Expanding Australian psychiatry training settings beyond metropolitan public hospitals: background and issues

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Objective: The aim of this paper is to provide an overview of the rationale behind the expansion of specialist psychiatry training positions outside of major public teaching hospitals, as expounded by the Australian Federal Government's Expanded Settings for Specialist Training (ESST) Program.

Conclusion: Alternative training settings are required to help address the anticipated growth in numbers of medical graduates and to meet the need of psychiatry trainees for greater experience in treating high prevalence mental disorders. To progress the expansion of training settings within psychiatry, it is essential that comprehensive consultation be undertaken to understand the implications of this program for trainees, existing training facilities and expanded setting providers to ensure that all stakeholders, including patients and carers, derive benefit.

Key words: Australia, expanded settings, psychiatry, specialist training.

There is growing concern that psychiatry trainees have too little exposure in metropolitan public hospitals to the commonest psychological disorders—anxiety, depression and substance abuse—to equip them properly for their future clinical practice. It is hoped that broadening training experiences and settings will produce better rounded specialists with the skills to assess and treat patients with low and high frequency conditions, using psychological and biological therapies, either single-handedly or as part of a multi-disciplinary team. As additional benefits, these broader opportunities will, it is hoped, attract more medical graduates to specialize in psychiatry and to work in areas of need, most notably in rural and regional Australia.

With these goals in mind, the Federal Government’s Department of Health and Ageing (DoHA) has established an Expanded Settings for Specialist Training (ESST) Program with a particular focus on psychiatry reflecting the Government’s interest in the mental health and wellbeing of all Australians. In rolling out this program, DoHA has sought guidance and support from specialist medical colleges including the Royal Australian and New Zealand College of Psychiatrists (RANZCP – ‘the College’), state and territory health departments, and providers of public and private mental health services.

This paper outlines the opportunities and risks of expanded specialist training from the perspective of the College, public and private mental health services, psychiatry training programs and psychiatry trainees.

BACKGROUND

The mental health services provided through Australian public metropolitan teaching hospitals encompass inpatient and community adult, child
and adolescent, aged and forensic psychiatry with an emphasis on patients with severe, chronic disorders. Expanded specialist training settings are defined broadly as rotations outside this spectrum. They include private psychiatric hospitals and clinics, specialists’ rooms, general medical practices, services to outer metropolitan, regional and rural areas, Aboriginal mental health services and non-clinical domains (e.g. research, teaching and clinical leadership).1

Aligning training to practice

The National Mental Health Strategy dating from 1992 has led to the replacement of stand-alone psychiatric hospitals with general hospital inpatient units, community mental health teams and non-government rehabilitation and support services.3 Private psychiatric services have grown considerably, supported by Medicare and the health insurance industry, with the result that 41% of psychiatrists now work exclusively in the private setting and another 36% combine work in private and public settings.4 These initiatives aimed to expand the focus of psychiatric services from the relatively small numbers of people with very severe disorders to the much larger numbers of people whose anxiety, depressive and substance use disorders present such a challenge at a personal, family, occupational and societal level.3

Public mental health services typically care for patients across the life-span, in a range of settings (community, residential and inpatient), with attention to specific conditions (e.g. eating and postpartum disorders) and circumstances (e.g. general hospital and forensic psychiatry). These services provide trainees with rich experiences in assessment, diagnosis, pharmacotherapy and multi-disciplinary practice. They give limited exposure, though, to the anxiety, affective and substance use disorders that accounted for 13% of the disease burden in Australia in 2003.5 In the 2007 National Survey of Mental Health and Wellbeing, 20% of Australian adults had experienced an anxiety, affective or substance use disorder in the previous year.6 Anxiety disorders were most common (14%), followed by affective disorders (6%) and substance abuse (5%). Expanding training into settings outside public teaching hospitals will give trainees greater exposure to these conditions, thus ensuring a better alignment with their future work environments. Even psychiatrists who work exclusively in public practice need an adequate range of experiences to prepare them to teach medical students, liaise with other health practitioners, and inform public and College policy.

