes. These included:

- Roadmap action plans and progress updates
- governance and committee papers
- implementation and activity reports
- monitoring and evaluation materials
- RANZCP administrative data extracts
- consultation data from internal and external stakeholders
- relevant contextual workforce data and policy documents.

The **document review** was used to clarify the Roadmap's design and intent, assess progress against planned actions, understand governance and implementation arrangements, and identify evidence of emerging outputs and outcomes.

**Qualitative consultation data** were analysed thematically to identify implementation enablers, barriers, perceived impacts, and opportunities for refinement. Thematic analysis focused on patterns across stakeholder groups, while also identifying differences by jurisdiction, role and local context.

**Quantitative analysis** drew on available RANZCP administrative data and relevant secondary data sources. This included descriptive and directional analysis of iMIS and InTrain data, trainee exit survey data, RPTP activity and financial reporting, and LearnIT engagement data where available. Contextual workforce data from sources such as the Australian Institute of Health and Welfare, AHPRA Medical Training Survey and Psychiatry Supply and Demand Compendium were also considered.

Together, these data sources were used to examine:

- implementation progress against Roadmap actions
- trainee characteristics and participation
- training activity and progression
- rural rotation patterns
- supervisor and training post distribution
- changes to educational delivery
- early workforce distribution and retention signals
- alignment with broader workforce and policy priorities.
- Where possible, findings were triangulated across data sources.

**Consultations** were undertaken with a broad cross-section of internal and external stakeholders to inform the evaluation. This included engagement with 10 RANZCP staff, five RDOTs, 11 trainees, three supervisors, one SIMG, three Fellows and five other stakeholders (Table 2).

**Table 2: Consultations conducted to date**

| Stakeholder group | Stakeholders interviewed to date |
|---|---|
| **RANZCP staff** | 10 |
| **RDOTs** | 5 |
| **Trainees** | 11 |
| **Supervisors** | 3 |
| **Fellows** | 3 |
| **SIMGs** | 1 |
| **Other stakeholders**[10] | 5 |
| **Total** | **38** |

Source: HealthConsult consultation record (2026)

### 1.4.3. Data limitations

Due to limitations in available quantitative data, the findings in this report are primarily informed by comprehensive stakeholder consultations, supported by descriptive analysis of available administrative data and document review. Quantitative findings have therefore been

[10] Additional stakeholders included representatives from the Commonwealth Department of Health and a consultant previously engaged to work on elements of the Roadmap.

interpreted cautiously and used to identify broad patterns and early signals, rather than to attribute outcomes directly to the Roadmap.

The main limitation is that several datasets provide a single point-in-time snapshot only (including data current as at 10 March 2026). This limits the ability to assess whether observed patterns represent change over time, or whether they reflect pre-existing workforce distribution, jurisdictional differences or broader system trends. This means the evaluation cannot provide a comprehensive longitudinal view of rural psychiatry training and workforce change over the Roadmap implementation period.

There are also limitations in the granularity and consistency of available geographic data. For some cohorts, data can only be reported at jurisdictional level, meaning it is not possible to determine how SIMGs or Fellows are distributed across regional, rural and remote locations. Where Modified Monash Model (MM) data are available for trainees, this data does not always allow analysis of where trainees were located at different points in their training journey. As a result, the evaluation cannot comprehensively assess rural training exposure, movement between rural and metropolitan settings, or the extent to which trainees are completing most of their training in rural locations.

The evaluation was also unable to consistently link data across trainee characteristics, rural background, pathway participation, rotation history, supervision arrangements, progression and post-Fellowship employment outcomes. This limits the ability to quantitatively assess whether Roadmap initiatives are contributing to improved trainee progression, retention in rural locations or changes in the distribution of psychiatrists after Fellowship.

Qualitative data also have limitations. While consultations were conducted with a broad range of stakeholders, it was not possible to speak with all relevant individuals across every jurisdiction, training site or stakeholder group. Findings therefore reflect the perspectives of a sample of individuals who agreed to participate. Consultation findings have been used to identify recurring themes, examples and perceived impacts, but should not be interpreted as representing the experience of all trainees, supervisors, Fellows, SIMGs or health services.

These limitations reflect the maturity of current data systems and indicate opportunity for significant improvement in how data is collated and captured. The evaluation has therefore focused on implementation progress, stakeholder experience and early signals of change, rather than definitive assessment of long term workforce outcomes. Strengthening routine data collection, improving geographic and pathway-level reporting, and enabling longitudinal tracking will be important for future evaluation of the Roadmap.

## 1.5. Structure of this report

The remainder of this report is structured as follows:

- **Chapter 2 – Implementation progress** summarises progress against Roadmap actions and identifies key factors shaping implementation.

- **Chapter 3 – Assessment of progress and performance** examines progress across the Roadmap's main action areas (governance, selection and onboarding, education programs, clinical rotations and supports).
- **Chapter 4** – **A current-state snapshot** of available data on Fellows, trainees and SIMGs.
- **Chapter 5 – Early workforce impacts** examines emerging evidence of changes in trainee demand, pathway viability, supervision capacity and early workforce pipeline signals.
- **Chapter 6 – Sustainability and opportunities for refinement identifies** key risks to sustainability and practical opportunities to strengthen implementation over the next phase.
- **Chapter 7 – Alignment with other medical workforce priorities** considers how the Roadmap aligns with RANZCP, government and broader medical workforce reform priorities.
- **Chapter 8 – Conclusions and Recommendations** which draws together overall conclusions on the Roadmap's progress, early impacts and strategic alignment, and sets out nine recommendations to guide the next phase of implementation.

# 2. Implementation

This chapter addresses KEQ1 by examining how the Roadmap has been implemented to date. It summarises the progress made towards each of the 45 action items contained in the Roadmap, considers the implementation structures, processes and enablers that have supported delivery, including governance arrangements, project coordination, stakeholder engagement and integration with relevant RANZCP functions. This chapter also identifies key implementation challenges, including the complexity of progressing actions across multiple committees, business units and external partners; reliance on dedicated project resourcing; and the broader system factors that have influenced the pace and consistency of implementation.

## 2.1. Roadmap progress to date

Table 3 summarises progress against the 45 Roadmap action items, based on implementation updates provided by RANZCP, document review and stakeholder consultations. The table is intended to provide a high-level view of implementation status rather than a detailed assessment of each action. Some actions have been completed or substantially progressed, particularly those relating to governance, policy reform, selection, remote supervision and rural training promotion. Other actions remain ongoing by design, reflecting their role in longer-term partnership development, advocacy and workforce support. Actions requiring broader system change, including workforce funding, employment portability, supervisor capacity and comprehensive support packages, have generally progressed more slowly and remain dependent on external partners, jurisdictional systems and future advocacy.

**Table 3: Summary of progress against Roadmap action items**

| # | Roadmap action item | Status | Summary of progress to date |
|---|---|---|---|
| 1 | Establish RPTP bi-national governance arrangements and rural representation within the current RANZCP committee structure | Complete | Bi-national governance arrangements have been established, including the Regional, Rural and Remote Training Steering Group (RRRSTG). Rural representation has increased across a number of RANZCP committees, although rural representation is not formally required across all governance structures. |
| 2 | Review current competency-based Fellowship regulations to enhance the RPTP pathway | Ongoing | This action is ongoing, reflecting the dynamic nature of Fellowship pathway reform. Recent progress includes revisions to mandatory rotation requirements for Consultation-Liaison (C-L) and Child and Adolescent Psychiatry (CAP), supporting broader recognition of cumulative rotations and competencies across settings. Future work is expected to include review of rural content within formal education courses, with potential development of additional content specific to rural training and practice. |
| 3 | Appoint an RPTP National Director, coordinator and administrative support | Complete | A dedicated RPTP team has been established to support Roadmap delivery. |
| 4 | Initiate partnerships required to develop the RPTP, including with governments, health services, workforce bodies, universities, regional training hubs and other RANZCPs | Ongoing | Partnership development is ongoing and expected to continue across the life of the Roadmap and into business-as-usual. Recent activity has focused on strengthening relationships with health services, health regions, workforce planning bodies, universities, regional training hubs and other RANZCPs. |
| 5 | Develop initial funding and sponsorship proposals to deliver the RPTP | Complete | Funding proposals were submitted to the Psychiatry Workforce Program, Flexible Approaches to Training in Expanded Settings (FATES) and Specialist Training Program, and successfully funded. |

| # | Roadmap action item | Status | Summary of progress to date |
|---|---|---|---|
| | | | This enabled establishment of the RPTP team and the commencement, delivery and completion of Roadmap projects. |
| 6 | Develop RDOT positions and seek funding within each jurisdiction to support these positions | Complete | RDOT positions have been created, and are being funded or are seeking funding within each jurisdiction. . These roles are now contributing to local training coordination, pathway development and workforce planning. |
| 7 | Develop an RPTP implementation plan, in consultation with key stakeholders, to commence the RPTP from 2023 | Partially complete | An implementation plan was developed; however, it has not been consistently maintained or updated. |
| 8 | Develop a Monitoring, Evaluation and Learning framework for the RPTP | Complete | A Monitoring, Evaluation and Learning (MEL) framework was developed in February 2024. It has provided a foundation for monitoring Roadmap progress and identifying reporting and data capability needs. |
| 9 | Develop data collection and reporting capability to support RPTP delivery, monitoring and evaluation | In progress | Work is underway to strengthen data collection and reporting capability. Data systems are still maturing and limitations continue to affect the extent to which some Roadmap outcomes can be assessed. |
| 10 | Create and promote a positive rural and generalist Fellowship culture across the RANZCP membership | In progress / ongoing | By nature, the entire Roadmap underpins the creation and promotion of a positive rural generalist Fellowship culture. Specific outcomes, such as the Rural Champions[11] initiative, are intended to more overtly address this item. The Rural Champions and Rural Readiness projects are examples of more targeted initiatives intended to foster a positive culture. |

[11] Rural Champions are trainees and psychiatrists in rural locations who are dedicated to promoting a positive rural generalist culture across RANZCP.

| # | Roadmap action item | Status | Summary of progress to date |
|---|---|---|---|
| 11 | Conduct a mid-term review of RPTP progress in 2026 | In progress | HealthConsult was commissioned in January 2026 to undertake the mid-term review of the Rural Psychiatry Roadmap. The review is scheduled for completion in June 2026. |
| 12 | Formally evaluate the RPTP by 2031 | Not yet commenced | This action is expected to occur later in the Roadmap period. |
| 13 | Amend selection regulations and develop selection criteria to prioritise rural applicants for the RPTP | Complete | Selection criteria have been amended and are now reflected in RANZCP-wide policy. Applicants of rural background/origin who meet eligibility criteria proceed directly to interview. |
| 14 | Amend selection regulations to prioritise eligible Aboriginal and Torres Strait Islander applicants for the RPTP | Complete | Selection criteria have been amended and now prioritise eligible Aboriginal and Torres Strait Islander applicants who meet eligibility criteria to proceed direct to interview. |
| 15 | Develop and deliver an RPTP communications and promotion strategy | Ongoing | Communication activities are ongoing and embedded across individual Roadmap projects. The RPTP team provides regular content for RANZCP communication channels and has worked with the Office of the President and CEO and Communications team to promote rural psychiatry priorities. |
| 16 | Consider inclusion of a dedicated rural stream within the Psychiatry Interest Forum program for medical students and junior doctors | Complete | A dedicated rural stream was considered in consultation with the Psychiatry Interest Forum. Agreement was reached that a separate rural stream was not appropriate. However, PIF has increased activities aimed at trainees in a rural location and works closely with the RPTP team for those events. |
| 17 | Deliver rural readiness workshops for trainees | Complete | The Rural Readiness Project delivered workshops in six jurisdictions: Victoria, Northern Territory, New South Wales, Western Australia, Queensland and South Australia. Across the workshops, |

| # | Roadmap action item | Status | Summary of progress to date |
|---|---|---|---|
| | | | there were 85 participants, 46 presenters and consistent positive feedback. An implementation guide has been developed to support future local delivery. |
| 18 | Deliver rural readiness and supervision workshops for Specialist International Medical Graduates | Complete (delivered through broader rural readiness activity) | SIMGs were included within the Rural Readiness Project. The workshops supported trainees, early-career doctors and SIMGs to better understand and prepare for rural training and practice. |
| 19 | Work with governments and health services to develop an RPTP information hub, including available rural training posts and jobs | Near complete | The development of an RPTP information hub is in progress and 95% complete. A communications and engagement plan has been developed, with launch expected in the second half of2026. |
| 20 | Facilitate buddy arrangements for new rural trainees with current trainees | Complete | A buddy program was established in 2024. |
| 21 | Continue to develop and promote the rural training pipeline through partnerships with universities, regional training hubs, health services and other education and medical agencies | Ongoing | Pipeline development is ongoing. Activities include such as the development of specific Rural Training Pathways (for example in WA and QLD) enable and inform the creation of pathways, in tandem with, regional training hubs, the Psychiatry Interest Forum, medical student events and conference opportunities. |
| 22 | Establish a rural exam support program for rural trainees, particularly for written exams | Complete | The online module is launched: New resource for rural trainees and SIMGs preparing for the MEQ and MCQ exams \| RANZCP<br><br>Online workshop is fully scoped and ready to be delivered, pending facilitator recruitment. |

| # | Roadmap action item | Status | Summary of progress to date |
|---|---|---|---|
| 23 | Improve access to research and quality improvement project opportunities and support/supervision for rural trainees undertaking Scholarly projects | Early stage / limited progress | Initial scoping and discussion have commenced, but limited progress has been made to date. |
| 24 | Establish a strong rural trainee peer support network | Not commenced | The development of specific networks has not commenced, however a number of the competed deliverables (e.g. Rural Readiness, Rural Champions, buddy options) underpin the development of trainee peer networks at jurisdiction/site level. |
| 25 | Increase rural supervisor levels to support exam preparation programs, exam delivery and assessments | In progress | This action is approximately 25% complete, with completion targeted for December 2026. The action is linked to broader RANZCP initiatives including the Supervisor Reference Group, Supervisor Development Program, New Fellowship program, *Member Wellbeing Action Plan 2023-2027* and RANZCP *Strategic Plan 2026-2030*. |
| 26 | Develop rural education modules for existing Formal education courses that meet curriculum requirements and provide rurally appropriate content | Not commenced | This action has not commenced because it is dependent on completion of the RANZCP's Formal education course review. The review was completed in 2025, and it is proposed that the first series of modules will include rurally appropriate content. |
| 27 | Complete and implement the review of Formal education courses to incorporate RPTP strategies and activities | Not commenced | This action is dependent on the broader Formal education course review and continuing engagement with the RPTP Team thereafter. |

