

31 August 2017

Mr Trevor Hunt
Manager, Mental Health and Drugs Workforce
Portfolio Strategy and Reform
Department of Health and Human Services
50 Lonsdale Street
MELBOURNE VIC 3000

Dear Mr Hunt

Re: Final report to DHHS on the Victorian Psychiatry Workforce

The Victorian Branch of the Royal Australian and New Zealand College of Psychiatrists (RANZCP) wishes to present the Victorian Department of Health and Human Services (DHHS) with the report *Psychiatry Attraction, Recruitment and Retention Needs Analysis Project*.

The DHHS approached the RANZCP in 2015 to undertake a project that would contribute to psychiatry workforce planning and development for Victoria's public mental health sector.

The project objectives, activities and deliverables were to:

1. Undertake a research and consultation exercise to identify factors and challenges influencing the psychiatry workforce.
2. Develop recommendations for future short-, medium- and long-term project work to address challenges faced by psychiatry in Victoria, with a particular focus on attraction, recruitment and retention to rural settings and to public mental health settings.
3. Produce a final report on methods, findings and proposals for possible future work that addresses attraction, recruitment and retention issues for psychiatry.

The final report outlines the methods and findings from an extensive review of literature and data sources, together with more than 40 key informant interviews with psychiatrists working across Victoria.

The report concludes that Victoria's Approved Mental Health Services (AMHS) struggle to perform their role, with barely the capacity to care for Victorians during periods when they are severely mentally ill. Along with population and demographic changes over recent decades, public mental health services have experienced a reduction of funding in real terms to cope with these changes. This has created a shortage and a maldistribution of the psychiatry workforce across metropolitan, regional and rural Victoria, which means that needs for mental health services are no longer being met.

The findings of the report reveal that challenges besetting Victoria's psychiatry workforce are multifaceted and stem from a range of causes. Identification of these issues, however, has enabled the formulation of a comprehensive and detailed suite of recommendations to address them.

Of the 55 recommendations in the final report, the RANZCP Victorian Branch has prioritised the following 10 broad recommendations:

1. Develop and implement urgent safety measures to address the unacceptable threats of aggression, violence and occupational safety risks experienced by psychiatrists and trainees.
2. Improve employment conditions for psychiatrists and trainees (including incentives and leave cover), as well as conditions for training and supervision.
3. Pilot and evaluate clinical models that meet acute clinical demand 7 days per week.
4. Improve workplace conditions for rural and outer metropolitan psychiatrists (including professional isolation) and develop a model to attract psychiatrists into rural and outer metropolitan practices.
5. Rectify the maldistribution of the psychiatry workforce, including in communities of need, as well as the significant shortages in some subspecialties like consultation–liaison psychiatry, child and adolescent psychiatry and psychiatry of old age.
6. Establish ongoing funding for a Director of Training Specialist International Medical Graduate (DOT-SIMG) position.
7. Improve contractual conditions for psychiatrists working in Aboriginal mental health services and explore incentives to recruit and retain consultant psychiatrists to Aboriginal outreach mental health services.
8. Undertake a pilot of psychotherapy services in the public sector to determine the impact on patient outcomes, re-admissions and health care costs.
9. Address the lack of clinical academic positions to improve recruitment and retention in subspecialties, specifically in forensic psychiatry and addiction psychiatry.
10. Undertake a comprehensive review of the current funding model for addiction psychiatry services, recognising that the current model does not support clinical service delivery by psychiatrists and fails to provide adequate training opportunities in addiction psychiatry/medicine.

The RANZCP Victorian Branch also encourages the DHHS to advocate for the continuation of Specialist Training Program funding, and to also make a proposal to the Commonwealth Government to increase the Medicare rebate to 100% of schedule fees in socio-economically disadvantaged District of Workforce Shortage areas rather than attempting to attract SIMGs who are subject to the 10-year moratorium to work there.

Thank you for the opportunity and funding to undertake this crucial project, which has been led by the Victorian Branch Committee and oversighted by the RANZCP Board. The RANZCP Victorian Branch Committee would also like to thank the many psychiatrists and trainees who contributed their experience and insights. We look forward to working with the DHHS to implement recommendations to address the identified workforce issues.

To further discuss the final report and recommendations, I can be contacted via Rosie Forster, Executive Manager, Practice, Policy and Partnerships via rosie.forster@ranzcp.org or by phone on (03) 9601 4943.

Yours sincerely



Associate Professor Richard Newton
Chair, Victorian Branch Committee

Report: Victorian Psychiatry Workforce

Executive Summary

August 2017

Authorising Committee	RANZCP Board RANZCP Victorian Branch Committee
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The RANZCP wishes to thank in particular the:

- Victorian Branch Committee
- Victorian Branch Committee members who were project advisors, being Dr Mahendra Perera and Dr Nader Yakoub
- Psychiatrists and trainees interviewed for the report.

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Executive Summary

Victoria's Approved Mental Health Services (AMHS) struggle to perform their role, with barely the capacity to care for Victorians during periods when they are severely mentally ill. Along with population and demographic changes over recent decades, public mental health services have experienced a reduction of funding in real terms to cope with these changes. This has created a shortage and a maldistribution of the psychiatry workforce across metropolitan, regional and rural Victoria, which means that needs for mental health services are no longer being met.

In 2015, the Victorian Department of Health and Human Services (DHHS) commissioned the Royal Australian and New Zealand College of Psychiatrists (RANZCP) prepare a report on the Victorian psychiatry workforce. The report was to focus in particular on workforce issues in the public sector and rural workforces, and provide recommendations for action to address workforce issues identified. The report was finalised in early 2017.

The findings of the report reveal that challenges besetting Victoria's psychiatry workforce are multifaceted and stem from a range of causes. Identification of these issues, however, has enabled the formulation of a comprehensive and detailed suite of recommendations to address them. These findings and recommendations are summarised below.

Part A of the report presents general findings and recommendations on the subsets of the psychiatry workforce including the subspecialties, trainees and Specialist International Medical Graduates. It includes a discussion of state-wide issues of attraction, recruitment, difficult-to-fill positions, gaps, and retention for the Victorian psychiatry workforce. Opportunities, best practice, and innovative approaches to address the issues are proposed.

Part B of the report presents a profile of each Victorian AMHS, and their unique issues, and recommendations to address these.

Key findings

Workforce profile

The psychiatry workforce includes consultant psychiatrists, RANZCP trainee psychiatrists, Specialist International Medical Graduates (SIMGs) on the pathway to RANZCP Fellowship, hospital non-specialists (e.g. non-accredited registrars, career medical officers). There are also a small number of Junior Medical Officers (JMO) positions in the public sector for junior doctors (postgraduate year 1 or 2) to undertake an elective psychiatry rotation.

In 2016, there were 1,029 consultant psychiatrists working in Victoria, which was 29% of the national psychiatry workforce and 6% of the total Victorian medical specialist workforce (16,037).

A total of 329 trainees were undertaking the RANZCP Fellowship in Victoria, which was 26% of trainees nationally. At this time, the Victorian psychiatry workforce included 46 SIMGs, who were on a modified training pathway. The Victorian psychiatry workforce also included approximately 111 hospital non-specialists.