Workforce planning

A report on the specialist psychiatry workforce in Australia in 2006 found evidence of a shortage of psychiatrists to meet the needs of the population, especially in outer metropolitan, regional and rural areas. Over 90% of psychiatrists worked in major cities that were serviced on average by 22 full-time equivalent (FTE) specialists and trainees per 100 000 population, compared with six FTE in inner regional areas and three FTE in outer regional and remote areas.4

Although the FTE numbers of psychiatrists including trainees increased nationally from 3089 in 2000 to 3392 in 2004, the number of trainees successfully completing the College’s training program is not sufficient to meet vacancies in most jurisdictions and matters are likely to worsen. Workforce data gathered by the College in 2005 indicated that 17% of psychiatrists planned to retire in the next 5 years, while another one-third wished to reduce their hours of work. Workforce ageing and retirement from practice are bigger issues for psychiatry than other disciplines: nearly 75% of psychiatrists are aged over 40 years compared with 65% of other specialists and 58% of general practitioners.4 Based on projections of specialist inflows and outflows, the Mental Health Workforce Advisory Committee recommended increasing the number of commencing psychiatry trainees to 131 annually to achieve an average annual output of 120 specialists in contrast to the present output of about 80.4

The Commonwealth Government has responded to the medical workforce shortage by increasing the number of medical student places both in existing and newly established schools. New medical schools have opened since 2000 in the Australian Capital Territory, New South Wales, Queensland, Victoria and Western Australia, resulting in a projected increase of 62% in the numbers of medical graduates, from 1300 in 2005 to more than 2100 a year after 2010.7 By the time new graduates reach vocational training, the capacity of specialist training programs to accommodate them and provide quality, accredited rotations will be severely constrained.

Given that psychiatry training is currently delivered via an apprenticeship model supervised by College fellows, the current and predicted shortages of psychiatrists, combined with the increasing number of medical graduates requiring vocational training, are matters of grave concern to the profession and governments. It will be important to explore new training opportunities in non-traditional settings with the object of producing sufficient well-rounded specialists to meet the needs of the Australian populace for high-level input into mental health care delivery, teaching, research and policy development.

PRECEDENTS

The World Federation for Medicine Education’s Edinburgh Declaration of 1998 espoused the importance of enlarging the range of educational settings to include all health resources available within a community, not just hospitals.8 Within Australia, a number of educational and training opportunities have been devised in...
line with this principle across the spectrum from undergraduate to vocational training.

Medical undergraduates

The growth in numbers of both local and international medical students make it difficult to provide adequate clinical exposure at a time when hospital stays are shorter and patients are sicker.8 Medical schools are coping with this pressure by conducting teaching in community settings, including general practices, specialists’ private rooms and private hospitals.9 Clinical simulation centres have also proved popular, providing students with the opportunity to practice procedural skills (e.g. suturing, cannulation and resuscitation) under direct supervision without risk to patients.10 Rural and regional placements are especially important, both as a means of broadening students’ clinical exposure and of encouraging them to work, and then stay, in these localities. There are currently 14 rural clinical schools throughout Australia, each operating multiple training sites, and 11 university departments of rural health.11,12 Their results seem encouraging. In Queensland, for example, locally trained interns were more likely to work in Rockhampton and Toowoomba, which were both allied with a clinical school, than Mackay, which was not.13 Rural schools have been especially innovative in providing all or most specialist teaching in general practice settings.14 Other strategies have included rural medical scholarships and community sponsored scholarships.15,16

Pre-vocational doctors

The Rural and Remote Area Placement Program piloted by DoHA from 2000 as a 3-year scheme provided community-based training terms to junior doctors in postgraduate years 1 to 3.17 The success of this initiative led to the continued funding and expansion of the program – re-titled the Prevocational General Practice Placements Program – to outer metropolitan, regional, rural and remote general practice and primary health care placements.18 State governments have crafted their own approaches. In New South Wales, the Rural Resident Medical Officer Cadetship Program, established in 1998, contracts recipients to complete two of their first three postgraduate training years in a rural hospital in return for financial support in their last 2 years of undergraduate study. Nearly half the cadets were still working in rural areas 5 years later.19 In Western Australia, the Community Residencies Project piloted in 2007 gave junior doctors the opportunity to spend an extended period of time in either an outer metropolitan or rural area while undertaking combined training in specialty disciplines (e.g. general practice and paediatrics).20

Vocational trainees

Consultations undertaken with 10 Australian medical specialist colleges between 2005 and 2006 found that many had recognized the potential of expanding training rotations outside major public teaching hospitals. Examples of novel options included rotations in private hospitals, private consulting rooms, outer metropolitan hospitals and clinics, primary care and simulation centres.2

International graduates

Given the contribution made to the Australian healthcare system by international medical graduates (IMGs), especially in rural and remote areas, it is incumbent to reduce barriers to their participation in further training, including ESST programs. Steps that assist in this process will include better orientation to Australian culture and clinical practice, better matching of positions to previous experience, closer supervision and mentorship, and assistance to pass College examinations.21 One such model is being trialed at present in a rural Victorian mental health service.22

BENEFITS AND BARRIERS

There is general agreement that psychiatry trainees will benefit from exposure to a broader range of conditions, types of treatments and settings irrespective of their final choice of practice. To ensure that the ESST program is implemented successfully on a sustainable basis, barriers to its successful implementation must be considered and addressed. Possible impediments and their solutions are addressed below.