| # | Roadmap action item | Status | Summary of progress to date |
|---|---|---|---|
| 28 | Examine potential for rural education collaborations with GP RANZCPs | Ongoing | This action is ongoing. Interest in the rural readiness workshops from regional training hubs suggests potential for future collaboration between GP RANZCPs, regional training hubs and universities. |
| 29 | Develop networked arrangements to expand rural training opportunities, including links with and within the private sector | Not commenced | This action has yet to formally commence, although it is noted that networked arrangements often arise informally and are perpetuated. The more specific detail of this deliverable regarding rotations will require a detailed project scope. |
| 30 | Develop regulations for remote supervision, including remote case review and online clinical team meetings | Complete | Remote supervision regulations have been developed. This action has direct links to exam support, supervisor capacity and expansion of training in locations with limited local supervision. |
| 31 | Broaden settings and regulations in which consultation-liaison and child and adolescent psychiatry can be provided, recognising cumulative rotations and competencies | Complete | C-L and CAP guidance documents have been developed. These changes support broader recognition of cumulative rotations and competencies across settings for mandatory Stage 2 training. |
| 32 | Advocate to increase service funding for additional rural training posts or specialised teams in high-need rural locations | Ongoing | Advocacy activity is ongoing and expected to continue across the life of the Roadmap. Activities include , pre-budget submissions and broader media campaigns calling for increased service funding in rural areas. |

| # | Roadmap action item | Status | Summary of progress to date |
|---|---|---|---|
| 33 | Conduct rotation forward planning with individual trainees and at health service, regional and jurisdictional level | In progress | Initial scoping has commenced. This remains an important area for further development to support retention and pathway continuity. This project requires a large data review, including a gap analysis. |
| 34 | Build supervisor capacity in new training locations or where there is insufficient supervision capacity to expand training opportunities | Ongoing | This action is ongoing and linked to Roadmap items 22, 25 and 30. Progress depends on broader supervisor development, remote supervision and workforce capacity initiatives. |
| 35 | Streamline post planning, allocation and accreditation processes | Ongoing | Progress against this action has been supported primarily through the continuity of the RDOT role. RDOTs provide a dedicated mechanism for raising rural training issues within post planning and allocation processes, helping to identify barriers and advocate for smoother planning and allocation. While evidence is largely anecdotal and difficult to attribute directly, stakeholder feedback suggests the role has improved the visibility of rural training needs and supported more responsive management of issues affecting trainees and posts. |
| 36 | Facilitate portable employment and education arrangements to enable trainees to move within and between states and territories | Planned / advocacy pending | Advocacy focus for this area is planned by December 2026. Employment portability remains largely outside the RANZCP's direct control, with the RANZCP's role likely to be advocacy and facilitation. |
| 37 | Ensure greater transparency of decision-making and advice in allocation of Specialist Training | Complete | RANZCP has introduced several changes to improve transparency and consistency in STP/IRTP allocation processes. These include clearer communication that funding is a contribution to training costs, more explicit information about program requirements, departmental priorities and key performance indicators (KPIs) in expression of interest (EOI) materials, strengthened messaging about RANZCP's decision-making authority, and system-level eligibility checks to |

| # | Roadmap action item | Status | Summary of progress to date |
|---|---|---|---|
| | Program (STP)/Integrated Rural Training Pipeline (IRTP) positions | | reduce ineligible applications. These changes have improved stakeholder understanding of the allocation process, reduced queries and challenges, and supported a more consistent and defensible approach to post allocation. |
| 38 | Build capacity to expand rural training to smaller rural centres through access to supervisors and networked arrangements | Planned / in progress | This action has interdependencies with supervisor capacity and remote supervision work. Advocacy is planned by December 2026, and the New Fellowship program may influence future priorities. |
| 39 | Develop and support pathways for rural trainees to undertake subspecialist training rotations in metropolitan locations | Pending / potentially affected by Fellowship program reform | The New Fellowship program may influence this action. Project scoping has commenced for delivery at the end of 2026. . |
| 40 | Develop a comprehensive support package for rural trainees | Planned / advocacy pending | This action will draw on deliverables in the Roadmap and more widely across the RANZCP that support trainees in a rural location. Development of the package will commence post 2026. Please use this response for Item 40, 44 as well. |
| 41 | Develop a comprehensive support package for rural supervisors | Planned / advocacy pending | This action is linked to broader supervisor capacity and workforce sustainability issues. |
| 42 | Ensure appropriate infrastructure is available so rural trainees have access to education, supervision and peer support | Complete | Guidelines have been developed and incorporated into Accreditation Standards. Key elements from RPTP guidelines were adopted into a comprehensive RANZCP-wide standard. |

| # | Roadmap action item | Status | Summary of progress to date |
|---|---|---|---|
| 43 | Provide retention incentive packages for rural trainees, including incentives to remain in a rural location after Fellowship and Transition-to-Practice programs | Planned / advocacy pending | This action remains important to supporting retention and transition from trainee to rural consultant roles. |
| 44 | Develop a comprehensive support package for rural psychiatrists | Planned / advocacy pending | Advocacy focus for this action is planned by December 2026. This action is linked to broader workforce sustainability and retention. |
| 45 | Continue to develop supports for the rural psychiatry workforce | Ongoing | Support development is ongoing. The RPTP team continues to contribute to RANZCP and external advocacy on rural workforce inequity, including through pre-budget submissions, media activity, engagement with medical RANZCPs and peak bodies and alignment with New Fellowship program priorities. |

## 2.2. Implementation key findings

**F1. Early implementation has established key foundations; remaining priorities require more complex system and funding changes**

There has been clear progress in establishing the foundational requirements for implementation of the Roadmap. This includes the development of governance structures, leadership roles, monitoring and data systems, and RDOT roles. There has also been significant progress made on reforms to selection and onboarding of trainees, and education and clinical rotation arrangements.

**Key achievements include:**

- Establishment of RDOT positions including securing ongoing funding from jurisdictions to support these positions.
- Development and roll out of guidelines for high quality remote supervision that support trainees to complete their required training experiences in rural and remote settings, address local supervision shortages and support continuity of training.
- Expansion of Consultation-Liaison (C-L) and Child and Adolescent Psychiatry (CAP) training settings, including greater recognition of cumulative rotations and competencies across settings for Stage 2 training requirements.
- Amendments to selection criteria and processes to prioritise Aboriginal and Torres Strait Islander applicants and applicants from rural backgrounds/origin.

Early implementation has largely focused on deliverables that could be progressed within existing structures and systems. These changes have enabled rapid progress to be made and established important building blocks for further reform.

However, stakeholders noted that the remaining priorities increasingly require broader system, policy and funding changes. This includes shifts in workforce models, training pathways, and coordination across jurisdictions and services. As a result, implementation is entering a more complex phase, where progress is likely to be slower and more dependent on alignment across multiple stakeholders and systems, both within and external to RANZCP.

Lack of ongoing funding is a key risk to continued implementation and sustaining progress. Key coordination and support roles are funded through time-limited funding arrangements. Without ongoing investment, there is a risk that progress achieved to date may not be sustained, and that the momentum built may slow.

The Roadmap has also helped position psychiatry and the RANZCP as a leader in rural specialist medical training reform. Rather than treating rural training as a peripheral or local implementation issue, RANZCP has established a structured national approach to strengthening rural psychiatry training pathways, supported by dedicated governance, rural training leadership and project coordination. Multiple stakeholders identified that psychiatry training

was one of very few (and sometimes the only) training programs that could be completed locally in their jurisdiction without having to move to complete rotations in another area. In line with this, a senior stakeholder noted that the RANZCP is seen as a leader and innovator in this space, with the Roadmap attracting invitations to present across medical RANZCPs, health departments, chief psychiatrist forums and Commonwealth workforce settings. This influence appears to extend beyond psychiatry, with other RANZCPs keen to understand how the Roadmap had been implemented. Stakeholders viewed this as an important achievement, particularly in a context where rural specialist training pathways often remain fragmented, dependent on local champions and difficult to sustain without dedicated coordination.

### F2. Implementation progress is shaped by local context, leadership and system conditions

Roadmap implementation has progressed differently across jurisdictions and local settings due to the range of workforce needs, service requirements and training environments across the sector. Progress has been strongest where there is alignment between RANZCP priorities, local health service leadership, available supervision capacity and jurisdictional workforce planning. In these contexts, Roadmap actions have been used to support broader workforce development, rather than being implemented as discrete training initiatives.

Stakeholders consistently emphasised that local leadership is a key enabler of implementation. In several cases, local leaders advocated for increased workforce, and were able to demonstrate to trainees the strengths and positives associated with training in rural locations.

> Our previous Clinical Director created a really stable consultant workforce; lots of collegiality, including interdepartmental. We've got a fantastic relationship with the Emergency Department. So that's the experience that the trainees are getting. They're seeing a service that functions well within itself, but also within the whole service, which is really important because you don't always get that in metro.
>
> Supervisor

Roadmap actions have been more readily translated into practical changes in locations where there are locally embedded Rural Champions, RDOTs, supportive health service executives and strong relationships with regional training hubs or universities. For example, improved pathway planning, stronger trainee recruitment, greater integration between training and service planning, and more proactive retention strategies.

Conversely, progress has been slower where implementation is constrained by workforce shortages, limited supervision capacity, fragmented relationships between training and employment systems, or competing service pressures. In these settings, even well-designed Roadmap initiatives can be difficult to implement because local services may not have the capacity, infrastructure or workforce depth required to support training expansion.

> We have so few registrars, because they can't attract them, and we also don't have adequate supervisors. People burn out quite quickly, even locums… A single registrar will have between 10-

> 15 patients, and the consultant is here only one day per week. A lot of registrars don't feel overly supported in this environment, so retention isn't great. We're often left short staffed. We do doubles to cover the evenings. If you're doing the evening shift you will be on-call until 8am the next morning. Trying to support each other without burning out and attend to study independently because you can't make it to the facilitated teachings is not ideal.
>
> Trainee

This highlights that the Roadmap is being implemented within a complex and uneven system. The Roadmap can provide frameworks, policy levers, advocacy, coordination and support, but many conditions required to improve the availability of psychiatry services in regional and rural areas sit outside the RANZCP's direct control, including: employment arrangements, local service funding, consultant workforce supply, and availability of specialist services.

# 3. Assessment of progress and performance

This chapter continues to address KEQ1 examining the progress made towards the Roadmap's intended outcomes. It considers the extent to which implementation has contributed to stronger governance, improved rural training pathways, enhanced supervision and support arrangements, and increased visibility of rural workforce priorities within the RANZCP. The assessment draws on document review, program data and stakeholder consultation to identify areas of strong progress, actions that are underway but not yet fully realised, and areas where implementation has been constrained by system-level barriers, limited data or the need for sustained resourcing and coordination.

## 3.1. Governance

**F3. Rural perspectives are more visible in RANZCP governance, but representation does not always translate into influence**

Overall, rural representation across several key RANZCP governance structures has expanded during the Roadmap period, increasing the visibility of regional and rural perspectives in key decision-making. While rural representation is not formally mandated across key committees, stakeholders noted that rural representation has improved in practice. This has supported more consistent consideration of rural issues and priorities.

> The Roadmap has helped with changing the internal governance of the RANZCP from a metropolitan focus to one that now considers the impact of its decisions on rural communities. The internal processes have always been the barrier… Having rural based governance is a change in the status quo.
>
> RANZCP stakeholder

The Regional, Rural and Remote Training Steering Group (RRRSTG) was established to provide oversight of Roadmap delivery with clear reporting lines to the Education Committee and the Board. Several RRRSTG members also provide cross-representation through membership of other internal governance committees. Interviewees also commented that RANZCP committees have improved representation of members from rural areas since Roadmap implementation commenced, including the Education Committee, the Committee for Training, and the Accreditation Committee.

While these changes have improved the visibility of rural priorities, their influence on decision-making remains variable. Stakeholders noted that committee representation alone is not sufficient to drive change, particularly in the context of competing RANZCP priorities and limited resourcing.

Overall, the Roadmap has strengthened rural visibility within RANZCP governance, however it is important to note that there was no rural representative on the new Fellowship Program taskforce. The challenge for the next phase of the Roadmap will be to ensure that this visibility translates into consistent influence in decisions that affect rural training pathways, accreditation, supervision and resource allocation.

### F4. Early implementation has relied on dedicated project support, creating a sustainability risk

The Roadmap has been well supported at the RANZCP level during the first five years of implementation. Dedicated governance arrangements, project coordination and resourcing have enabled significant progress to be made.

This dedicated resourcing has helped establish the Roadmap as a recognised RANZCP priority and has enabled progress across several foundational action areas, including selection, remote supervision, rural readiness activities, and workforce pipeline initiatives. Stakeholders identified dedicated RPTP project resourcing as a major enabler of this progress, particularly because the Roadmap requires active coordination, advocacy and follow-up across multiple RANZCP functions and external partners.

> RRRSTG overseeing the working groups is essential. RANZCP training admin are so stretched, so funding that came with the supports for the Rural Roadmap has been critical in enabling this to happen. Previously trying to even facilitate discussions about this in the past was so difficult without resources. You need a way of funding and developing alternate models and processes nationally.
>
> Rural Director of Training

Stakeholders also noted that there is a risk that without this dedicated resourcing, Roadmap progress would not be sustained. Rural priorities are only one element of a wide range of other RANZCP reforms and operational pressures. Without dedicated resourcing and continued attention from senior leadership and decision-makers, there is a risk that Roadmap priorities may lose momentum or actions may become fragmented across committees and business units. This will be particularly important as implementation moves beyond foundational actions into more complex system and policy change.