Only around a quarter (23–25%) of the psychiatry workforce works exclusively in the public sector. The remainder either work exclusively in the private sector or practise in both. This trend is increasing and concerning. Between 2011 and 2014, the proportion that worked only in the private sector increased significantly from 34% to 45%, while the proportion that worked in both the public and private sectors declined significantly from 43% to 31%. This indicates that a number of psychiatrists who were working in both sectors have ceased working in the public sector.

The psychiatry workforce is disproportionately concentrated in metropolitan areas, and this trend is growing. While the number of Victorian psychiatrists in RA1 (Major Cities) increased by 11%, and in RA2 (Inner Regional Australia) by 26% between 2011 and 2014, the number of psychiatrists in RA3 (Outer Regional Australia) remained relatively constant (i.e. has not increased), which is of concern.

A further trend is the increasing proportion of the psychiatry workforce in Victoria who are female. In 2015, 38% of consultant psychiatrists in the state were female and 62% were male, broadly consistent with national proportions. Over the previous five years, the number of female psychiatrists grew by at a rate of 4%, while males only grew by 1% (Australian Department of Health, 2016). Among Victorian trainee psychiatrists in 2015, 58% were female and 42% were male – proportions consistent with national trends.

Workforce attraction, recruitment, and retention

Ensuring that there are sufficient consultant psychiatrists, that they are distributed effectively throughout the state, and that they are retained in the public system are critical issues. This reflects a number of challenges in addition to the overall workforce shortage. There is particular difficulty in attracting and recruiting staff to work in inpatient units, a challenge which becomes harder the further hospitals are from Melbourne. All rural services reported difficulty in recruiting locally-trained psychiatrists.

The maldistribution of consultant psychiatrists contributes significantly to the challenge of providing mental health services in disadvantaged metropolitan as well as rural areas. Two of the lowest-ranking local government areas (LGAs) for socio-economic disadvantage in Victoria are urban areas (Greater Dandenong in the south-east and Brimbank in the west).

Both metropolitan and rural AMHS reported that academic psychiatry appointments are helpful from both a recruitment and a retention perspective. Conversely, the lack of an academic position in certain specialties (for example, forensic psychiatry) has an impact on both short-term and long-term provision of services.

There are significant workforce gaps in certain specialties, including child and adolescent psychiatry, community liaison psychiatry, forensic psychiatry, psychotherapy, and addiction psychiatry. There is also a need to increase the number of senior registrar positions, not only to address workforce shortages but also for supervisory purposes.

Retention of psychiatrists is a primary workforce challenge for the public system. Reasons for the migration of consultant psychiatrists to work exclusively in the private system include lack of financial rewards; overwork and stress due to workforce shortages; feeling undervalued; increasing bureaucracy and paperwork; lack of basic administrative support, which reduces time available for clinical work; and increased risk of violence and abuse from aggressive patients.

Findings and recommendations on this issue are found under the relevant specialist headings below, with specific recommendations at R48–R55. These include establishing staff–patient ratios and benchmarking service delivery, taking into account local demographics and socio-economic indicators, supervision and leave requirements, along with other factors; developing an array of long-term incentives to recruit and retain consultant psychiatrists in the public sector; considering further DHHS support for the Specialist Training Program (STP) Recruitment into Psychiatry project in Victoria, given that Commonwealth funding for STP projects will cease in 2018; and exploration of how the number of JMO positions can be increased, and how JMOs can be encouraged to undertake a psychiatry rotation.

Workforce issues in rural areas

Whatever the issues facing the psychiatry workforce and delivery of effective mental health services in Victoria, it is safe to say that these are exacerbated in rural areas. Some of the reasons for this are related to the ‘tyranny of distance’ which affects service provision over large geographic areas, such as travelling time for the delivery of outreach services; transit time for patients/families; availability of public transport; availability of ambulance and other emergency services; and community support services used. Rural communities also experience greater mental health mortality and morbidity, being more vulnerable to mental health problems related to natural disasters, financial hardship, lack of or inaccessibility to health services, and geographical and social isolation.

Providing the psychiatry workforce for rural areas is a major challenge for Victoria. It has been, and continues to be, difficult to find sufficient consultant psychiatrists to work in rural areas. It is especially difficult to recruit and retain in specialist areas, such as child and adolescent psychiatry, old age psychiatry, and perinatal psychiatry. A particular concern is provision of Aboriginal outreach mental health services where management structures and processes are ill-defined and work against delivery of good mental health care. Contractual conditions for consultant psychiatrists in these services are also diminishing. Rural areas are very reliant on SIMGs and other trainees to provide mental health services, yet these are often isolated, vulnerable, and unsupported in an unfamiliar environment.

The reasons for these difficulties are various, and include the personal (for example, greater employment and educational choices for family members in a city; remuneration; individual preference for living near family, friends, and access to metropolitan activities) and professional (fewer career pathways and professional development opportunities, higher workplace pressures such as fewer colleagues to share weekend work, for example, as well as limited administrative support).

Findings and recommendations on this issue are found under the relevant specialist headings below, with specific recommendations at R48–R55. These include development of incentives to work in rural areas (including improved remuneration and professional support); establishment of a RANZCP training program in towns with a rural medical school and increasing the number of junior medical officers (JMOs) and hospital medical officers (HMOs) allocated to psychiatry for rural AMHS; measures to address professional isolation; improved provision of Directors of Training (DoTs) in rural areas for training and support for SIMGs and other trainees; establishment of a locum scheme dedicated to the psychiatry workforce; exploration of more effective models for provision of Aboriginal outreach mental health services; and incentives to recruit and retain consultant psychiatrists to these services.

Summary of findings

Adult psychiatry

- F1 Workforce levels are chronically inadequate.
- F2 The five days per week workforce model (with staff on-call after-hours and at weekends) is outdated and does not meet contemporary clinical and social demands.
- F3 Clinical loads are continually being distributed across a sub-optimal number of staff because leave and supervisory requirements are not factored into workforce requirements.
- F4 Chronic staff shortages are a welfare issue because they have created a chronically stressed workforce.
- F5 There are serious occupational safety issues because of inadequate resources and facilities to manage mentally unwell patients who are violent.

Addiction psychiatry

- F6 The addiction psychiatry workforce is in acute need of root and branch reform.
- F7 There is a lack of training opportunities in addiction psychiatry/medicine.
- F8 There is a lack of incentive to train in addiction psychiatry because of lack of consultant positions available.
- F9 The current funding model does not support clinical service delivery by psychiatrists.
- F10 Training for the psychiatry workforce to upskill in addiction medicine is inadequate.

Consultation–liaison psychiatry (CLP)

- F11 There is insufficient funding for CL psychiatrists and support staff to meet the clinical demand of patients in inpatient units and emergency departments (EDs) across the state.
- F12 There is an absence of benchmarking to determine the correct requirements for CLP services within hospitals and health services.
- F13 There are insufficient numbers of CLP positions for trainees.

Forensic psychiatry

- F14 The lack of academic appointments reduces the attractiveness of forensic psychiatry in Victoria.
- F15 There is a reliance on SIMGs to meet workforce requirements.
- F16 Victoria lacks competitive edge in the financial incentives it offers SIMGs relative to other jurisdictions.

Child and adolescent psychiatry (CAP)

- F17 There is a state-wide shortage and maldistribution of CA psychiatrists.
- F18 A shortage of CAP training positions is restricting the intake of first year trainees each year, causing a reliance on SIMGs to fill senior registrar positions.