Workforce shortages

Shortages in the supply of psychiatrists and trainees mean that new ESST positions might either go unfilled or result in flow-on vacancies in public metropolitan mental health services. Neither result is desirable. Private, rural and other non-traditional settings will naturally require posts to be filled consistently with high-quality junior doctors. Conversely, directors of public mental health services must be confident of back-filling vacancies while trainees rotate through ESST posts. While funding is provided for this purpose, suitable applicants might not be forthcoming in the present climate. The rapidly growing numbers of medical graduates should correct this discrepancy when their numbers peak after 2011, but gaps will arise in the interim. Some faith is required, therefore, that the ESST program will attract sufficient new graduates to this newly conceptualized, broadened and more engaging training program. It is helpful that IMGs enrolled in the College’s examination exemption program can fill ESST posts to the benefit of the candidates themselves and their future patients.
Supervision

It is imperative that trainees are properly supervised and mentored when undertaking ESST rotations. While the expansion of training outside major public hospitals will boost the number of available supervisors, it will be important to consider the quality and level of supervision, the impact on supervisors’ workloads and practices, and access to teaching supports. The College has prepared materials to inform new supervisors of their responsibilities to trainees to ensure that they meet the highest possible standards.

Resources

New models of clinical training will almost certainly require novel approaches to funding to ensure that services and non-salaried supervisors are properly, but not excessively, compensated. The ESST program covers trainees’ salaries and most on-costs but indirect costs to hospitals and supervisors may be substantial. The presence of surgical trainees in operating rooms can lead to a 30% slowing of procedures, reducing the income of both hospitals and supervisors. While a reduction of this magnitude seems unlikely in psychiatric practice where supervisors and trainees typically work in parallel rather than jointly, imposts will include formal and informal supervision, office space, access to computers and journals, medical indemnity insurance and administrative support.

There are costs, too, for the parent mental health service in back-filling positions and for psychiatry training programs in accrediting posts, supporting trainees and meeting College requirements. ESST trainees in non-public settings have access to site-specific Medicare provider numbers which generate income payable to the employer. It will be important to map the income generated by each position and to confirm that it is distributed equitably between the employer, supervisor, parent service and training program.

Accreditation

The expansion in training positions will increase the workload, time pressures and costs for those involved in the accreditation of training positions and programs. Any increase in the number of training positions must be done in consultation with the members of local training committees who conduct accreditations, sometimes in their own time, to ensure that they are sufficiently supported in this process and to prevent a detrimental impact on the quality of the accreditation process and its outcomes.

Indemnity

It is not always clear who holds responsibility for providing medical indemnity cover when trainees rotate externally into a community or private sector position. Some State governments prohibit the extension of public indemnity to staff on secondment to non-public positions, making it advisable for trainees to hold indemnity independently and for non-public services to declare the presence of trainees to their insurers.

Patient attitudes

Access to patients within new care delivery sectors and their willingness to be included within the training experience will significantly impact on the range and quality of training opportunities that can be provided. With appropriate consent, patients in the public sector are generally amenable to the involvement of specialist trainees in their care, but this may not be reflected to the same extent in the private sector. If patients veto or limit trainee participation, the impact on the number of patients seen and the range of conditions managed by trainees may reduce a rotation’s value. If an expansion of training settings is to occur, there must be sufficient numbers of consenting patients to support the program’s objectives.

CONCLUSIONS

The training issues associated with the anticipated growth in medical graduates and the need to align training experiences to future clinical practice, whether in the public or private sectors, are widely acknowledged. The ESST program has the potential to broaden training opportunities, expose trainees to new settings, including regional and rural practice, expand placements for new graduates, and bring private and other non-public services into the training spectrum.

At the same time, the program should not strip public services of trainees if positions cannot be back-filled with suitably qualified applicants. The object of the exercise is to help all mental health sectors, now and in the future. Hopefully, ESST rotations will make training programs more attractive and help trainees (including IMGs) prepare for College examinations.

This is a new endeavour and many questions are unanswered. Pressing issues include ESST take-up rates; trainees’ clinical exposure and quality of supervision; financial on-costs and rebates; the distribution of ESST and Medicare income; the repercussions of ESST positions for public services and training programs; medical indemnity cover; and private patients’ attitudes to trainees. These issues concern all colleges, not just RANZCP, and will be monitored closely in coming years to ensure the program’s success.

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REFERENCES