Overall, findings suggest that RANZCP level support (non-financial, strategy-level support) has been essential to early implementation. The key challenge for the next phase will be to ensure that Roadmap priorities are not only represented in governance structures, but embedded into routine RANZCP processes, accountabilities and resourcing decisions.

### F5. Collaboration has supported Roadmap development and implementation, but developing partnerships is dependent on dedicated coordination

Collaborative relationships have played an important role in supporting the development and implementation of the Roadmap. Engagement with health services, regional training hubs,

universities, workforce planning bodies, governments and other medical RANZCPs has helped build awareness of the Roadmap and strengthen the rural training pipeline.

These relationships are important because many Roadmap outcomes depend on broader health system and medical education stakeholders. This includes health services, which shape trainee employment, supervision capacity, local service models and transition-to-practice opportunities, as well as regional training hubs and universities, which support pipeline development and engagement with medical students and junior doctors.

The RPTP team has undertaken active relationship development, including engagement with organisations such as the National Rural Health Alliance, , regional training hubs and universities. These relationships have supported activities such as information sharing, promotion of Roadmap initiatives, engagement with Rural Champions and interest in future rural readiness activities. These relationships are expected to continue across the life of the Roadmap.

Partnership activity is resource intensive and depends heavily on dedicated RPTP coordination. Stakeholders noted that without ongoing resourcing, partnership-building may prove challenging, particularly as the Roadmap moves into a phase requiring more advocacy and external system influence. This presents a sustainability risk, as many of the remaining Roadmap priorities rely on continued engagement with jurisdictions, services and workforce partners.

### F6. RDOT roles are contributing to Roadmap progress and strengthening local workforce development

RDOT roles have been developed and implemented across a range of jurisdictions, and are contributing strongly to Roadmap implementation. These roles provide locally embedded leadership and coordination, helping to connect RANZCP training requirements with local health service needs and workforce planning.

RDOTs have supported Roadmap progress by improving coordination of rural training pathways, strengthening trainee recruitment, supporting rotation planning, and advocating for training arrangements that are responsive to rural service realities. Their local presence enables them to build relationships with trainees, supervisors, health service leaders and regional stakeholders, which is particularly important in settings where training pathways need to be actively designed and coordinated.

Stakeholders identified RDOTs as important contributors to local workforce development. In some locations, RDOTs have supported a shift from short-term rural placements towards more intentional local training pathways, where trainees are supported to remain in place and transition into consultant roles after Fellowship.

> I'm confident I'll get a consultant position. I imagine in different services it depends on the Clinical Director, and how much they've advocated for funding and roles. We have a really good Director of Training here.
>
> Trainee

Importantly, RDOT positions have also transitioned from initial RANZCP funding arrangements into being funded through ongoing jurisdictional support. This is a clear example of where targeted Roadmap investment has become embedded in local systems.

RDOT coverage is not consistent across all states and territories, and not all rural and regional areas have access to this form of locally tailored coordination. Stakeholders also noted that RDOT roles are resource intensive and require sufficient administrative support to maximise their impact.

Overall, RDOTs appear to be one of the clearest examples of a Roadmap initiative contributing directly to local implementation and workforce development. Further expansion and resourcing of these roles is likely to be important in seeing similar progress across more regions.

### F7. The RANZCP has taken active steps to promote a positive rural and generalist psychiatry culture

The RANZCP has undertaken a range of activities to promote the rural agenda and strengthen a positive rural and generalist fellowship culture. These activities include the Rural Champions initiative, promoting psychiatry in a rural location through communications channels, engagement through the Psychiatry Interest Forum, visibility at RANZCP events including the annual Congress, and rural readiness activities that were directed through RANZCP and funded by FATES and STP.

The Rural Champions initiative is a particularly notable example of the work undertaken towards promoting a positive rural and generalist psychiatry culture. Five Rural Champions were appointed in January 2026 and have undertaken activities including member profiles, branch engagement, written publications, digital education, conference participation, learning resource development and engagement with medical students and regional training hubs. The “Rural, unpacked” webinar, delivered by the Rural Champions, attracted 84 registrations (resulting in 25 attendees) and explored psychiatry in a rural location as a meaningful and professionally rich career pathway.

These activities contribute to cultural change by challenging perceptions that high quality training and practice are primarily metropolitan. They position psychiatry in a rural location as a complex, relational and rich professional experience with opportunities for growth and development as a psychiatrist as well as leadership opportunities within the health sector, while also acknowledging the practical realities of rural practice. This is important because workforce development depends not only on training posts and supervision capacity, but also on whether trainees, junior doctors and Fellows see rural psychiatry as a viable and valued career pathway. One Supervisor commented on increased leadership opportunities since Roadmap implementation, and suggested that these are underpinned by modules to assist emerging leaders in rural areas with management and leadership skills.

> It is important if we're wanting to keep people in the region, and it doesn't need to be certificates, but…how do we do the leadership and management modules and get those competencies. It's

not as easy to do it in the region compared to the city where they just spoon feed you those modules each week and get you signed off. We don't want to make it a barrier to them finishing, but we also want to make sure they're going to be good leaders as well.

Supervisor

At this stage, the impact of these cultural and promotional activities cannot be measured, due to the timing of implementation. However, stakeholder feedback suggests they are contributing to increased visibility of rural psychiatry and strengthening the rural training pipeline. Continued integration of these activities into business-as-usual communications, training and engagement structures will be important to sustain momentum.

**F8. A monitoring and evaluation framework has been developed for the Roadmap which has identified areas for monitoring, but data systems and reporting capability are still maturing**

A Monitoring, Evaluation and Learning (MEL) framework was developed for the Roadmap. This framework provides an important foundation for tracking Roadmap implementation and identifying what data are required to assess progress and outcomes. The MEL framework has been implemented in part, with further work underway to strengthen data collection and reporting capability.

Several MEL framework recommendations have been progressed, including:

- The introduction of a mandatory address picker in InTrain and the application of Modified Monash Model (MMM) classifications at the location level. This was implemented in 2025 and will enable more robust tracking of changes in trainee distribution and rural exposure over time.
- The development of a monitoring and reporting dashboard to standardise and centralise the monitoring and reporting of Rural Psychiatry Training Pathway data.
- Updates to the Application to Register form to capture rural background and origin information for successful applicants to the RANZCP Training Program. While this information was not available at the time of the mid-term review and is not yet incorporated into the dashboard, it will be available for reporting moving forward.

The current evaluation includes data that is available at jurisdiction level, including the current training locations of active trainees by MMM. Data limitations include the inability to consistently track trainees across MMM categories over time, which would enable a deeper understanding of trainee movements as their training and careers progress. There are also limitations in detailed information on trainee pathways, rural background, rotation history, supervision arrangements and post-Fellowship retention(see sections 1.4.3 and 4.4 for additional detail).

These limitations constrain the extent to which the evaluation can quantify the Roadmap's contribution to early outcomes. They also make it difficult to distinguish between changes associated with Roadmap implementation and broader workforce or jurisdictional trends.

Improving data capability will be important for the next phase of the Roadmap. This includes strengthening data definitions, improving consistency of data capture, linking datasets where feasible, and ensuring that data systems can support both monitoring and decision-making. The MEL framework provides a useful basis for this work, but continued investment will be required to convert it into a robust ongoing reporting system.

## 3.2. Selection and onboarding

**F9. Selection policy has been amended to prioritise applicants from rural areas and by background, including Aboriginal and Torres Strait Islander applicants, but implementation is shaped by jurisdictional recruitment systems**

The RANZCP has amended selection policy to prioritise applicants from rural backgrounds and Aboriginal and Torres Strait Islander applicants. This represents an important change aligned with the Roadmap's intent to strengthen the rural training pipeline and support more equitable access to psychiatry training.

However, the implementation of selection reforms occurs within a broader recruitment and employment system that is not fully controlled by the RANZCP. While the RANZCP can set selection policy and training requirements, Branch Training Committees and jurisdictional employers operate within distinct local employment environments. These environments vary in terms of recruitment processes, available posts, funding arrangements and alignment with RANZCP priorities.

As a result, the extent to which selection policy changes translate into increased rural trainee numbers, increased Aboriginal and Torres Strait Islander trainee numbers or improved workforce distribution is not yet clear. The evaluation has not been able to assess applicant-level data in sufficient detail to determine how consistently these reforms have been implemented across jurisdictions, or whether prioritised applicants are progressing into training positions at higher rates.

This finding highlights an important distinction between where the RANZCP has influence and where there are other system controls that may have a greater influence. The RANZCP has made a meaningful policy change, and understanding the longer-term impact of this change may depend on collaboration and alignment with industry stakeholders influencing training to employment pathways. Further data collection and reporting will be needed to assess outcomes over time.

**F10. Early engagement with medical students and junior doctors helps strengthen the rural psychiatry pipeline, however this varies across state and locations**

The Psychiatry Interest Forum is an important mechanism for connecting medical students and junior doctors to psychiatry, and potentially to rural psychiatry pathways. It provides an established platform through which the RANZCP can promote psychiatry as a career, share rural training opportunities, and expose early-career doctors to rural psychiatry role models.

There is further scope to use the Psychiatry Interest Forum and related engagement activities to strengthen the rural training pipeline. This could include more explicit promotion of rural psychiatry pathways, stronger integration with Rural Champions, links with regional training hubs and universities, and targeted communication about the supports available for rural training.

Stakeholders highlighted examples of where the Forum had engaged with a regional training hub to promote medical student engagement with psychiatry. This included sponsoring student events, providing resources for local activities, contributing to regional training information, and maintaining direct engagement with students and junior doctors. This early engagement appears to be influencing student interest in psychiatry.

> "Back in about 2018, we had a careers fair with directors o
>
> f clinical training for all the different specialties, and no one went into the psychiatry room. But then by 2023, psychiatry was the busiest."
>
> Regional training hub stakeholder

While at this stage, evidence is anecdotal and should be interpreted cautiously, it suggests that sustained early engagement, visible local role models and practical career information may be shifting student perceptions of psychiatry as a viable and attractive regional training pathway.

Rural Readiness workshops have also contributed to early pipeline development and onboarding. These workshops were well attended, with 85 participants across six states and an average net promoter score of 74. The workshops were designed to help trainees, Forum members and SIMGs better understand, prepare for and engage with rural training and career pathways. Several districts have requested that the workshops be repeated, suggesting there is ongoing demand for this type of practical, experience-based event.

These activities are valuable because they do more than promote rural training; they help set realistic expectations about rural practice. This is important for retention, as trainees who are better prepared for rural contexts may be more likely to have positive rural experiences and remain engaged with rural pathways.

The evaluation also noted that promotion of the rural training pipeline varies across states and locations. In some areas, strong relationships between the RANZCP, health services, regional training hubs, universities and local champions have supported active promotion of rural psychiatry pathways. In other areas, promotion appears more limited or dependent on individual initiatives.

This variability reflects the broader place-based nature of Roadmap implementation. Local relationships are critical to engaging medical students, junior doctors, trainees and health service leaders. Where these relationships are strong, Roadmap initiatives can be amplified through local networks and connected to practical training and employment opportunities.

Where they are less developed, rural training pathways may be less visible to potential applicants.

The Roadmap has supported a range of pipeline promotion activities, including Rural Champions, Rural Readiness workshops, Psychiatry Interest Forum engagement, university events, regional training hub partnerships and communications through RANZCP channels. However, sustaining and scaling these activities will require continued coordination and resourcing and clearer mechanisms for sharing effective approaches across jurisdictions.

## 3.3. Education programs

**F11. Exam support for rural trainees has improved, but remains dependent on local support structures**

Exam support for rural trainees has improved through the development of targeted resources and planned online supports. A rural exam support program is approximately 90% complete, with an online written exam support module to be launched in mid-2026 and an online workshop scoped for the September 2026 written exam intake.

These resources have the potential to address some of the challenges rural trainees face in preparing for written exams, including professional isolation, limited access to peer study groups, and fewer local teaching resources. Online modules and workshops may be particularly valuable because they can be accessed across geographically dispersed locations.

Support for exam preparation remains influenced by local support structures and workforce capacity. Trainees in locations with strong supervision, protected teaching time, peer cohorts and local teaching arrangements are likely to be better supported than trainees in smaller or more isolated settings. As a result, centralised exam support resources are important, but may not fully address local variation in trainee experience and rural access.

> In a rural service where there's not a lot of staff members, you can't just disappear from the ward to attend online sessions, for example, on exam preparation, and they're not recorded. Getting our protected study time isn't always feasible either.
>
> Trainee

Embedding exam support into business-as-usual operations will be important to ensure that rural trainees have consistent access to preparation resources over time. There may also be value in linking exam support to broader supervisor development, peer support and rural trainee networks.

**F12. Supervisor distribution has reportedly increased in regional and rural areas; however, data limitations make it challenging to verify current distribution**

Administrative data indicates that supervisor location data remains highly concentrated in metropolitan locations, with over 80% of supervisors located in Modified Monash (MM) 1 areas (Table 2). While there is evidence of growth in the number of supervisors located in regional

areas, particularly in MM2–3 locations, expansion into more remote areas (MM4–7) remains limited. This suggests that increases in supervision location data are occurring primarily in areas with existing service infrastructure and workforce base. However, supervision location data should be interpreted with caution as supervisor numbers are based on unique supervisor IDs rather than supervision load or availability. While the number of supervisors (Table 4) suggests substantial overall capacity in the system, the data does not show how many trainees each supervisor is actively supervising, or whether supervisors are available in the locations and subspecialties where trainees require support.