Old age psychiatry

- F19 Funding for aged care MHS has not kept pace with demand from the increasing ageing population.
- F20 Changes to the physical health of aged care patients have altered the requirements of the psychiatry workforce to patient ratios.

Psychotherapy

- F21 There is insufficient funding for psychotherapy services in the public sector.
- F22 There is a lack of recognition within the public sector of the value of psychotherapy in the healing process.
- F23 Diminution of psychotherapy services in the public sector is affecting trainee access to training and supervision in psychotherapy.

Aboriginal outreach MHS

- F24 There is a lack of recognition of how consultant psychiatrists can contribute to service development.
- F25 There is a lack of formal requirements for how consultant psychiatrists should contribute to Aboriginal outreach MHS.
- F26 Contractual conditions for consultant psychiatrists are diminishing.

Perinatal psychiatry

- F27 There is a critical shortage of perinatal psychiatrists to meet the clinical demand state-wide.
- F28 There is difficulty accessing perinatal psychiatrists to support the work of the Children's Court Clinic.

Trainee workforce

- F29 Funding for DoTs and Directors of Advanced Training (DoATs) is inadequate.
- F30 On-call work for trainees has steadily increased and is now becoming a welfare problem – workforce shortages are undermining the capacity for adequate trainee support which is leading to burnout.
- F31 The amount of time devoted to meeting *Mental Health Act 2014* requirements has created a workforce burden.
- F32 There is a lack of psychotherapy opportunities in the public sector.
- F33 Inconsistencies exist between AMHS for personal safety mechanisms.
- F34 There are an inadequate number of senior registrar positions state-wide.
- F35 Data collection systems for trainee workforce are inadequate.

Trainee workforce: Commonwealth-funded Specialist Training Program (STP)

- F36 STP training posts have not been linked to strategic workforce planning.
- F37 AMHS are heavily reliant on STP funding to maintain critical mass for the RANZCP training program.
- F38 Health services are increasingly having to subsidise the cost of STP posts because the funding is not indexed.
- F39 Substantial reduction in funding from 2018 for the delivery of STP support projects for SIMGs.

Specialist International Medical Graduate (SIMG) workforce

- F40 The majority of SIMGs fill positions that are otherwise hard to fill by locally trained psychiatrists.
- F41 SIMGs are the most vulnerable members of the psychiatry workforce and require extra support in acculturation, education, training and supervision.
- F42 The restrictions created by Section 19AB of the *Health Insurance Act 1973* may not be relevant to psychiatry, or used properly to address the maldistribution of the psychiatry workforce.
- F43 Districts of Workforce Shortages (DWS) determination for the purposes of Medicare does not distinguish between psychiatry subspecialties, which means these areas can be oversubscribed in one subspecialty and undersubscribed in others.
- F44 There is no link between Areas of Need (AoN) and DWS determination and methods.

Private psychiatry sector

- F45 Undertaking trainee experience in the private sector is beneficial for trainees because it gives them the opportunity to learn:
 - about services offered in the private sector
 - how the private sector works
 - the differences between the private and public sectors
 - the appropriate mental health conditions for which to refer patients in the public sector to the private sector
 - whether they would like to work in the private sector
 - the differences in infrastructure and environment between the private and public sectors. For example, in the private sector patients cannot be subject to a Compulsory Treatment Order without being transferred to a public unit.
- F46 There is a misconception that only the public sector treats acutely mentally unwell patients. This is not the case, however, as the private sector is increasingly treating acutely unwell patients. While these patients will generally have Private Health Insurance (PHI), this does not mean they are necessarily wealthy.
- F47 Patients without PHI have difficulty accessing drug and alcohol services.
- F48 When working in the private sector, the role of the psychiatrist includes undertaking case conferences, family meetings, and telephone consultation and liaison services.
- F49 Regular formal meetings by a psychiatry subspecialty unit, such as adult psychiatry, must be in place to meet the requirements of the RANZCP training program for the subspecialty.
- F50 The outer south-eastern area of Melbourne has an undersupply of public and private psychiatrists.
- F51 Formal linkages between the public and the private sectors may increase efficiencies in the process of transferring patients between them.
- F52 The private sector has the capacity to better assist rural areas, with access to psychiatry services through the provision of telehealth and outreach services.

Recommendations

Adult psychiatry

- R1 Improve transparency about the state-wide distribution of MHS funding.
 - R2 Introduce a funding model that meets acute clinical demand 7 days per week.
 - R3 Undertake an analysis of correct workforce requirements and introduce staff–patient ratios.
 - R4 Develop and implement safety measures for both patients and staff to address the unacceptable risks of aggression and violence.
-

Addiction psychiatry

- R5 Review the current Victorian funding model for addiction psychiatry services.
-

Consultation–liaison psychiatry

- R6 Develop and implement an adequate CLP model for Victoria that incorporates the following:
 - CLP teams situated within the AMHS
 - CLP teams be multidisciplinary and proportional to the hospital size at clinical EFT of 1.8 per 100 beds, plus administration and management - supported by activity-based funding (ABF) and the achievement of key performance indicators (KPIs)
 - framework with which hospitals can develop additional CLP resources for specialist programs within a cohesive system of mental health care
 - uniform state-wide dataset for CLP
 - an evaluation of CLP services every 5 years. Evaluation should include changes in the general health care system, gap analysis, performance measures, and stakeholder surveys.
 - R7 Undertake a pilot of this model at a selection of Victorian hospitals in preparation for state-wide implementation (RANZCP, 2016).
-

Forensic psychiatry

- R8 Establish clinical academic positions to improve the attractiveness of forensic psychiatry in Victoria.
 - R9 Investigate incentives to attract SIMGs to Forensicare and give it a competitive edge over other jurisdictions.
-

Child and adolescent psychiatry

- R10 Take measures to address the shortage and maldistribution of CA psychiatrists in Victoria.
 - R11 Explore ways in which the number of CAP training posts can be expanded across the state.
-

Old age psychiatry

- R12 Explore what is required to support expansion of aged care outpatient services.
 - R13 Undertake a needs analysis of the correct CLP workforce requirements for aged care AMHS.
 - R14 Review the cost per psychogeriatric bed in light of the contemporary health profiles of the ageing population.
 - R15 Investigate international combined geriatrics–psychiatry models of care.
-

Psychotherapy

- R16 Undertake a pilot of psychotherapy services in the public sector to determine the impact on patient outcomes, re-admissions and health care costs.
 - R17 Undertake a feasibility study to explore the potential for establishing public–private partnership clinics, in which patients would be bulkbilled, in areas of disadvantage where it is difficult to attract private practice psychiatrists. The study would need to include the cost of start-up funding and whether there would be adequate interest by a sufficient number of psychiatrists.
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Aboriginal outreach MHS

- R18 Evaluate systems for establishment of a model that ensures teamwork and structure, and streamlines and ensures continuity of care.
 - R19 Undertake a needs analysis for a consultant psychiatrist role that can provide input into team structures, tertiary input, supervision, clinical leadership, service development and review.
 - R20 Explore incentives to recruit and retain consultant psychiatrists to Aboriginal outreach MHS.
-

Perinatal psychiatry

- R21 Undertake an analysis of correct workforce requirements to support the Children’s Court Clinic.
- R22 Analyse the incentives required to attract perinatal psychiatrists to rural public sector positions.

Trainee workforce, including supervision

- R23 Review the required Full-time Equivalent (FTE) for DoTs and DoATs.
- R24 Review the administrative requirements for DoTs and DoATs.
- R25 Assess the adequacy of current occupational safety requirements. Introduce regular duress alarm drills and, for first year trainees, aggression management training (AMT) at each Victorian hospital in which they undertake a rotation.
- R26 Undertake an analysis of correct workforce requirements in inpatient units to ensure that trainees receive adequate supervision.
- R27 Explore how psychotherapy services can be introduced in public outpatient clinics.
- R28 Explore how the number of trainee placements in the private sector can be expanded to increase the opportunity for trainees to get experience in these settings.
- R29 Undertake a needs analysis for more administrative staff in public settings to increase efficiencies in the psychiatry workforce.
- R30 Undertake a needs analysis of the correct senior registrar workforce requirements for inpatient units.
- R31 Develop and implement formal data collection processes relating to the trainee workforce, ranging from expressions of interest in psychiatry as a career, to rotations undertaken.

Trainee workforce: Specialist Training Program (STP)

- R32 Advocate to the Commonwealth for ongoing funding for the STP training posts and support projects.
- R33 Explore how STP training places can become formally incorporated into strategic workforce planning.
- R34 Review the impact on supervisors in the public sector of the STP positions and develop strategies, including funding to address issues.
- R35 Investigate the pre-requisites to increase the amount of training undertaken in the private sector, in primary care, and in rural and regional locations.
- R36 Investigate the required FTE for DoTs and DoATs, and the required administrative assistance.
- R37 Develop strategies to recruit and support supervisors in private practice and rural locations and/or to trial remote supervision of trainees. Blended models of supervision may be considered to ensure that trainees can receive appropriate supervision to train in regional/rural areas.

Trainee workforce: Specialist International Medical Graduate (SIMG workforce)

- R38 Investigate the required assistance for SIMGs in rural training locations.
- R39 Establish ongoing funding for a DoT-SIMG position:
 - The DoT-SIMG requires 1.0 EFT with at least 1.0 EFT administrative support, based on current needs, to support Victorian SIMGs. Alternatively, two part-time SIMG DOTs (0.5 EFT each) could be appointed, one each for metropolitan-based and rurally-based trainees. The estimate of 1.0 EFT is based on current numbers, 46 in total, and with consistent average of 8-10 new applicants every year.
 - The objectives and role of DoT-SIMGs can be in line with RANZCP expectations of DoTs and work within similar governance (i.e. the Victorian Psychiatry Training Committee (VPTC)).
- R40 Make proposals to the Commonwealth government to:
 - Consider increasing the Medicare rebate to 100% of schedule fees in socio-economically disadvantaged DWS areas rather than attempting to attract SIMGs who are subject to the 10-year moratorium to work there
 - Review the applicability of DWS requirements for the psychiatry workforce
 - Consider the psychiatry subspecialty of a SIMG when granting exemptions.

Private psychiatry sector

- R41 Investigate the possibility of introducing formal linkages and pathways between public and private hospitals to increase efficiencies when transferring patients.
- R42 Explore the possibility of facilitating joint meetings between the public and private sectors to increase communication and learning opportunities.
- R43 Investigate incentives that could be introduced to attract private psychiatrists to work in areas of socio-economic disadvantage.
- R44 Investigate how relationships between public and private sector psychiatrists can be strengthened, such as networking and educational opportunities.
- R45 Determine options for how people in rural areas can better access private psychiatry services including:
 - establish more formalised links between large rural areas and the private sector, such as through Primary Health Networks
 - raise awareness of private psychiatry services amongst rural Primary Health Networks and rural medical practitioners
 - establish seamless referral processes between rural areas and private psychiatry clinics with services such as telehealth, fly-in-fly-out (FIFO) and other outreach services.
- R46 Investigate opportunities for RANZCP trainees to rotate through the private sector to increase the understanding of the private psychiatry sector by:

- R47 Consider if public–private partnerships would support the creation of day programs for which the public sector may not have the resources. Such programs could draw on the expertise of psychiatrists in the private sector and would be designed to support the public sector by helping to reduce the burden of repeat admissions.

Attraction, recruitment, and retention

- R48 Maintain the STP-funded Recruitment into Psychiatry projects to attract medical students and JMOs. As Commonwealth funding for the STP support projects will cease in 2018, consideration should be given to establishing such projects tailored to Victoria.
- R49 Explore how the number of JMO positions can be increased and how JMOs can be encouraged to undertake a psychiatry rotation during their Postgraduate Year 1 (PGY1) or PGY2. Adequate supervision and support should be in place for these JMOs during their rotation.
- R50 Develop long-term incentives for consultant psychiatrists in the public sector.
To improve the recruitment and retention of psychiatrists in the public sector, an array of long-term incentives should be developed. This should include exploration of other countries with good public service retention rates. Incentives should address in particular:
- remuneration
 - professional development opportunities
 - career pathways
 - administrative support to optimise psychiatrists' time for undertaking clinical work.
- R51 Establish staff-patient ratios.
Staff–patient ratios should be established. Inpatient unit benchmarking should be the first priority, and then the entire system. The algorithm used for benchmarking should take into account both supply and demand of services including:
- socio-economic disadvantage
 - clinical demand
 - current and future demographics
 - Aboriginal populations
 - culturally and linguistically diverse requirements
 - private and community resources available
 - senior-to-junior staff ratios
 - supervision requirements
 - type and number of support staff available – for example, Registered Nurses (RNs) and Allied Health Professionals
 - all types of leave requirements including annual, sick, study, travel time associated with study, sabbatical and long service leave.
- Other factors to consider when determining correct workforce requirements are:
- *Mental Health Act 2014* requirements
 - health policies such as consumer engagement, National Emergency Access Target (NEAT) targets
 - administrative requirements
 - complexity of patients' conditions – for example, comorbidities and dual diagnoses which requires longer psychiatric assessments and consultations.
- The following issues should also be taken into consideration when determining the unique needs of regional and rural AMHS:
- FTE loading
 - Greater mental health mortality and morbidity (for example, ABS suicide data) experienced by rural communities (which are vulnerable to mental health problems related to natural disasters, financial hardship, lack of or inaccessibility to health services, and geographical and social isolation)
 - Long distances that need to be covered across large geographical areas which affect:
 - travelling time for the delivery of outreach services
 - transit time for patients/families
 - availability of public transport
 - availability of ambulance services
 - community support services used, such as police.
- R52 Resolving weekend workforce shortages is an imperative for retaining psychiatrists in the public sector. To address this, consideration should be given to workforce models that meet acute clinical demand 7 days per week for metropolitan AMHS. Any such model would need to be acceptable to the members of the psychiatry workforce. The Alfred Hospital 3 month trial of a 7 days per week psychiatry workforce model could be used as a prototype and, once evaluated, adapted for AMHS elsewhere to determine the correct weekend psychiatry workforce requirements.
- R53 Develop a range of substantial and competitive incentives.
The first step is to establish an adequate FTE consultant psychiatry workforce, with the correct level and mix of subspecialties, which can meet RANZCP requirements for trainee supervision. This could be achieved through offering an array of incentives including:

- supporting employers to offer competitive salary packages to attract locally-trained psychiatrists to rural areas. Remuneration could be graded according to the distance from Melbourne
 - relocation costs
 - development of rural health services information packages by regional and rural AMHS for prospective and new employees covering:
 - local services and amenities (for example, childcare, schools, accommodation, social, recreational and cultural activities, public transport, safety issues, supermarkets, cafes)
 - rural health services, including a snapshot of local demographics and public health profile; local health workforce, support services, and referral pathways (RANZCP, 2015e).
- R54 Establish RANZCP training program in towns with a rural medical school.
For regional and rural services with a significant medical school and continuing student presence, the 'grow your own' approach offers a sustainable solution whereby students remain and work in areas where they have trained. This approach captures a workforce that has already experienced and enjoyed a regional or rural health service and lifestyle. To help with recruitment to the RANZCP training program, enrolment targets and weighting of enrolment criteria in favour of regional/rural students could be established.
- Other initiatives that would help sustain a rural psychiatry workforce are funding to:
- support a medical education psychiatrist/registrar position to facilitate support programs and increase psychiatry conversion rates
 - increase the numbers of JMOs and HMOs allocated to psychiatry for rural AMHS.
- R55 Address professional isolation.
Owing to the tyranny of distance between rural towns and metropolitan Melbourne, professional isolation is a key issue that needs to be addressed for both consultant psychiatrists and trainees. There are many effective initiatives that can help with this:
- Video-conferencing resources for Masters of Psychological Medicine (MPM) that are interactive and online friendly. Good quality technology would enable rural trainees to attend classes face-to-face on an occasional, rather than a weekly, basis. This would offset welfare issues of trainees travelling while fatigued as well as offset the weekly workforce shortages created by their need to attend classes in person.
 - Grants to attend professional development events/conferences.
 - Educational webinars.
 - Mentoring program via the internet. The program could enhance clinical leadership and management skills and provide a variety of opportunities including practice visits, networking, peer support groups and supervisor access.
 - Face-to-face workshops for both trainees and SIMGs that:
 - provide exam preparation/fellowship, e.g. coaching
 - provide education for clinical practice skills
 - create opportunities for networking with peers and senior psychiatrists, and engaging with the RANZCP to learn more about professional opportunities.
 - Rural DoTs to coordinate training for both trainees and SIMGs.
 - Psychiatrist Councils within each rural Local Hospital Network (LHN). These Councils were a successful component of the RANZCP NSW Rural Psychiatry Project. The Councils were the only mechanism for all psychiatrists from rural LHNs to regularly meet as a collective group. Most councils met once per year and 25–50% of all psychiatrists in the region attended. The preference for face-to-face meetings was much stronger than those via video-conferencing.
 - The most valued aspect of the Council meetings was the opportunity for networking and information sharing from a range of areas including public, private and academia. A by-product of the meetings has been greater collaboration because of the psychiatrists becoming aware of and familiar with other personnel, programs and resources. From an evaluation of the NSW Rural Project, it was concluded that the ideal number of meetings was three per year including one face-to-face, an annual video conference and an all-inclusive rural meeting.
 - Locum assistance for improved access to professional and personal leave. The ready availability of backfill while psychiatrists take leave is an important factor in supporting self-sustaining rural workforces. A best practice option to facilitate quality locum psychiatry services could be the establishment of a locum scheme dedicated to the psychiatry workforce.
A model that could be adapted for such a scheme is the Rural Locum Assistance Program (Rural LAP) (formerly the Rural Obstetric and Anaesthetist Locum Scheme). Federally funded, Rural LAP is especially designed to support the rural health workforce to *inter alia*:
 - support staff in taking leave and undertaking CPD activities
 - improve retention
 - improve the attractiveness of rural practice.
 Rural LAP offers locum travel, accommodation and financial incentives, and can provide locum coverage for up to 14 working days per financial year for recreation and CPD leave. For more information visit: www.rurallap.com.au.

Victorian Psychiatry Attraction, Recruitment, and Retention Needs Analysis Project Report



Report: Victorian Psychiatry Workforce

Part A

Psychiatry Attraction, Recruitment, and Retention Needs Analysis Project Report

August 2017

Authorising Committee	RANZCP Board RANZCP Victorian Branch Committee
Responsible Department	RANZCP Practice, Policy and Partnerships
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1 Introduction

The Victorian Department of Health and Human Services (DHHS) approached the Royal Australian and New Zealand College of Psychiatrists (RANZCP) in 2015 to undertake a project to contribute to workforce planning and development for Victoria's public mental health sector: the *Psychiatry Attraction, Recruitment and Retention Needs Analysis Project*.

The project aimed to:

- better understand and define attraction, recruitment and retention issues for psychiatry
- develop recommendations for future project work to specifically address the workforce challenges.

The project objectives, activities, and deliverables were to:

1. Undertake a research and consultation exercise to identify factors and challenges influencing the psychiatry workforce in Victoria including:
 - size, characteristics and driving factors such as workforce distribution across geography, service setting (public/private) and speciality; vacancies, difficult-to-fill positions and gaps; the impact of vacancies/gaps on the workforce and on service provision; movement between public and private sectors; and workforce development issues
 - barriers and opportunities to attract, recruit and retain psychiatrists to rural and public mental health settings
 - best practice and innovative approaches to attract, recruit and retain psychiatrists to rural and public mental health settings.
2. Develop recommendations for future short, medium, and long-term project work to address challenges faced by psychiatry in Victoria, with a particular focus on attraction, recruitment, and retention to rural settings and to public mental health settings.
3. Produce a final report on methods, findings, and proposals for possible future work that addresses attraction, recruitment and retention issues for psychiatry.

The project aligned with the RANZCP Strategic Plan 2015–2017, specifically to support and advocate for workforce planning, recruitment, growth, and retention of psychiatrists. The RANZCP entered into an agreement with the DHHS in 2015, with the project to be managed by the Victorian Branch of the College, reporting to the RANZCP Board. The project was completed in late 2016 and the report finalised in early 2017.

This final report outlines the methods and findings from an extensive review of literature and data sources, together with more than 40 key informant interviews with psychiatrists working across Victoria.

Part A of the report presents general findings and recommendations on the subsets of the psychiatry workforce including the subspecialties, trainees, and SIMGs. It includes a discussion of state-wide issues of attraction, recruitment, difficult-to-fill positions, gaps, and retention for the Victorian psychiatry workforce. Opportunities, best practice, and innovative approaches to address the issues are proposed.

Part B of the report presents a profile of each Victorian AMHS, and their unique issues, and recommendations to address these.

The report details significant issues currently facing the psychiatry workforce, particularly in regional and rural Victorian public mental health settings. However, alongside the identification of workforce challenges and barriers, psychiatrists and trainees who participated in the study contributed insightful recommendations about what could be done to improve attraction, recruitment, and retention of the psychiatry workforce in Victoria to meet the mental health needs of the community.

2 Background

Psychiatrists are a critical component of the Victorian medical workforce. In addition to delivering clinical services to patients, psychiatrists provide clinical leadership and governance to MHS, and teach and supervise psychiatry trainees and medical students.

Access to quality mental health services in Victoria relies on a workforce with appropriate skills. Workforce supply constraints are felt more strongly in rural and regional areas, where recruitment and retention can be difficult. Skilled and motivated mental health professionals, including psychiatrists, in sufficient numbers at the right place and the right time are critical to delivering effective health services and improving health outcomes.