**Table 4: Current supervisors by state and MM**

| Jurisdiction | MM1 | MM2 | MM3 | MM4 | MM5 | MM6 | MM7 | Total |
|---|---|---|---|---|---|---|---|---|
| ACT | 40 | 0 | 0 | 0 | 1 | 0 | 0 | **41** |
| NSW | 500 | 1 | 70 | 7 | 1 | 0 | 0 | **579** |
| NT | 0 | 23 | 0 | 0 | 0 | 5 | 0 | **28** |
| QLD | 323 | 116 | 3 | 3 | 1 | 0 | 0 | **446** |
| SA | 135 | 0 | 13 | 0 | 2 | 0 | 0 | **150** |
| TAS | 0 | 38 | 1 | 0 | 0 | 0 | 0 | **39** |
| VIC | 565 | 45 | 40 | 3 | 0 | 0 | 0 | **653** |
| WA | 132 | 11 | 16 | 3 | 0 | 5 | 0 | **167** |
| **Total** | **1,695** | **234** | **143** | **16** | **5** | **10** | **0** | **2,103** |

Source: RANZCP supplied administrative data

There is also notable variation across jurisdictions. While some states have achieved greater distribution of supervisors in non-metro areas (e.g. the proportion of non-metropolitan supervisors in Queensland and Western Australia is 28% and 21% respectively), other large jurisdictions, including NSW and Victoria, remain predominantly metropolitan (non-metropolitan supervisors comprise only 16% and 13% respectively). This highlights uneven progress in building regional training capacity across the system, which may be impacted by several factors, including the availability of both supervisors and training places located in regional areas.

Qualitative findings from consultations support these patterns, with stakeholders identifying specific locations where the number of supervisors has increased substantially over the Roadmap implementation period. These gains have often been driven by local health service investment and targeted funding initiatives (e.g. Specialist Training Program and related

workforce expansion programs) and have improved local capacity to support trainees in those settings.

Stakeholders consistently emphasised that sustainable training environments depend on sufficient workforce scale across both supervisors and registrars. Where there are adequate staffing numbers, staff report that the on-call arrangements are more sustainable, there is improved distribution of clinical load, adequate time to complete training requirements, and greater capacity to provide consistent supervision and teaching.

The distribution of supervisors is uneven across locations, and in some states and regions, it continues to be constrained by broader workforce supply issues and competing service demands. This reinforces that while progress has been made, supervisor distribution remains a key limiting factor in the expansion and sustainability of regional and rural training pathways.

### F13. Access to research, quality improvement and Scholarly project support remains challenging for some rural trainees

Some rural trainees continue to face challenges accessing research and quality improvement opportunities, as well as supervision and support for Scholarly projects. These challenges are often linked to the smaller scale of rural services, limited academic infrastructure locally, fewer local research supervisors, and competing service demands.

> Research, quality improvements and Scholarly projects are a huge challenge
>
> Rural Champion

Efforts to improve access to research and quality improvement project opportunities have begun, but progress remains limited. This indicates that, while the issue is recognised, further work and dedicated funding are needed to develop practical, scalable support models. Stakeholders, including trainees and supervisors, also identified gaps in research support in rural areas, with some noting the need for funded, dedicated roles to address these gaps.

> We need to have some money set aside to fund a research coordinator, either for Australia or state-centric. There must be someone full-time that can help the trainees, because we do not have professors of psychiatry here in rural psychiatry…The RANZCP and the Roadmap needs to really look at the leadership and funding around research coordination.
>
> Rural Director of Training

One RDOT shared an example approach taken to support Scholarly projects, by securing funding for external consultant support.

> We provide extra support… we've consulted an external specialist to support trainees to get their Scholarly projects done and published… They don't have to pay for their research, Scholarly project, advice and guidance, we provide that.
>
> Rural Director of Training

This remains an important area of focus for the later stages of the Roadmap because Scholarly project requirements can become a bottleneck for trainees in rural settings if appropriate supervision and project opportunities are not available locally. It may also contribute to inequity between rural and metropolitan trainees, particularly where metropolitan trainees have greater access to academic departments, research networks and established project pipelines.

In addition to providing funded research support, potential approaches could include developing a central register of available research opportunities and quality improvement projects, linking trainees with remote academic supervisors, building partnerships with universities and regional training hubs, and embedding scholarly activity into rural service improvement priorities.

### F14. Changes to Child and Adolescent Psychiatry (CAP) and Consultation-Liaison (C-L) requirements may help address bottlenecks in mandatory training

Recent changes to CAP and C-L Psychiatry requirements now allow recognition of cumulative rotations and competencies across a broader range of settings for mandatory Stage 2 training. This has addressed some previous bottlenecks that affected rural trainees' ability to complete training requirements in these areas.

These reforms are important because access to CAP and C-L training has historically been constrained in some regional and rural locations, particularly where specialist services, inpatient units or dedicated funded positions are limited. Greater recognition of cumulative experience and competencies across settings provides more flexibility and may reduce the need for trainees to relocate solely to meet mandatory requirements.

However, these changes do not remove all barriers. Implementation will depend on local service configuration, supervisor availability, training accreditation, and awareness among trainees and supervisors. It will also be important to monitor whether these reforms are improving trainee progression and reducing delays in practice.

### F15. Portable employment and education arrangements remain difficult to progress and sit largely outside direct RANZCP control

Portable employment and education arrangements remain an important but challenging area of Roadmap implementation. Some progress has occurred within jurisdictions, including Western Australia, where trainees on the Rural Training Pathway reported easily securing terms in other locations.

> The services are both small, while it's possible to do it all in one location, there's not that many supervisors or a huge diversity of terms. I wanted diversity in clinical supervision and to see how other services do things. Getting the term was easy. The move itself was a bit messy due to different entitlements across the different regions.
>
> Trainee

Portability across the rural and metropolitan training pathways in Western Australia was highlighted as an ongoing issue constraining trainee's ability to pursue their chosen advanced training area, limiting the expansion of these skills in rural areas.

> I looked into older adult advanced training; there were some issues with rural trainees in terms of standardisation with metro. I would have done it in metro if my rural position wouldn't be threatened by wanting to do it. I was of the understanding that if I went metro, then my place in rural could be taken.
>
> Trainee

Broader portability across states and territories remains challenging because employment arrangements are controlled by health services and jurisdictional employers rather than the RANZCP. The RANZCP can influence training standards, education requirements, accreditation settings and advocacy positions, but it does not control trainee employment contracts, funding arrangements or workforce deployment. As a result, Roadmap actions relating to portability require system-level advocacy and partnership rather than direct implementation by the RANZCP alone.

The ability to move between rural sites, regions or jurisdictions while maintaining continuity of training could support greater access to required experiences and reduce barriers for trainees. However, without alignment across employment and training systems, portability is likely to remain inconsistent.

> "If you need to move back for a specialist rotation, you often need to start with another health service, who aren't great with secondment arrangements that transfer entitlements. It's a problem. Less of a problem in states like Queensland where everyone's employed by Queensland health, more a of a problem in places like Victoria."
>
> Fellow

For future implementation, the RANZCP's role may be best framed as facilitation and advocacy: identifying barriers, convening jurisdictions and health services, clarifying education requirements, promoting models that support continuity of training across settings, and lobbying at national level for portability across state and territory borders.

### F16. Specialist Training Program (STP) funding has been used in some locations to augment Roadmap actions and expand training capacity

STP funding has been used in some locations to support or augment Roadmap actions, particularly where additional positions or capacity are needed to deliver rural training. This has enabled some services to strengthen training pipelines, increase supervision capacity or support expansion of rural training opportunities.

> "The quality in my service has changed since the Roadmap. Previously, there was no IRTP or STP, no rural training pathway. There were 3.5 psychiatrists and 2 registrars. One CL, no child and adolescent, no specialised older age [psychiatrists]. Because we've been able to expand, we

could spend money on consultants and supervision capacity for more registrars. There are more subspecialties as well so registrars can learn those skills."

RANZCP stakeholder

The use of STP funding demonstrates how Roadmap objectives can be advanced when training policy, workforce funding and local service priorities are aligned. In these cases, funding has helped create the conditions required for local implementation, including additional posts, supervision support or local workforce development.

However, reliance on targeted or time-limited funding also creates sustainability risks. Where Roadmap progress is dependent on temporary funding, gains may be difficult to sustain unless positions and supports are embedded into longer-term workforce models. This reinforces the importance of aligning Roadmap implementation with jurisdictional workforce planning and service funding decisions.

## 3.4. Clinical rotations

**F17. The ability to complete training in rural settings has improved, with the strongest outcomes in locations that have used the Roadmap to drive coordinated training and workforce redesign.**

There is anecdotal evidence that the ability for trainees to complete the majority (or in some case, all) of their training in a regional or rural setting has improved over the Roadmap implementation period. In some regions, the establishment of coordinated rural training pathways, increased supervision capacity and more flexible approaches to training has enabled trainees to progress without needing to relocate to a metropolitan centre.

In many locations, there is now deliberate and intentional planning for retention of trainees after they have achieved Fellowship, rather than simply hoping that trainees will stay. In these settings, training pathways have been actively designed to support trainees to stay in place through early identification of placement, coordination of rotations and alignment of training with local workforce needs.

The strongest examples of this shift are evident in training sites that have used the Roadmap as a lever for broader workforce redesign. In these settings, training and service planning are closely integrated, with local leadership (typically facilitated through the RDOT) supporting place-based workforce planning and development of sustainable training pipelines.

**Increasing numbers of psychiatrists call the North Coast of NSW home**

Strong examples of a "grow your own" rural psychiatry training model are emerging across Australia. Northern NSW is a great example of a Local Health District (LHD) that has built a strong local training pipeline, with trainee numbers increasing alongside early evidence that locally trained psychiatrists are staying on in the region after becoming fellows. Northern NSW LHD spans a large geographic footprint with psychiatry training located across Tweed Heads, Byron Bay and Lismore. Trainees can complete their entire training program locally, rather than remaining on a metro-based contract.

A major enabler of training pipeline growth has been the locally embedded RDOT. This has enabled more place-based workforce planning, closer links between service and training, and a stronger training program that provides a high-quality training experience.

**Key successes include:**

- Strong growth in local training capacity growing from with training posts expanding from 25 in 2023 to 31 in 2026, reducing reliance on metro trainees on mandated rural rotations.
- The number of trainees who identify as local has increased from 12 in 2023 to 30 in 2026.
- Clear evidence of an emerging local workforce pipeline- four locally trained psychiatrists have completed fellowship and have taken on consultant roles in the region, with further workforce expansion expected over the coming years.
- Integration of service planning and training planning - the RDOT is involved in forward planning with hospital services.
- Improved trainee support and training conditions with more focus on protected teaching time, local teaching arrangements and support for trainees including support to complete RANZCP assessment requirements such as in-person psychotherapy supervision and funding of exam courses.
- Practical action on rural incentives - the service recognised that local trainees were financially disadvantaged compared with trainees undertaking rural rotations and introduced an equivalent incentive payment for local trainees who committed to 18 months or more in the region.
- Leveraging remote supervision to expand access to subspecialty training opportunities.

While Roadmap initiatives including remote supervision and more flexible training arrangements support improved access in some contexts, their uptake and effectiveness vary across regions and depend on local system readiness and workforce capacity.

Overall, these findings indicate that while the ability to complete training in rural settings has improved, sustained impact on workforce distribution is most evident where training pathways are intentionally designed and embedded within workforce planning.

### F18. Remote supervision is an effective enabler of rural training, but uptake and suitability are dependent on local workforce and system conditions

While findings are qualitative at this stage, interviewees reported that remote supervision has strong potential as an effective way to support training in regional and rural settings, particularly where local supervision capacity is limited. Stakeholders reported that the development of remote supervision guidelines has been successful, and that remote supervision can now be supported by clear guidelines, structured processes and tools to support implementation.

Early feedback from supervisors and trainees indicates that the quality of supervision delivered through a remote model is high, and in some cases more structured and intensive than face-to-face supervision. This reflects the deliberate design of the guidelines for remote supervision which incorporates additional full-time equivalent (FTE) roles, safeguards, planning and oversight to ensure quality is maintained.

Stakeholders emphasised that the effectiveness and sustainability of remote supervision depends on local system conditions. Consistent on-site support is critical for safe, effective training, and where workforce capacity is limited or unstable (e.g. reliance on locums), remote supervision alone is insufficient. Some raised concerns that fully remote supervision could lead to the loss of consultant roles and face-to-face services in communities. Trainees valued on-site support but noted that more flexible arrangements, such as access to remote supervision outside strict MM4–7 classifications, could improve training and retention in regional and remote areas.

Findings suggest opportunities to expand remote supervision more flexibly to increase training capacity. Current eligibility rules can limit its use, for example, MM2 sites serving rural populations, or mismatches between trainee and supervisor locations, may be excluded. These constraints reduce flexibility and may limit the effectiveness of remote supervision in underserved areas. Stakeholders indicated that more flexible, context-based eligibility criteria could better utilise supervision capacity and expand access to training opportunities.

### F19. Limited availability of advanced and specialised training opportunities in regional and rural settings creates challenges for trainee progression and retention.

While there is evidence of growth in overall training capacity, stakeholders consistently identified limited availability of advanced training pathways and some specialised aspects of training (e.g. the ability to complete training in ElectroConvulsive Therapy (ECT)) as a significant ongoing barrier to training in regional and rural areas. Although some regional locations do offer a broad

range of advanced training opportunities, qualitative reports indicate that access remains constrained in many areas, with demand exceeding opportunities.

> If you want to do generalist training that's fine, but if you want to do something else you have to go elsewhere. For some specialisations we have the wards and facilities, but supervision is the barrier.
>
> Rural trainee

Access to advanced training opportunities is further limited by structural factors including the availability of an appropriate clinical load, specialist supervision and infrastructure. As a result, trainees often need to leave rural locations (at least temporarily) to access these opportunities. This can disrupt training continuity and reduce the likelihood of retention in rural areas. Some trainees indicated that they felt they would have higher-quality training in their chosen advanced training area if they completed this in a metropolitan area.

> I would like to do advanced training in addiction psychiatry. Right now, I can only do this in the capital. Even if it was offered in country I'd want to do it in the city because that's where there are more complex cases and services, and it would offer the most intensive and broad experience. This is the area I'd like to practice in when fellowing, but I would prefer to work in the country.
>
> Trainee

Stakeholders provided some examples of flexible training pathways, which were able to be established to support trainees to access advanced training opportunities in non-metropolitan areas. While relevant to Roadmap implementation, these pathways were also enabled by broader system contexts including funding availability. Supportive supervision was also highlighted as key to their establishment.