Victoria's specialist mental health workforce framework: Strategic directions 2014-24 (the Framework) and an accompanying three-year implementation plan were released in 2014. This project aligns with and supports achievement of a number of objectives of the Framework, specifically:

- Plan for the development of a workforce that has the size, skill mix and distribution to meet projected population growth, changing service models and consumer needs and preferences (Objective 1.1).
- Improve the attraction and recruitment of new entrants and experienced workers into the specialist mental health sector (Objectives 1.4 and 1.5).
- Increase the attraction of capable staff to regional and rural specialist mental health settings (Objective 2.2).
- Improve the capacity to retain and support the specialist mental health workforce in regional and rural locations (Objective 2.3).

The RANZCP is well positioned to contribute to this work, being the principal organisation representing the medical specialty of psychiatry in Australia and New Zealand with responsibility for training, examining and awarding the qualification of the RANZCP Fellowship.

The RANZCP Fellowship training program has a minimum five-year duration. All trainees graduate as consultant generalist psychiatrists. In the latter stage of training, they can elect to undertake a Certificate of Advanced Training in one of the following internationally-recognised subspecialties:

- adult psychiatry
- addiction psychiatry
- consultation–liaison psychiatry (CLP)
- psychotherapy
- child and adolescent psychiatry (CAP)
- old age psychiatry
- forensic psychiatry.

Consultant psychiatrists also have the option of undertaking a postgraduate Certificate of Advanced Training in one of these subspecialties.

Following completion of training, most psychiatrists continue to be members of the RANZCP, which as well as providing training and education, also represents psychiatrists and advocates for mental health in Australia and New Zealand. In addition to consultant psychiatrists and trainees, the psychiatry workforce includes Specialist International Medical Graduates (SIMGs on the pathway to RANZCP Fellowship (refer to section 5.1.3) and hospital non-specialists (section 5.1).

The Australian Government's *Health Workforce Australia 2025* (Department of Health, 2012) report stated the national psychiatry workforce had shortages, particularly in acute psychiatry and adolescent psychiatry within the public sector. Concerns about the distribution of the psychiatry workforce were supported by the high reliance on SIMGs in regional and rural areas. The RANZCP noted challenges existed to attracting Australian-trained graduates to the profession, under-utilisation of the private sector for training purposes, and strains on supervisory capacity.

The subsequent *Australia's Future Health Workforce – Psychiatry* report (Department of Health, 2016) indicated that some of the above issues have changed. For example, the number of Australian-trained psychiatrists is increasing and the Commonwealth-funded Specialist Training Program (STP) has expanded the number of training places in the private sector.

These changes have not addressed the maldistribution of the psychiatry workforce across Victoria, however. Rural communities continue to have reduced access to medical care across all medical specialties owing to the difficulty in attracting and/or retaining medical practitioners. As well as most people having a strong preference to live and work in major cities, other inhibiting factors include:

- poorer remuneration
- professional isolation
- incongruity with lifestyle and family needs (for example, partner's employment, and children's schooling)
- restricted career opportunities
- lack of specialist positions at regional hospitals
- large size of patient base
- burden of frequent on-call work
- long distances to travel for outreach services.

The RANZCP released a [media statement on this critical state of psychiatry services in rural Australia](#) in June 2016.

Maldistribution of the psychiatry workforce also exists in metropolitan Melbourne, with workforce shortages in areas of socio-economic disadvantage especially. Paradoxically, while disadvantaged areas have greater levels of psychiatric disorder, user rates of most consultant psychiatry services are much higher in more advantaged areas. Disadvantaged people have reduced access to MHS for two key reasons: a general inability to afford the cost of private psychiatry services, and lack of availability of local public services owing to the preferences of professionals to work close to where they live (Meadows et al, 2015).

3 Methodology

3.1 Description of methodology

Broad research was undertaken initially to identify and obtain relevant qualitative and quantitative literature. Sources included RANZCP internal reports, position papers, and databases; Australian Government reports and databases; peer-reviewed journal papers; and Medical Board of Australia (MBA) data. The RANZCP commissioned the Australian Institute of Health and Welfare (AIHW) to provide customised data on the psychiatry workforce. Consultation services were commissioned to translate the data into a report.

A governance structure was established and remained active throughout the duration of the project (**Appendix 1**). The framework for the project's direction and key deliverables included the RANZCP Victorian Branch Committee, Chief Executive Officer (CEO), and the Board. The Victorian Branch Committee appointed a committee member (RANZCP Fellow) as Project Adviser to provide guidance to the project team. The RANZCP Victorian Psychiatry Training Committee (VPTC) – which includes DoTs and DoATs – provided guidance and advice on the psychiatry training landscape and issues.

In the first half of 2016, the project team interviewed 41 members of the Victorian psychiatry workforce to inform the project (in person, by telephone or videoconference). To ensure that issues affecting the workforce state-wide would be identified, interviewees comprised a broad cross-section of the workforce, including:

- Clinical Directors of all the state-wide AMHS (public sector, including rural)
- Clinical Directors within the private sector
- Senior psychiatrists in various subspecialties (old age, addiction, CAP, psychotherapy, forensic, perinatal, Aboriginal MHS)
- DoTs and DoATs
- RANZCP trainees.

To allow interviewees to raise issues unique to their AMHS or subspecialty, open-ended questions were used, based on an interview guide. Key issues not raised during the course of the discussion were followed up. Health services and AMHS contributing to this report – including their profiles, key issues, and recommendations – can be found in Part B of the report.

Given the overlap and synergies between the public and private sectors of psychiatry, key informants from the private sector were invited to participate to gain a more balanced and global perspective of workforce issues. This included input from psychiatrists and other senior staff members from the following private hospitals:

- Albert Road Clinic
- Epworth
- St John of God Pine Lodge Clinic
- Melbourne Clinic
- Victoria Clinic.

3.2 Limitations

As outlined in the DHHS Project Brief, the quantification of demand for psychiatrists in Victoria was beyond the scope of this project.

Limitations of qualitative and quantitative data collated/collected for the project include:

- Interviews with the key informants were conducted in an open-ended style. The responses received are anecdotal and shaped by the issues unique to the AMHS or subspecialty of the key informant, as well as their own priorities, personal perspectives, and experiences. Not all responses can be supported by evidence.
- Although the RANZCP has presented the most up-to-date quantitative data available as at 2016, variances exist in the data for many reasons including that:
 - multiple agencies have a role in workforce data collection and reporting
 - the most up-to-date data available from the Australian Institute of Health and Welfare (AIHW) was as at 2014, based on data collected by the Australian Health Practitioners Regulation Authority (AHPRA)
 - MBA/AHPRA workforce survey data is self-reported, and not every medical practitioner fills out the annual workforce surveys
 - The AIHW data for 2011–2014 was supplemented with data available for 2015 and 2016 from the RANZCP membership database; however, of note, membership of RANZCP is not obligatory for consultant psychiatrists to practise in Australia.
 - data definitions vary across sources
 - collection time point/cut-off for each data set differs
 - denominator for calculating FTE may differ between sources
- type and range of data collected have limitations. Data collection in regard to expressions of interest and applications to the RANZCP training program is incomplete.

The report does not include the psychiatry workforce for disability services.

Data on the number of JMO positions in psychiatry was not collected.

4 Findings and Recommendations

4.1 Overview

The Victorian psychiatry workforce (see Figure 1 below) is comprised of:

- consultant psychiatrists
- RANZCP trainee psychiatrists
- SIMGs on the pathway to RANZCP Fellowship
- hospital non-specialists (e.g. non-accredited registrar, career medical officer).

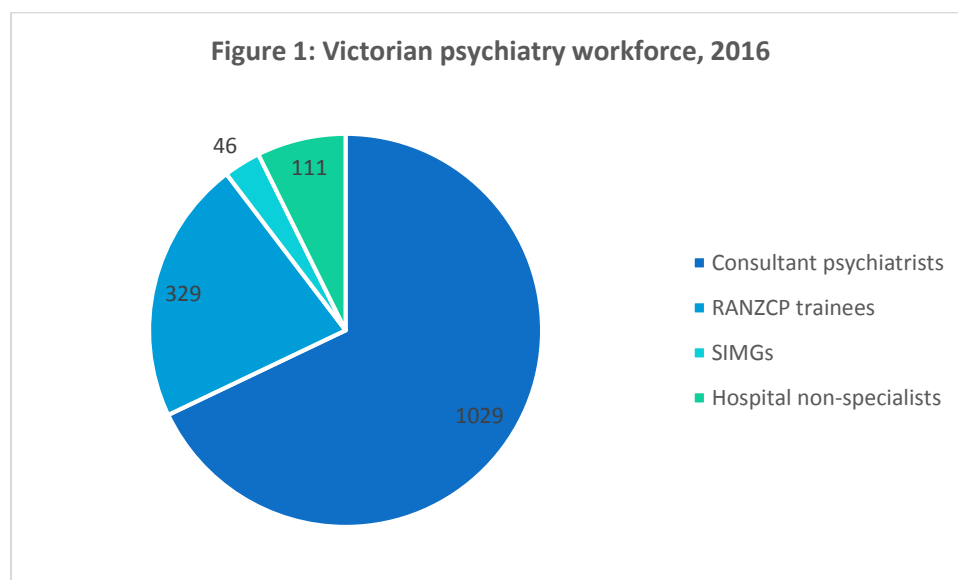
In addition, there are a number of JMO positions (PGY1 or PGY2) in the public sector for junior doctors to undertake an elective psychiatry rotation.

As at 2016, there were 3,550 consultant psychiatrists in Australia (RANZCP). Of these, 1,029 were in Victoria, which was 29% of the national psychiatry workforce and 6% of the total Victorian medical specialist workforce (16,037).

At 1 November 2016, a total of 1,286 trainees were undertaking the RANZCP Fellowship within Australia, 329 (26%) of whom were located in Victoria. At this time, the Victorian psychiatry workforce also included 46 SIMGs, who were on a modified training pathway.

Of note the duration of training of each SIMG varies according to whether the psychiatry training they received overseas is considered 'Partially Comparable' or 'Substantially Comparable' to the RANZCP training requirements.

As at 2016, the Victorian psychiatry workforce also includes approximately 111 hospital non-specialists. A hospital non-specialist is a medical practitioner employed in a non-accredited registrar salaried hospital position who does not have a recognised specialist qualification and who is not in training to gain one (however, may be desirous of applying to enter the training program).



Source: RANZCP data and workforce interviews, 2016

Victoria's Approved Mental Health Services

To gather qualitative data on the Victorian psychiatry workforce, 18 Clinical Directors of AMHS were interviewed. Each of these AMHS, which are geographically defined areas according to the Australian Standard Geographical Classification 2003 edition, have a discrete psychiatry workforce. In addition to the Clinical Director, whose position is full-time, each workforce has a range of consultant psychiatrists – the number and EFT of which varies – with differing subspecialties. Eleven of the AMHS are situated in Metropolitan Melbourne; the remaining eight are spread across rural Victoria. Interviewing the Clinical Director of each AMHS ensured local and/or general workforce issues were identified state-wide.

Almost two-thirds of the AMHS are funded for an academic psychiatry position. Many consultant psychiatrists work on a part-time basis in both the public and private sectors. Those who work on a part-time basis in a rural AMHS often do so on a FIFO/drive-in-drive-out (DIDO) basis. Most of the AMHS psychiatry workforces are supported by HMOs, who may or may not have had prior psychiatry experience.

Most of the AMHS have accredited training places for the RANZCP Fellowship program. These workforces, therefore, are also comprised of one or more RANZCP trainees – who generally work on a full-time basis – at various stages of their training program. Most of the AMHS have at least one Commonwealth-funded STP funded accredited training place.

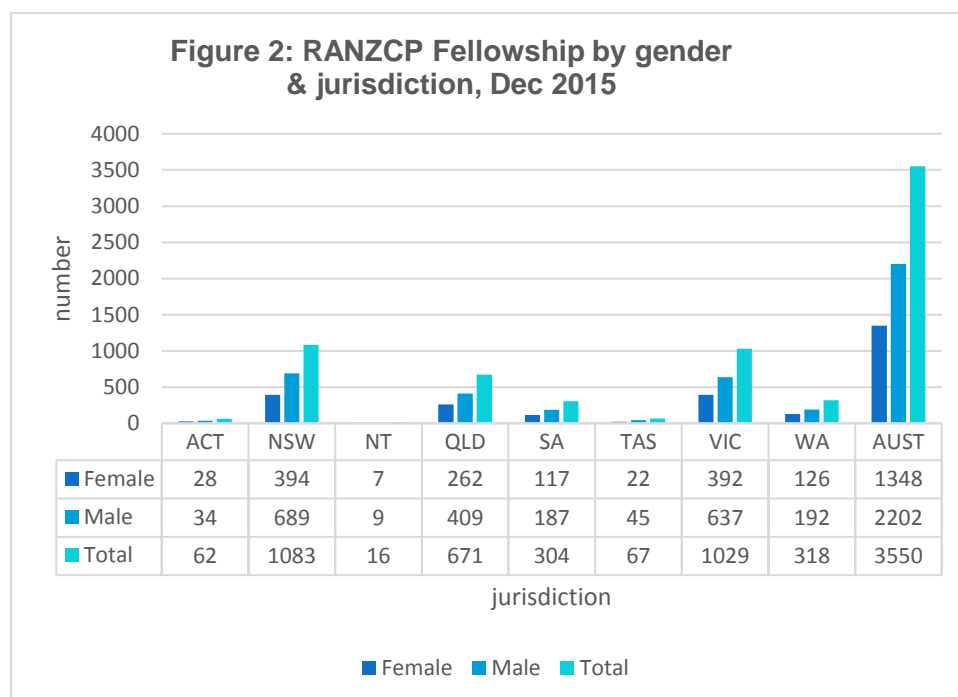
Irrespective of the presence of a Fellowship training program, the AMHS may also have one or more SIMGs who will be undertaking a modified RANZCP training program, as part of the workforce. As a general rule, consultant psychiatrists within the local workforce serve as supervisors to the trainees and SIMGs (the exception to this is supervision for psychotherapy in which the supervisors will be sessional consultant psychiatrists).

For a detailed profile of the workforce of each of Victoria’s AMHS, refer to Part B of this report.