> We carved out a relatively unique, untrodden child and adolescent advanced training pathway in the area. We invented the position and invented an advanced training infrastructure for me. I had a very supportive supervisor… (and) statewide director of child and youth training… I had the timing of a statewide child and youth mental health service reform, which meant there was money to create positions. So a cluster of things all came together with a trainee who was willing to have a punt in uncharted waters and be adaptable. By contrast, if I didn't want to do child and adolescent training I would have had to relocate.
>
> Rural Champion

These limitations contribute to an ongoing tension between promoting rural generalist practice and supporting trainees to pursue specialised areas of interest. While rural settings often provide broad, generalist training aligned with local service needs, trainees often aspire to develop subspecialist expertise. Trainees suggested that remote supervision could be more flexibly administered to support advanced training opportunities in non-metropolitan areas.

> Having the ability to get supervision by telehealth would be really appreciated. We get a lot of pushback regarding that. Fly-in-fly-out are here for a single day of the week, so you're not hitting supervision duration requirements. Being able to use telehealth would open advanced training opportunities. The supervision is the roadblock.
>
> Trainee

Stakeholders also highlighted a broader debate regarding the desired profile of the rural psychiatry workforce. Some emphasised the value of developing strong generalists who can respond flexibly to the diverse and complex needs of rural communities, particularly in settings with limited specialist availability. Others raised concerns that an over-reliance on generalist models may limit access to specialised expertise and risk diluting the quality or breadth of services available to rural and regional populations.

This tension reflects a fundamental system challenge in balancing service accessibility with depth of expertise. It reinforces the importance of training models that support both generalist capability and access to specialist skills, whether through local service availability, visiting services or networked models of care and training.

## 3.5. Rural Champions and peer support networks

**F20. Rural Champions are helping to promote peer connection, visibility and pathways for rural psychiatry training, with further opportunities to embed and scale their roles**

Rural Champions have contributed to peer support, visibility and promotion of rural psychiatry pathways. These roles provide visible examples of psychiatrists and trainees who are engaged in rural practice and can speak directly to the opportunities, challenges and professional value of rural psychiatry.

The Rural Champions initiative has supported a range of activities, including member profiles, branch engagement, digital education, written publications, conference activity, mentoring-related projects and engagement with medical students and junior doctors. These activities have helped create opportunities for connection and have contributed to the broader goal of promoting a positive rural and generalist psychiatry culture.

Peer connection is particularly important in rural training contexts, where trainees may experience professional isolation or have limited access to local cohorts. While the Rural Champions initiative is not a substitute for a formal rural trainee peer support network, it may contribute to a stronger sense of rural psychiatry identity and visibility within the RANZCP.

Broader peer support remains an area for development. Buddy arrangements have been established but are under-subscribed and not well utilised, and work on a strong rural trainee peer support network has not yet commenced. This suggests that while promotional and informal connection activities are progressing, more structured peer support mechanisms may be needed. In addition to the work being done by Rural Champions, some trainees were

independently establishing peer support networks, which the RANZCP could identify and support to ensure their continuation.

> I've sought support through my own avenues, trying to find supports though other organisations, and friends who have already finished psychiatry training that I met at university. The RANZCP does have a mentor/mentee program. I have a mentor ready to go, but we haven't done the induction. I created my own rural psychiatry group. Once a month a couple of the registrars come to my place. We invite Junior Medical Doctors (JMOs) and medical students to my home. My idea is to get more of a trainee base and hopefully retain them into consultancy.
>
> Trainee

Future work could focus on clarifying the purpose of different support mechanisms, understanding why the buddy program has had limited uptake, and developing peer support models that are attractive, low-burden and responsive to rural trainee needs.

# 4. Current state snapshot

This chapter presents a current state snapshot of available data on Fellows, trainees and SIMGs. Its purpose is to provide context for interpreting Roadmap implementation and emerging workforce impacts, rather than to assess change over time or attribute outcomes directly to the Roadmap. It provides a baseline, alongside targeted recommendations, to support more comprehensive data collection and analysis, to assess the remainder of Roadmap implementation.

The available quantitative data have important limitations to note (see section 1.4.3). For these reasons, the data in this section should be interpreted cautiously. Sections 4.4 and 6.2 of this report identify opportunities to strengthen data collection, linkage and reporting so that future monitoring and evaluation can more robustly assess Roadmap implementation, trainee pathways and longer-term workforce outcomes.

## 4.1. Workforce distribution

At present, RANZCP provides internal data that enables a current state and MMM-level view of the distribution of current trainees and past fellows. Whilst geographic reporting is possible, data reporting is limited in enabling longitudinal tracking to understand an individual's movements over time. For active fellows, MMM-level data is not currently available, and the figures reported in the tables below reflect RANZCP membership or registration addresses, rather than actual practice or service delivery locations. It was not possible to capture change which could be associated with the Roadmap, as data is captured for a specific point in time (this report uses data captured on 10 March 2026). Table 5 shows there are 5,731 active fellows and 2,486 active trainees across Australia.

**Table 5: Total active* trainees and past fellows**

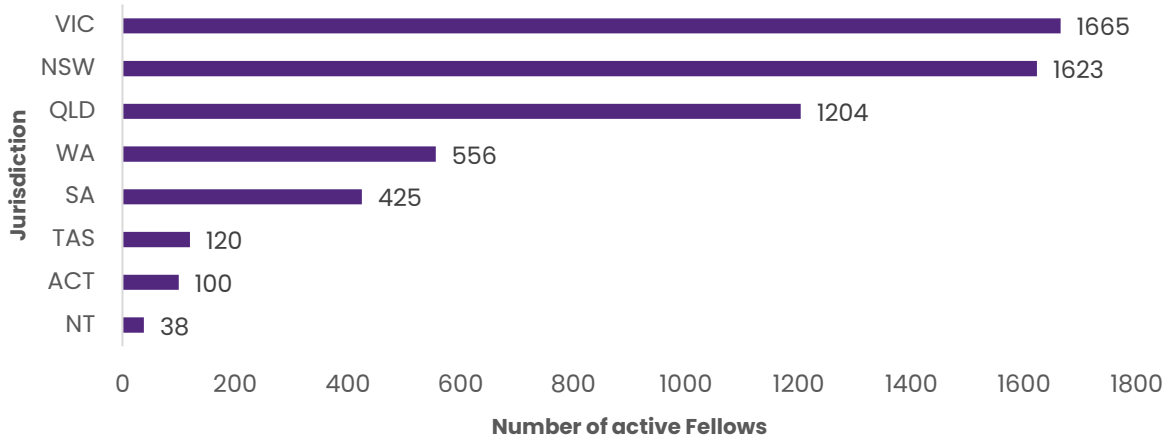
| Psychiatry specialist (stage) | Number |
|---|---|
| Active trainees | 2486 |
| Active fellows | 5731 |
| **Total** | **8217** |

Source: RANZCP provided internal data. *Note that the data was correct at 10 March 2026

### 4.1.1. Fellows[12]

Active fellows are mainly located across eastern Australia, with just under a third in each of Victoria (29%, n=1665) and New South Wales (28%, n=1623) (Figure 1). Approximately one fifth of active Fellows (21%, n=1204) are in Queensland, 10% (n=556) are in Western Australia, and 7% (n=425) in South Australia. There are very few active Fellows in Tasmania (2%, n=120), the ACT (2%, n=100), and the Northern Territory (1%, n=38).

**Figure 1: Active Fellows by jurisdiction**



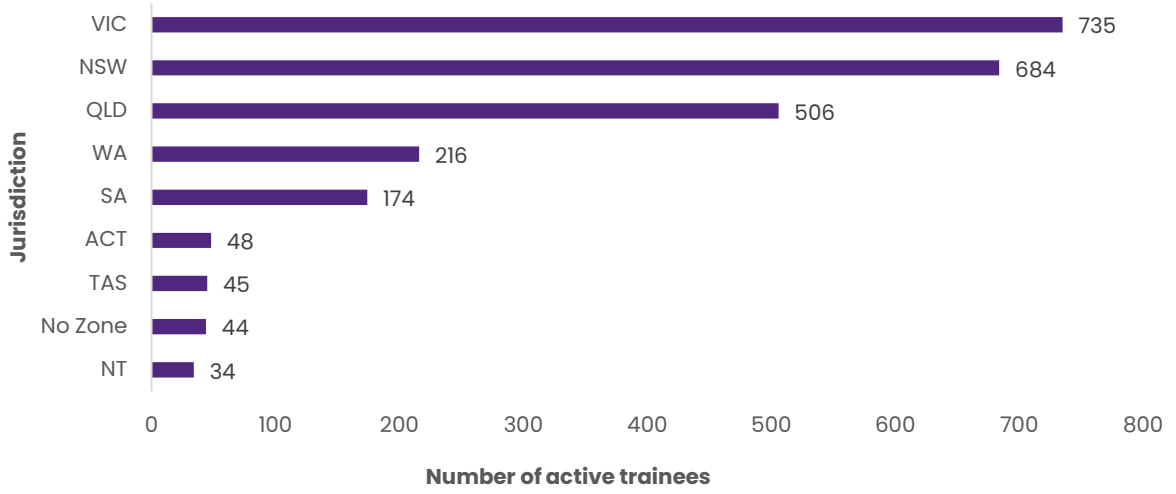

Source: RANZCP provided internal data. *Note that data were correct at 10 March 2026

### 4.1.2. Trainees

The distribution of active trainees is broadly aligned with that of active Fellows. Most active trainees are in Victoria (30%, n=735), New South Wales (28%, n=684) and Queensland (20%, n=506), as shown in Figure 2. While jurisdiction-level data does not allow for granular assessment of rurality, MM-level data are available for trainees and provide a direct measure of geographic rurality at a snapshot point in time.  it is notable that the two jurisdictions with the lowest number of active trainees are the Northern Territory (1%, n=34), and Tasmania (2%, n=45). Both Tasmania and the Northern Territory contain no MM1 areas, and also have significantly lower populations than other states, which would likely influence the number of psychiatrists (including trainees) per capita. All trainees in these areas, therefore, are located in regional, rural or remote locations. At a minimum this suggests an ongoing trainee gap in non-metropolitan areas.

[12] The figures presented here are derived from RANZCP administrative data, which reflect the address or membership details held by RANZCP. They do not represent Fellows' practice locations or service delivery settings, as this information is not systematically collected post Fellowship.

**Figure 2: Active trainees by jurisdiction**




Source: RANZCP provided internal data. *Note that data were correct at 10 March 2026. ** 44 trainees were recorded as 'No Zone', and could not be linked to a jurisdiction

## 4.2. Trainee characteristics

**F21. Trainees are largely concentrated in MM1 areas.**

Captured data shows the MM locations of all active trainees in rotation 1, 2026. As displayed in Table 6, current active trainees are overwhelmingly located in MM1 locations (80%, n=1,613). While 11% (n=225) are in MM2 locations, and 7% (n=147) in MM3 locations. There are only 19 trainees in MM4 (1%), 9 in MM5, 5 in MM6 (0% respectively due to rounding), and none in MM7.

**Table 6: Current trainees that commenced intake from 2018*-2026**

| | MM1 | MM2 | MM3 | MM4 | MM5 | MM6 | MM7 | Total |
|---|---|---|---|---|---|---|---|---|
| NSW | 499 | 0 | 78 | 10 | 1 | 0 | 0 | **588** |
| QLD | 308 | 112 | 3 | 3 | 0 | 0 | 0 | **426** |
| VIC | 508 | 45 | 43 | 5 | 0 | 0 | 0 | **601** |
| SA | 131 | 0 | 9 | 0 | 1 | 0 | 0 | **141** |
| WA | 129 | 10 | 14 | 1 | 0 | 5 | 0 | **159** |
| NT | 0 | 21 | 0 | 0 | 5 | 0 | 0 | **26** |
| TAS | 0 | 37 | 0 | 0 | 0 | 0 | 0 | **37** |
| ACT | 38 | 0 | 0 | 0 | 2 | 0 | 0 | **40** |
| **Total** | **1613** | **225** | **147** | **19** | **9** | **5** | **0** | **2018** |

Source: RANZCP provided internal data.
Note that data were correct at 10 March 2026. * Provided data for 2018 was labelled 'pre-2018', exact intake year is unspecified.

While it is currently not possible to assess change in trainee distribution over the Roadmap implementation period, the current distribution of trainees shows significant gaps for MM4-7 areas. The remainder of the Roadmap implementation period should focus on accurate data collection and tracking of trainee distribution. At a minimum, this could entail snapshot data (as reported above) to be recorded at the commencement of each trainee rotation period.

**F22. Current data provide a baseline for monitoring Aboriginal and Torres Strait Islander trainee participation over time**

Forty trainees identified as Aboriginal, representing just under 2% of the total number of trainees, while only one identified as Torres Strait Islander. These figures represent unique trainee counts.

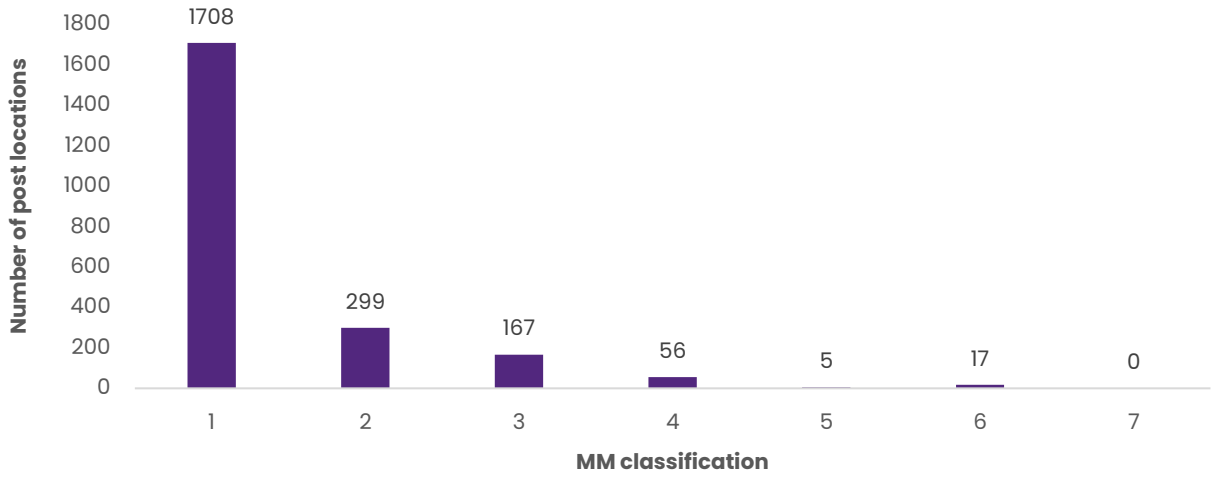
While selection criteria have been amended to prioritise eligible Aboriginal and Torres Strait Islander applicants, available data do not yet allow assessment of whether this has increased participation or progression over time, relevant to a prior baseline. It is also important to note that changes in identification rates or reporting practices may influence observed numbers independently of actual changes in participation. Continued monitoring will be important to strengthening accurate data related to Aboriginal and Torres Strait Islander representation over time.

## 4.3. Accredited training posts

Across Australia, there are 1,968 accredited training posts. Accreditation is conducted at the post level, however, a post may be associated with one or more locations (total locations n=2,252), which can be classified by MM category. One post can also have more than one full-time equivalent (FTE) supervisors. Figure 3 shows that post locations are overwhelmingly concentrated in MM1 (76%, n=1,708), with fewer in MM2 (13%, n=299) and MM3 (7%, n=167).

Accredited posts and associated locations do not represent filled positions, which are dependent on recruitment processes at the jurisdictional level. However, they do represent an avenue through which the RANZCP can ensure accredited training capacity across non-metropolitan areas. Continued monitoring and accurate, longitudinal reporting of which locations (categorised by MM) are filled by trainees will support comprehensive assessment of the relationships between accredited post locations and trainee numbers in these areas through the remainder of the Roadmap implementation.

**Figure 3: Post locations by MM category**




Source: RANZCP provided internal data. *Note that data were correct at 10 March 2026

** More than one location can be associated with a training post; total locations do not equal total posts

## 4.4. Improving data recording and reporting

**F23. Improved data recording and reporting should be a priority for the remainder of Roadmap implementation.**

Improved data recording and reporting should be a priority for the remainder of Roadmap implementation. Current data provide useful descriptive snapshots, but do not yet enable consistent monitoring of rural training pathways, workforce distribution or change over time. This limits the ability to assess the extent to which the Roadmap is contributing to improved rural training access, trainee progression, supervision capacity and post-Fellowship retention.

**To strengthen future monitoring and evaluation, RANZCP should prioritise:**

- consistently embedding the capture of MM classification across all reporting outputs and data domains
- longitudinal trainee tracking, including rural background/origin, pathway participation, training location over time, rotation history, progression and completion, to further build on the accredited training post data already being collected and reported on
- Consistent longitudinal reporting of post occupancy data to track changes across rotations over time, including which accredited training posts are filled or vacant at each rotation period, and how this has changed throughout the Roadmap implementation period
- supervision data, including supervisor location, active supervision load, availability, specialty area and use of remote supervision
- rotation and training exposure data, including the type, duration and location of rotations completed in rural and metropolitan settings

- post-Fellowship outcomes, including whether trainees who complete part or all their training rurally remain in, return to, or leave rural practice
- consistent data definitions and reporting cycles, so that data can be compared across jurisdictions and over time
- exploring linkages across the RANZCP CRM currently under development, iMIS, InTrain and other relevant systems, where feasible, to support more complete analysis of trainee pathways and workforce outcomes.
- Strengthening data systems should focus on improving longitudinal linkage of trainee location, rotation history and MMM classification over time. While existing operational data can identify whether accredited posts are filled or vacant at a given point in time, the main analytical limitation is the ability to track where trainees are located across rotations and stages of training, and to link this with progression, completion and post-Fellowship outcomes. Addressing this would strengthen the final evaluation's ability to assess whether rural training exposure is contributing to longer-term workforce outcomes.

More robust data would enable RANZCP to better understand where rural training pathways are working well, where bottlenecks remain, and where further support or investment is required. It would also improve the RANZCP's ability to work with jurisdictions, health services and other partners on workforce planning, by providing clearer evidence about rural workforce distribution, training capacity and emerging retention outcomes.

Strengthening these data systems is also essential to implementing the MEL framework in practice. Without improved data capture, the MEL framework will remain a useful planning tool, but will have limited capacity to demonstrate measurable progress, identify implementation gaps or inform continuous improvement.

# 5. Early impacts on workforce pipeline

This chapter addresses KEQ2: Analyse the Roadmap's early impact in advancing Psychiatry Workforce Program objectives and outcomes. It considers the extent to which Roadmap implementation is contributing to early changes in the psychiatry workforce pipeline, including interest in training in a rural location, access to training opportunities in rural areas, progression through training, and emerging pathways into practice in a rural location after Fellowship.

**F24. The Roadmap strengthens the conditions for successful rural training, but does not directly aim to create additional training positions**

The Roadmap outlines actions to strengthen psychiatry training in a rural location, such as improving supervision, flexibility, coordination, trainee support, and career promotion, but it does not set a target to increase the number of accredited training posts in a rural location. This distinction matters for interpreting workforce impacts. The Roadmap's role is to create the conditions that enable effective training in a rural location, rather than directly controlling training post numbers.

The supply of regional and rural training positions is shaped by factors largely outside the RANZCP's control, including jurisdictional workforce planning, health service funding, supervisor availability, service models, employment arrangements, and infrastructure. Changes in trainee numbers therefore reflect the interplay between Roadmap initiatives and external drivers such as local investment, STP funding, and jurisdictional priorities.

Accordingly, the Roadmap's primary contribution is strengthening the systems that make training in a rural location viable and sustainable. This supports the quality of training and retention where positions exist. In some settings it has also been used to support broader workforce redesign, including reducing reliance on locums in favour of more stable trainee pathways.

> This is workforce redesign just as much as it is a training program. We've spent a lot of time having a look at the profile of the medical workforce and what it needs to be to be more sustainable in the future. By using the Rural Roadmap we've increased to having 37 trainees, but we haven't got any extra funding for trainees. All we've done is reshape the workforce that already existed. Replacing locums with salaried registrars means that you've now got a huge expansion in the number for the same price.
>
> Rural Director of Training

Future evaluation of the Roadmap should be assessing whether it improves the quality, viability, accessibility and sustainability of training pathways in a rural location, rather than creating more training positions. This should include whether trainees can access required experiences, remain connected to rural communities throughout their training, and transition into consultant roles in a rural location after Fellowship.

**F25. Demand for rural training places is increasing, reflecting growing interest in rural pathways, but workforce impact will depend on converting interest into rural practice.**

Stakeholder consultations indicate that demand for training places in a rural location is increasing across several jurisdictions. This reflects growing interest in training in a rural location. It also suggests that efforts to promote training in rural areas, improve pathway visibility and strengthen local training environments are beginning to influence trainee interest and uptake.

In some regions, increased demand has translated into substantial growth in trainee numbers, particularly where local initiatives, funding and leadership have supported the expansion of training capacity.[13]

> We are up to 30 trainees, and we used to have up to 8 vacancies. Now the city is asking for rural posts, and I don't necessarily have vacancies.
>
> Rural Director of Training

Stakeholders described examples where regional services have shifted from relying on metropolitan trainees undertaking mandatory rotations in a rural location to developing a more stable local trainee cohort. This indicates that training is becoming a more viable and attractive pathway in some rural settings.

> We're now starting to see people graduate, even though we're only 3 years in, we took people who were already part way through their training. We've had 12 people graduate and about 8 of them have already taken full-time positions rurally.
>
> Rural Director of Training

However, increased demand is not consistently matched by system capacity, with some stakeholders reporting that there are ongoing bottlenecks in accessing key training experiences (including mandatory terms in C-L psychiatry and CAP) for trainees in rural areas. Recently implemented Roadmap initiatives, focused on providing alternate pathways to achieve these training requirements, are expected to help address these bottlenecks but have not yet been consistently implemented in practice across Australia.

Increased interest in training in a rural location is a positive early signal, but it does not automatically translate into increased workforce supply. For demand to result in long term workforce growth, trainees need access to high quality supervision, required training experiences, peer support, and realistic pathways into post-Fellowship roles in rural areas.

Additionally, demand for training places is influenced by a range of factors including lifestyle considerations, housing availability, and access to specialised training opportunities that are not available in all areas. As a result, even trainees who intend to remain practising in a rural

[13] Note that data pertaining to funding amounts has not been provided and these findings are qualitative only.

location long-term after Fellowship may continue to move between rural and metropolitan locations.

Early insights therefore suggest that the Roadmap is contributing to increased interest and engagement in psychiatry training in rural locations, but that workforce growth will depend on the capacity of local systems to absorb, support and retain trainees.

### F26. Trainee awareness of the Roadmap is variable, with some trainees highly engaged and others having limited knowledge

Trainee awareness of the Roadmap appears to be variable. Some trainees who participated in consultations are highly engaged with Roadmap-related initiatives, and can identify specific supports, reforms or local changes that have influenced their training experience. Others had limited awareness of the Roadmap as a formal strategy, even where they may have benefited from initiatives delivered under it.

This variation is not necessarily unexpected. Many Roadmap actions are experienced by trainees indirectly through changes to training settings, supervision arrangements, rotation access, local coordination or support structures. As a result, trainees may notice improvements in their training environment without attributing these changes to the Roadmap.

This has implications for how impact is assessed. Low awareness of the Roadmap among some trainees should not be interpreted as evidence that the Roadmap is not influencing trainee experience. Rather, it suggests that some Roadmap impacts are embedded within the training system and may be experienced as part of normal training delivery.

However, limited awareness may limit trainee engagement with available supports. Where trainees are unaware of Roadmap initiatives, they may be less likely to access resources such as Rural Readiness activities, exam support, peer networks, remote supervision options or training pipeline initiatives. This suggests there may be value in strengthening communication to trainees about what supports are available, how these connect to rural training pathways, and how trainees can engage with them. This does not necessarily require promoting the Roadmap as a RANZCP strategy. Trainee communications could focus on practical supports, opportunities and pathways available to trainees in rural settings.

### F27. Locations with sufficient trainee and supervisor workforce depth report more positive training experiences

Stakeholders consistently reported that training in a rural location works best where locations have sufficient workforce depth across both trainees and supervisors. In these settings, trainees are more likely to have access to consistent supervision, peer support, local teaching, manageable on-call arrangements and a broader range of training experiences. This helps create a training environment that feels sustainable for both trainees and supervisors.

> Getting that critical mass to get off the ground is the hardest thing. To be able to build supervision and trainee capacity you need to put it to the service – do you want to retain trainees that know the area and the community, or do you want to pay expensive locums and throw money away?
>
> Fellow

A sufficient trainee cohort size appears to be particularly important. When there are multiple trainees in a location or region, trainees may feel less isolated and have greater access to peer learning and informal support. This can improve the overall training experience and make rural practice feel more sustainable. It also supports local teaching arrangements, study groups and shared learning opportunities that are more difficult to establish when trainees are dispersed individually across small sites.

Supervisor cohort size appears equally important. Where supervision responsibilities are distributed across several supervisors, services are less reliant on individuals, and this reduces the risk that training capacity is disrupted by leave, workload pressures or staff turnover. It also enables supervision to be distributed more appropriately across clinical, educational and assessment responsibilities.

> Our service was in a bad position; we were losing the Clinical Director. Then some people stood up and said that it wasn't sustainable. We got the Executive to aggressively recruit a psychiatrist… and they looked interstate and internationally. It's necessary because we will keep losing doctors in these areas because they will keep burning out… It's better here than it was. It's still incredibly busy and we're putting fires out most of the time, but at least we're not worrying that something will happen and there will be a very bad outcome, and that it could be unsafe. When I was a trainee, it was so unsafe with that level of staffing. You don't feel like you're doing a good job.
>
> Supervisor

In contrast, locations with very small trainee numbers or limited supervision capacity remain more fragile. In these settings, training quality and continuity may depend heavily on individual supervisors or Local Champions. Trainees may experience greater professional isolation, reduced access to peer support, and more difficulty meeting training requirements locally.

Several trainees and Fellows identified that a lack of workforce depth was a critical barrier to both attraction and retention in rural areas, and capacity restrictions were inhibiting the successful implementation of several Roadmap initiatives.

> Theres no fat in the system. If you're one person down, it puts a huge burden on the other people in the service. I don't know about my future here, because as it becomes really intense, there's not much to keep me here.
>
> Fellow

This finding reinforces the importance of considering the sustainability of local training settings, not only the geographic distribution of training opportunities. Smaller or more isolated rural sites can provide valuable clinical exposure and access to unique learning opportunities, but may be more viable when designed as short-term or targeted placements within a larger training

model. This would allow trainees to benefit from smaller site experience while maintaining connection to larger regional training settings that can provide more consistent supervision, peer support, teaching and pathway coordination. Initiatives such as online learning modules and workshops can also be utilised to fill gaps in available rural training placement opportunities.

# 6. Opportunities for refinement and continuous improvement

This chapter addresses KEQ3: Identify opportunities to refine implementation and support continuous improvement. It draws together findings to identify practical opportunities to strengthen the Roadmap over its remaining implementation period.

## 6.1. Embed Roadmap initiatives into business-as-usual RANZCP processes

A key opportunity for the next phase of the Roadmap is to ensure that completed actions are embedded into routine RANZCP processes, rather than remaining as discrete project tasks/achievements. Several initiatives have been successfully developed and implemented, including remote supervision guidelines, changes to selection criteria, Rural Readiness activities, communications initiatives and training supports. However, some of these remain dependent on dedicated RPTP resourcing, individual leadership or project-based coordination.

Embedding these initiatives into RANZCP business-as-usual would help sustain progress beyond the current funding period. This may include clarifying where ongoing responsibility for each initiative sits within RANZCP, incorporating Roadmap-related requirements into relevant governance, accreditation, training and communications processes, and ensuring monitoring continues beyond the life of specific projects.

This is particularly important for the long-term success of the Roadmap. Stakeholders consistently emphasised that rural priorities can be difficult to sustain alongside other RANZCP priorities without dedicated attention and follow-through. Committee representation is important but is unlikely to be sufficient on its own to maintain momentum.

**Practical opportunities for the future of the Roadmap include:**

- assigning clear ongoing ownership for completed Roadmap actions
- integrating Roadmap reporting into existing RANZCP governance cycles
- maintaining rural considerations within accreditation, supervision and training policy processes
- ensuring communications and engagement activities continue beyond project funding
- using the MEL framework to support regular monitoring and decision-making.

## 6.2. Strengthen data systems and reporting capability

The Roadmap's MEL framework has helped clarify what needs to be monitored, but data systems remain maturing. Current data limitations constrained the extent to which progress and early outcomes could be assessed in this evaluation, particularly in relation to trainee pathway participation, rotation history, supervision arrangements and retention after Fellowship.

Strengthening data systems will be important for both accountability and continuous improvement. Better data would allow the RANZCP to track whether Roadmap actions are influencing trainee distribution, progression, access to training experiences, supervision capacity and eventual workforce outcomes. It would also support more targeted decision-making by identifying where implementation is progressing well, where bottlenecks remain, and where further support is required.

**Practical opportunities for the future of the Roadmap include:**

- Assessing potential gaps or improvements for consistency of data capture across iMIS, InTrain and related systems
- strengthening data fields relating to rural background, training location, rotation history and pathway participation
- improving data on supervisors, including location, supervision load and availability
- developing routine reporting against key Roadmap indicators establishing a mechanism for collecting data to measure post-Fellowship workshop outcomes, and linking training data to the outcomes where possible
- using data to support forward planning with jurisdictions and health services
- As data systems mature, RANZCP should consider collecting cost, activity and outcome data in a way that would support future assessment of the Roadmap's efficiency, effectiveness and value for money.
- consider undertaking a data health check before the final evaluation phase to assess whether recent data improvements have strengthened the ability to measure Roadmap outcomes

## 6.3. Sustain RDOT roles and further support RDOT-style local coordination

RDOTs have emerged as one of the strongest enablers of local implementation of Roadmap priorities. RDOTs provide place-based coordination, support pathway planning, strengthen relationships between RANZCP and health services, and help align training with local workforce

needs. In several locations, RDOTs have supported growth in trainee numbers, improved training continuity and more proactive retention planning.

However, RDOT coverage remains uneven, and not all rural or regional areas have access to this form of locally tailored coordination.

Expanding RDOT coverage or developing equivalent local coordination models where RDOT roles are not feasible, would support more consistent implementation across jurisdictions. This would be particularly valuable in rural locations or jurisdictions where training pathways remain fragmented, or where relationships between training and workforce planning are less developed.

**Practical opportunities for the future of the Roadmap include:**

- reviewing gaps in RDOT coverage across jurisdictions to identify where RDOT roles, shared RDOT models or equivalent coordination roles would add value
- advocating for administrative support for RDOTs
- clarifying RDOT responsibilities in relation to training, workforce planning and retention
- establishing regular RDOT communities of practice to share models and practical solutions
- make more formal use of RDOTs as a bridge between RANZCP training requirements and health service workforce planning.

## 6.4. Improve alignment between training pathways and workforce planning

A major opportunity for refinement is to strengthen alignment between training pathway design and workforce planning. Emerging findings indicate that the strongest outcomes occur where health services have used the Roadmap as a lever to redesign workforce models, rather than simply increasing trainee numbers. In these settings, training pathways are linked to local service needs, rotations are planned with retention in mind, and trainees are supported to transition into local consultant roles.

In contrast, where training and workforce planning remain disconnected, trainees may complete placements without a clear pathway to ongoing employment in a rural location. This risks losing trainees who may otherwise be interested in remaining in a rural location.

While workforce planning sits primarily with jurisdictions and health services, RANZCP can influence alignment through accreditation processes, data provision, RDOT roles, advocacy and partnership mechanisms.

**Practical opportunities for the future of the Roadmap include:**

- encouraging forward planning for post-Fellowship consultant roles

- supporting services to map trainee pipelines against future workforce need
- using RDOTs to strengthen links between trainee progression and local workforce planning
- encouraging health services to consider transition-to-practice pathways for trainees completing Fellowship
- using RANZCP data to support discussions with jurisdictions about future workforce needs
- documenting examples where training and workforce planning are well aligned and successful in retaining staff.

## 6.5. Strengthen supervision capacity and sustainability

Supervision remains one of the most important constraints on training expansion in a rural location. While supervision capacity has increased in some places, it remains uneven and concentrated in metropolitan and larger regional centres. Smaller and more remote sites remain particularly vulnerable where supervision depends on a small number of clinicians.

Strengthening supervision capacity requires both expanding the number of supervisors and ensuring supervision is sustainable. This includes protected supervision time, supervisor development, peer support, administrative support and recognition of the additional workload associated with supervision in a rural location.

RANZCP does not control the employment or workload of supervisors, but it can influence supervision sustainability through standards, training, advocacy and support models.

**Practical opportunities include:**

- continue strengthening supervisor development pathways for psychiatrists in rural locations
- advocating for funded and protected supervision time
- supporting peer networks for supervisors in rural locations
- monitoring supervision load as part of accreditation processes and identifying areas of risk
- developing guidance on sustainable supervision models in rural settings.

## 6.6. Refine remote supervision policy and implementation

Remote supervision has been an important enabler of training in rural locations, particularly where local supervision capacity is limited. It has supported access to training opportunities and helped some trainees remain in rural settings while completing required experiences.

However, stakeholders identified opportunities to refine remote supervision eligibility and implementation. Current eligibility criteria may not always reflect service realities. For example, a main training site may be classified as MM2 but service a much more remote population, or a supervisor may be located in a more remote area while the trainee is based in MM2. These scenarios may limit the ability to use available supervision capacity flexibly.

There is an opportunity to consider whether remote supervision eligibility could better account for service context, workforce availability and training need, rather than relying only on strict geographic classification.

**Practical opportunities for the future of the Roadmap include:**

- reviewing remote supervision eligibility criteria
- considering service catchment, workforce capacity and training need in approval processes
- sharing examples of effective remote supervision implementation
- ensuring local support and escalation pathways are in place
- monitoring trainee and supervisor experience of remote supervision
- clarifying that remote supervision is not a substitute for local workforce development.

## 6.7. Develop more comprehensive supports across the rural training and workforce pathway

Roadmap initiatives to support trainees and supervisors in rural settings are emerging, but a more comprehensive and coordinated support model is not yet developed. Roadmap actions include support packages for trainees, supervisors, psychiatrists in rural locations, and the broader psychiatry workforce. Some progress has been made through Rural Readiness workshops, Rural Champions, buddy arrangements, exam support and remote supervision; however, several support-related actions remain in early stages or are not yet fully implemented.

A comprehensive support model should consider the whole pathway: early interest, selection, training, progression to Fellowship, transition to consultant practice and ongoing retention. This could include practical supports, peer connection, mentoring, exam support, Scholarly Project support, supervisor development, infrastructure, retention incentives and transition-to-practice supports.

**Practical opportunities for the future of the Roadmap include:**

- strengthen connections with Rural Clinical Schools and Universities
- refining a coordinated support package for trainees in a rural location

- strengthening support for supervisors in a rural location, including professional development and advocacy for protected time
- reviewing the buddy program to understand low uptake and expand reach
- developing structured peer support networks for trainees in a rural location
- expanding exam and Scholarly Project support
- developing transition-to-practice supports for trainees approaching Fellowship.

# 7. Alignment with wider medical workforce priorities

This section addresses KEQ4: Assess the Roadmap's continuing alignment with RANZCP and government strategies and priorities for mental health in rural locations. It considers how the Rural Psychiatry Roadmap 2021-2031 aligns with wider medical and mental health workforce reform directions, including priorities relating to rural workforce distribution, specialist training pathways, supervision flexibility, SIMG workforce contribution, Fellowship reform, and integrated rural models of care. The section also identifies opportunities to strengthen this alignment over the remaining implementation period.

## 7.1. Overall alignment

The Rural Psychiatry Roadmap 2021–2031 is well aligned with wider medical workforce priorities and reform directions, particularly those concerned with expanding training in a rural location, strengthening generalist capability, improving supervision flexibility, and building more coordinated and portable training pathways. Its value extends beyond psychiatry by supporting the broader rural generalist system and contributing to more integrated service models for regional and rural communities.

These priorities are reflected in several current workforce reform agendas, including the National Medical Workforce Strategy 2021–2031[14], the National Mental Health Workforce Strategy 2022–2032[15], the Specialist Training Program[16], Psychiatry Workforce Program[17], the Integrated Rural Training Pipeline[18], and RANZCP's own Fellowship reform and supervisor development priorities. Together, these strategies emphasise improving workforce distribution, growing regional and rural training pipelines, supporting flexible training models, strengthening supervision, and building a sustainable workforce that can meet community need.

Looking ahead, the Roadmap's continuing relevance will depend on sustained implementation, cross-sector partnership, and the ability to demonstrate measurable improvements in rural workforce supply, trainee support and long-term retention.

[14] Australian Government Department of Health. (2021). National Medical Workforce Strategy 2021–2031. Canberra: Commonwealth of Australia.

[15] Australian Government Department of Health and Aged Care. (2023). National Mental Health Workforce Strategy 2022–2032. Canberra: Commonwealth of Australia

[16] Australian Government Department of Health and Aged Care. (2024/2026). Specialist Training Program Operational Framework 2022–26. Canberra: Commonwealth of Australia.

[17] https://www.ranzcp.org/college-committees/public-partners/for-health-services-with-stp-posts/psychiatry-workforce-program-pwp

[18] Royal Australian and New Zealand College of Psychiatrists. (n.d.). Integrated Rural Training Pipeline (IRTP posts).

### Table 7: Alignment with key reforms and priorities

| Priority | How the Roadmap aligns | Evaluation findings | Implications for the next phase |
|---|---|---|---|
| National medical workforce reform | The Roadmap aligns with the National Medical Workforce Strategy 2021–2031 by supporting training in a rural location, workforce distribution, generalist capability, training reform and workforce flexibility. | Alignment is strongest where the Roadmap is being used to connect training pathways with local workforce planning, rather than simply allocating trainees to rural rotations. | Continue to position the Roadmap as a mechanism for linking psychiatry training reform with broader rural workforce planning and service sustainability. |
| National mental health workforce priorities | The Roadmap aligns with the National Mental Health Workforce Strategy 2022–2032 by contributing to a sustainable, skilled, distributed and supported mental health workforce. | Psychiatry workforce shortages remain a major constraint on access to specialist mental health care in rural and regional communities. The Roadmap contributes by strengthening the rural psychiatry training pipeline, supervision arrangements and supports. | Strengthen the Roadmap's contribution to broader mental health workforce objectives by focusing on trainee progression, retention, supervision sustainability and pathways into practising in a rural location. |
| Specialist Training Program and Integrated Rural Training pipeline | The Roadmap aligns with Commonwealth specialist training initiatives, particularly STP[19] and IRTP, which support rural specialist training positions and rural pipeline models. | STP and IRTP funding provide important infrastructure for Roadmap implementation. IRTP has enabled some regions to establish training in a rural location where it had not previously been possible. However, stakeholder feedback indicates that funding rules can create complexity where services manage multiple Commonwealth funding streams. | Ensure funded posts are embedded in coherent local training pathways, supported by supervision capacity and linked to post-Fellowship workforce planning. The next phase should focus not only on increasing funded posts, but on making sure they translate into sustainable rural workforce outcomes. |

Source: HealthConsult document and policy review (2026)

**F28. Specialist training and rural pipeline initiatives provide an important platform for Roadmap implementation.**

The Roadmap aligns closely with Commonwealth specialist training initiatives, particularly the STP and Integrated Rural Training Pipeline (IRTP). The STP supports specialist training positions in regional, rural and remote areas and in private settings, with the aim of improving specialist workforce distribution and giving trainees experience across a broader range of healthcare settings.

The IRTP is especially relevant to the Roadmap because it is explicitly focused on increasing the number of psychiatry trainees and specialists in rural and regional areas. IRTP posts are

[19] The Specialist Training Program (STP) is currently going through program reform, which may impact activities in 2028.

Australian Government-funded positions where funding "follows" the trainee through multiple settings, supporting a rural pipeline model. More broadly, IRTP models are intended to enable specialist trainees to complete substantial components of training in rural regions, with limited metropolitan rotations where needed to meet specialty requirements.

This aligns directly with the Roadmap's intent to enable trainees to complete the majority (or where possible, the entirety) of their training in rural settings. IRTP and STP funding provide important infrastructure for Roadmap implementation, particularly where funded posts are used to expand local training capacity, support rural rotations, and strengthen continuity of training. One RDOT was able to leverage IRTP funding to enable training in a rural location, where it had not previously been possible.

> Most of our training activities happened in the capital until the integrated rural training pathway came along, and then we had funds to put trainees in regional locations where we'd never placed trainees before. That is a big milestone for us. Up until about 2013, in the entire history of the state, only 2 or 3 psychiatrists had ever lived and practiced rurally and regionally. Since about 2019, when we recruited our first integrated rural training pathway trainee, we now have about 9 or 10 trainees that live and train rurally and regionally.
>
> Rural Director of Training

However, stakeholder feedback suggests that Commonwealth-funded training posts can be difficult to operationalise in some contexts, particularly where services rely on multiple funding streams. One stakeholder noted that in jurisdictions with a high proportion of federally funded posts across both STP and IRTP, IRTP funding rules can create additional complexity because it is attached to individual trainees. This can limit flexibility in moving trainees across posts and rotations, particularly where services are also managing STP-funded positions and seeking to avoid perceived duplication or overlap.

While the RANZCP was described as flexible and pragmatic in resolving these issues, stakeholders noted that the process can add administrative burden and make rotation management more complex. This suggests that the effectiveness of IRTP funding depends not only on the availability of funded posts, but on how well these posts are integrated into local training pathways, supervision arrangements and workforce planning.

Overall, specialist training funding is strongly aligned with Roadmap objectives and remains an important enabler of training expansion in rural locations. However, evaluation findings indicate that the benefit of funded posts is greatest where they are embedded in sustainable local workforce models, supported by sufficient supervision capacity, and linked to post-Fellowship workforce planning. Without this integration, funded posts may increase training activity in a rural location, without necessarily translating into long term workforce retention.

### F29. Fellowship reform and supervisor development create important opportunities to embed rural training priorities into core RANZCP business

The Roadmap is strongly aligned with RANZCP's internal priorities relating to Fellowship reform, supervisor development and training equity. Several Roadmap actions depend on, or may be affected by, changes to Fellowship requirements, training structure and assessment models. This includes actions relating to Formal Education Courses, mandatory rotations, recognition of competencies, remote supervision, networked training arrangements and equitable access to required training experiences.

The evaluation findings highlight the importance of ensuring Fellowship reform does not reproduce metropolitan assumptions about training access. Trainees in a rural location may have access to broad, high quality clinical experience, but may face barriers where requirements assume ready access to multiple subspecialty services, large consultant workforces, formal academic infrastructure or multiple accredited rotations in close geographic proximity.

### F30. There are opportunities to strengthen alignment between the Roadmap and SIMG workforce priorities in rural settings

SIMGs are an important component of the psychiatry workforce in a rural location and are likely to remain central to workforce supply in many regional and rural areas. The National Mental Health Workforce Strategy 2022–2032[15] explicitly recognises overseas trained professionals as part of Australia's approach to growing the mental health workforce, including in rural and remote settings.

While SIMGs are not a key priority group for the Roadmap, several Roadmap initiatives are relevant to SIMGs working or training in rural locations. These include Rural Readiness activities, remote supervision, pathway information, peer support, supervisor support and broader rural practice supports. SIMGs in rural settings may face overlapping challenges related to supervision access, professional isolation, service demand, workplace integration and rural lifestyle adjustment.

There is an opportunity to strengthen alignment between the Roadmap and broader strategies shaping the mental health workforce by ensuring SIMGs are considered in the design and delivery of rural supports where appropriate. This does not necessarily require separate SIMG-specific actions; rather, it requires ensuring existing rural initiatives are accessible and relevant to SIMGs in rural settings.

### F31. The Roadmap supports broader rural generalist and integrated care priorities by strengthening access to specialist mental health capability in rural settings

The Roadmap also aligns with broader rural generalist and integrated care priorities. Psychiatry in a rural location is not equivalent to rural generalist medicine. Psychiatrists in a rural location often work in settings requiring broad scope, flexible practice, collaboration and responsiveness

to local service needs. A stronger psychiatry workforce in rural settings supports not only specialist mental health care, but also the broader rural health system, including general practice, rural generalists, emergency departments, community mental health teams, Aboriginal Community Controlled Health Organisations, alcohol and other drug services and non-government providers.

This is consistent with broader rural workforce priorities that emphasise locally responsive care, multidisciplinary practice and working to full scope. However, evaluation findings also highlight an important tension: rural communities need psychiatrists with strong generalist capability, but they also need access to specialised expertise. The Roadmap is therefore best aligned with rural generalist reform when it supports both broad rural capability and access to specialist skills through networked training, remote supervision, visiting services and links between regional and metropolitan services.

## 7.2. Implications for the next phase of the Roadmap

Overall, the Roadmap is well aligned with national medical workforce reform, mental health workforce strategy, specialist training investment, RANZCP Fellowship reform, overseas trained doctor workforce priorities and rural generalist models of care. Its strongest contribution is that it translates these broad priorities into practical training system reforms: rural selection settings, RDOT roles, remote supervision, rural readiness, pathway coordination, training flexibility and support for rural workforce sustainability.

The next phase should focus on moving from alignment in principle to alignment in practice. This means embedding Roadmap priorities within:

- RANZCP Fellowship reform and supervisor development
- SIMG support and workforce strategies
- jurisdictional medical workforce planning
- rural generalist and multidisciplinary service models
- data systems that can demonstrate rural workforce outcomes.

The Roadmap remains highly relevant, but its ongoing value will depend on sustained implementation, stronger evidence of impact, and continued partnership between RANZCP, governments, health services and training stakeholders.

# 8. Conclusions and recommendations

This chapter draws together findings from across the review to present overall conclusions about the Roadmap's progress, early impacts and strategic alignment, and, assuming the RPTP Team continues, sets out recommendations to guide the next phase of implementation.

## 8.1. Implementation progress and foundations

The Roadmap has progressed a substantial proportion of its 45 deliverables. Completed or substantially progressed actions include the establishment of governance structures, the RPTP team, RDOT roles, the MEL Framework, selection reforms, remote supervision regulations, Rural Readiness workshops, STP/IRTP transparency improvements, changes to CAP and CL training requirements, and rural training pipeline promotion activities. These achievements reflect a significant volume of work and have established important building blocks for the second half of the Roadmap.

However, many remaining actions involve more complex system change that sits, at least in part, outside RANZCP's direct control. These include employment portability, comprehensive trainee and supervisor support packages, subspecialty training access, retention incentives and transition-to-practice programs. Progress on these actions is likely to be slower and more dependent on advocacy, partnership and alignment across jurisdictions, health services and workforce agencies. Although the implementation plan has not been consistently maintained or updated, the bi-monthly reporting of outcomes in the Project Visual and the RRR report has ensured consistent visibility of overall delivery accountability.

A further risk is around de-prioritization of Roadmap actions if they are transitioned into BAU activities. The Roadmap continues to require active prioritisation across RANZCP in order to sustain progress if dedicated resourcing is not continued.

**R1.** **Develop a transition plan before the current RPTP funding period concludes to maintain dedicated oversight of continuing Roadmap priorities (remote supervision, selection reforms, rural communications, rural readiness, reporting) while embedding completed actions into core RANZCP processes.**

**R2.** **RANZCP should clarify ownership, accountability and priority for all remaining Roadmap actions, identifying which require RANZCP delivery, advocacy, external partnership or monitoring, and update the implementation plan accordingly.**

## 8.2. Governance and accountability

Rural representation has increased across several key RANZCP committees and governance structures during the Roadmap period, increasing the visibility of rural perspectives in decision-making. The RRRSTG provides governance oversight with clear reporting lines to the Education

Committee and Board. Interviewees noted improvement in rural representation across the Education Committee, Committee for Training, and Accreditation Committee since the Roadmap commenced.

However, representation alone is insufficient to sustain Roadmap progress. Stakeholders noted that Committee representation does not guarantee that rural priorities are progressed between meetings, resourced adequately, or consistently considered in decisions that affect training, accreditation and workforce planning. Dedicated project coordination has been essential to early implementation, and its continuation or transfer to business-as-usual processes will be critical to maintaining momentum.

**R3.** **RANZCP should ensure that rural psychiatry training priorities are explicitly and structurally considered in relevant governance, accreditation, training policy, supervision and resource allocation decisions, and that this consideration is built into process rather than relying solely on the presence of rural representatives on committees.**

## 8.3. Rural Directors of Training

RDOT roles have emerged as one of the clearest enablers of Roadmap implementation and local workforce development. RDOTs provide place-based coordination, pathway planning, trainee recruitment, rotation management, and linkage between RANZCP training requirements and health service workforce needs. In several jurisdictions, RDOT positions have transitioned from initial funding via the Flexible Approach to Training in Expanded Settings program to ongoing jurisdictional funding, a meaningful indicator of local value and investment.

The experience of regions with well-established RDOT coordination illustrates what is possible: increased training posts, growth in locally-identified trainees, and locally-trained psychiatrists transitioning into consultant roles in rural settings. These outcomes represent exactly the kind of pipeline development the Roadmap was designed to achieve.

RDOT coverage remains uneven, and not all rural or regional areas currently have access to this form of locally embedded coordination. Stakeholders also identified the need for adequate administrative support to maximise RDOT impact.

Making the case for new RDOT positions will require jurisdictional investment. RANZCP should document the roles' contribution to rural training coordination, trainee support, supervision planning and local workforce development, and use this evidence to support jurisdictions in sustaining and expanding RDOT-style coordination, including lower-cost or adapted models where a dedicated position is not feasible.

**R4.** **RANZCP should review gaps in RDOT coverage, document the roles' value, and work with health services and jurisdictions to expand or adapt locally embedded coordination models in regions without dedicated rural training support, with adequate administrative and operational support.**

## 8.4. Data systems and monitoring

Current data limitations significantly constrained this evaluation. Available datasets provide a single point-in-time snapshot, do not allow consistent longitudinal tracking of trainee pathways, and cannot reliably link rural background, rotation history, supervision arrangements, progression and post-Fellowship outcomes. Geographic data are available primarily at jurisdictional level, limiting the ability to assess distribution across regional, rural and remote locations.

These limitations are not unusual for a mid-term evaluation of a 10-year reform, but they will need to be substantially addressed if the 2031 evaluation is to provide a rigorous assessment of the Roadmap's contribution to rural workforce outcomes. The MEL Framework provides a useful foundation for this work, but data systems need sustained investment to convert the framework into a practical monitoring tool.

**R5.** **RANZCP should prioritise strengthening data collection, linkage and reporting capability for the remainder of the Roadmap. This should include: consistent geographic coding (MM classification) for trainees, Fellows, SIMGs, supervisors and training posts; longitudinal trainee tracking from selection through to post-Fellowship outcomes; improved supervisor data including location, load and availability; and routine reporting against key Roadmap indicators. A data health check should be conducted well in advance of the 2031 evaluation to assess whether improvements are sufficient to support outcome measurement.**

## 8.5. Supervision capacity and remote supervision

Supervision remains the most important constraint on training expansion in a rural location. While stakeholders reported increased supervision capacity in some regional areas, available data indicate that the large majority of supervisors remain concentrated in MM1 locations. Rural and remote settings continue to face risks from small supervisor numbers, consultant turnover, reliance on locum or visiting psychiatrists and limited protected supervision time.

Remote supervision has been an important enabler and is generally regarded as high quality where implemented. However, its effectiveness depends on local workforce stability, clinical governance and service readiness. It should complement — not replace — local supervision capacity. Current eligibility criteria may also create mismatches between where supervision capacity exists and where it can be applied, for example where a lower MM-classified site serves a substantially remote catchment population.

**R6.** **RANZCP should continue to strengthen rural supervision capacity and sustainability, including advocating for funded and protected supervision time, expanding supervisor development pathways for rural psychiatrists, and supporting peer networks for rural supervisors.**

**R7.** **RANZCP should review remote supervision eligibility criteria to better account for service catchment context, workforce availability and training need, rather than relying solely on geographic classification. The review should also ensure that remote supervision is clearly understood as complementing, not substituting for, local workforce development.**

## 8.6. Workforce planning and post-Fellowship pathways

Growing interest in rural training pathways cannot be converted into sustained rural workforce growth unless trainees have clear pathways into post-Fellowship employment in rural settings. The strongest outcomes observed during this review have occurred where training pathways are intentionally designed around local workforce needs, with coordinated rotations, supervision planning and active planning for consultant roles after Fellowship.

Where training and workforce planning remain disconnected, trainees may complete rural placements without a clear pathway to ongoing rural employment. This limits the Roadmap's capacity to contribute to long-term workforce distribution outcomes. RANZCP's role in this space is primarily facilitation and advocacy, but it can strengthen alignment through data provision, RDOT roles, accreditation processes and partnership mechanisms.

**R8.** **RANZCP should work with health services and jurisdictions to strengthen alignment between rural training pathway planning and jurisdictional workforce planning, including encouraging forward planning for post-Fellowship consultant roles and supporting services to map trainee pipelines against projected workforce need.**

## 8.7. Trainee and supervisor support

Support for trainees, supervisors and psychiatrists in a rural location remains underdeveloped relative to the Roadmap's intent. Rural Readiness workshops, Rural Champions, buddy arrangements, exam support and remote supervision have all contributed to a more supportive environment. However, several planned support actions have not yet commenced, including comprehensive support packages for trainees, supervisors and psychiatrists in a rural location, a rural trainee peer support network, and transition-to-practice supports.

A comprehensive support model should address the full pathway — from early interest through selection, training, Fellowship and post-Fellowship retention. Evidence of trainees establishing informal peer networks suggests demand exists. Improving the uptake of the buddy program, expanding structured peer support and developing transition-to-practice arrangements should be priorities for the next phase.

**R9.** **RANZCP should continue to develop a comprehensive and coordinated support model for trainees, supervisors, psychiatrists and SIMGs in a rural location. This should address the full training and workforce pathway, including peer connection, exam support, Scholarly**

**Project support, supervisor development, mentoring and transition-to-practice arrangements.**

## 8.8. Fellowship reform and strategic alignment

The Roadmap is well aligned with the National Medical Workforce Strategy 2021–2031, the National Mental Health Workforce Strategy 2022–2032, the Specialist Training Program, the Integrated Rural Training Pipeline, and RANZCP's own Fellowship reform and supervisor development priorities. These strategies collectively emphasise improving rural workforce distribution, growing regional training pipelines, supporting flexible and portable training models, strengthening supervision and building sustainable rural workforces.

Fellowship reform is an opportunity to lock in progress made under the Roadmap and to ensure that training in a rural location continues to be recognised as high quality and equivalent in value to metropolitan training. The impact of Fellowship reform on rural training pathways remains an area to monitor closely, particularly in relation to mandatory rotations, rural content in Formal Education Courses and subspecialty training access in rural settings.

The Roadmap remains highly relevant. Its value lies in strengthening the conditions that make rural psychiatry training viable, high quality and connected to long-term workforce outcomes. The remaining years of the Roadmap are an opportunity to consolidate early gains, embed successful initiatives into core RANZCP processes, and focus effort on the system changes needed to sustain progress and deliver measurable improvement in the rural psychiatry workforce.

## 8.9. Looking ahead

The review found that the Roadmap has made meaningful progress in establishing the foundations for rural psychiatry training. It has strengthened governance arrangements, supported increased rural representation across RANZCP structures, introduced key policy and training reforms, enabled Rural Director of Training roles in several jurisdictions, and improved the visibility of psychiatry in a rural location as a viable and meaningful training and career pathway. However, progress is uneven, and sustainability is not yet assured.

The Roadmap is now entering a more complex phase. Foundational actions have largely been completed or substantially progressed. Remaining priorities depend on sustained resourcing, broader system change, greater alignment between training and workforce planning, and stronger integration of rural psychiatry into RANZCP business-as-usual. The central risk for the next phase is loss of momentum if Roadmap activities are not clearly owned, resourced and embedded.