4.1.1 Consultant psychiatrist workforce

Workforce gender composition

Of the consultant psychiatry workforce located in Victoria, as at 2015, 392 (38%) were female and 637 (62%) male (Figure 2). This workforce gender composition is broadly consistent with national proportions, where the relative rates are 34% female and 66% male. The *Australia’s Future Health Workforce – Psychiatry* report notes, however, that the number of female psychiatrists experienced the largest growth over the last five years, at a rate of 4%, while males have only grown at 1% (Australian Department of Health, 2016).

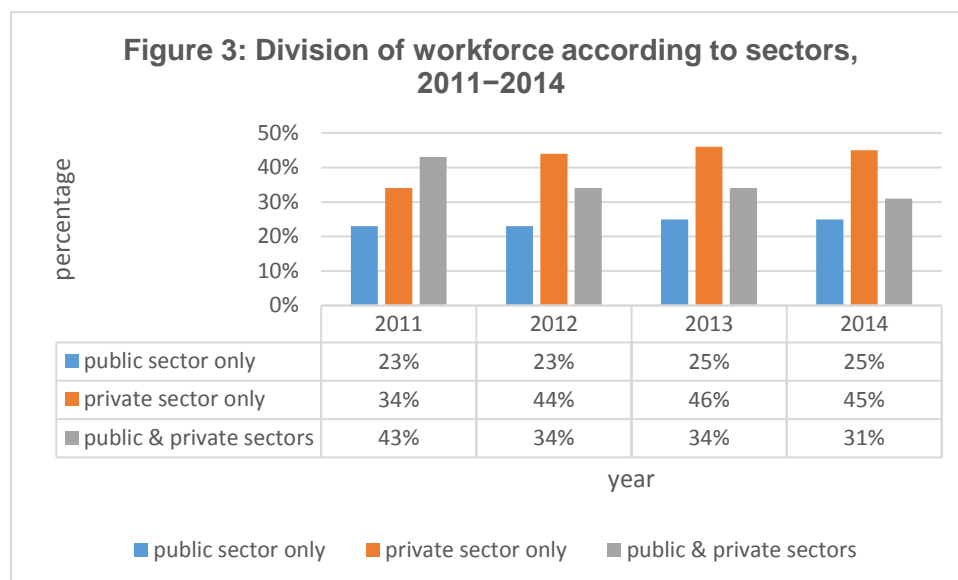


Source: RANZCP Data, (2015)

Distribution of consultant psychiatrist workforce by sector

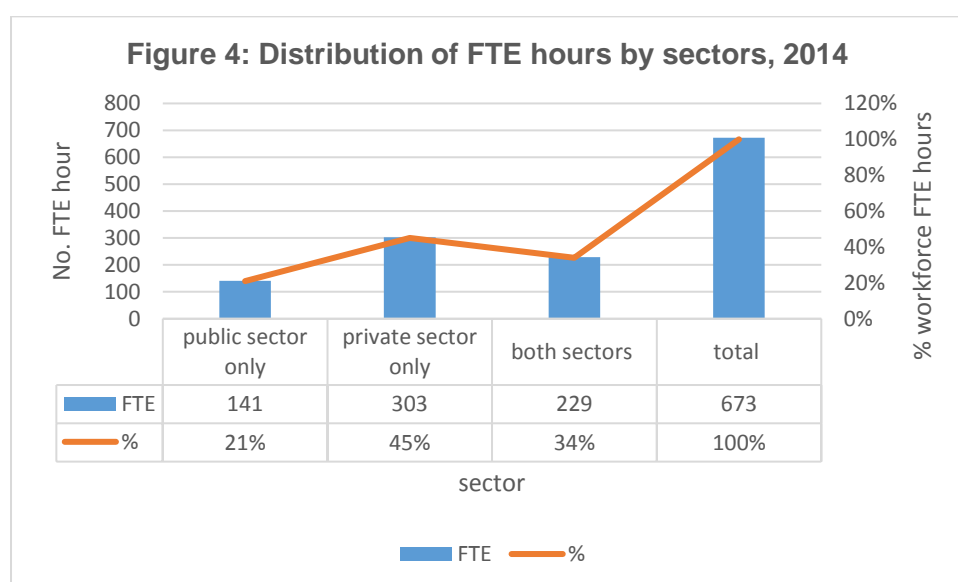
Figure 3 below provides a comparison between the trends in sector hours in the Victorian psychiatry workforce between 2011 and 2014. The proportion that worked only in the public sector remained reasonably constant (23–25%). In contrast, the proportion that worked only in the private sector during this period increased significantly from 34% to 45%, while the proportion that worked in both the public and private sectors declined significantly from 43% to 31%. This trend indicates that a number of psychiatrists who were working in both sectors have ceased working in the public sector.

Private practice psychiatrists may work in private hospitals and/or in private psychiatry practice (solo, partnership or group). At July 2016, RANZCP data showed that there were 476 private practice psychiatrists across Victoria. The details of the majority of these psychiatrists can be found on the RANZCP *Find a Psychiatrist* database located on the RANZCP webpage. However, of note, the database is opt-in and does not list all private practice psychiatrists nor does it host the names of those who work only in private hospitals.



Source: AIHW (2016)

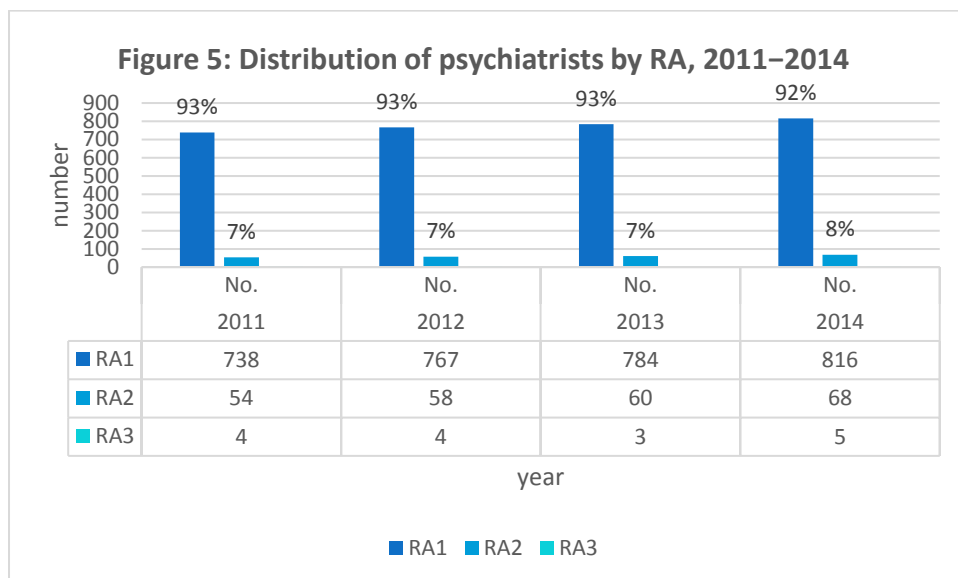
Figure 4 shows the distribution of FTE hours of consultant psychiatrists according to the sectors in which they work. In 2014, total FTE hours worked by consultant psychiatrists who worked only in the public sector accounted for approximately one-fifth (21%) of total workforce hours. Those who worked in both sectors accounted for just over one-third (34%) of total FTE hours, while just under half (45%) of total FTE hours were undertaken by consultant psychiatrists who worked only in the private sector. This demonstrates that the private psychiatry sector significantly complements the public sector in the delivery of mental health services.



Source: AIHW (2016)

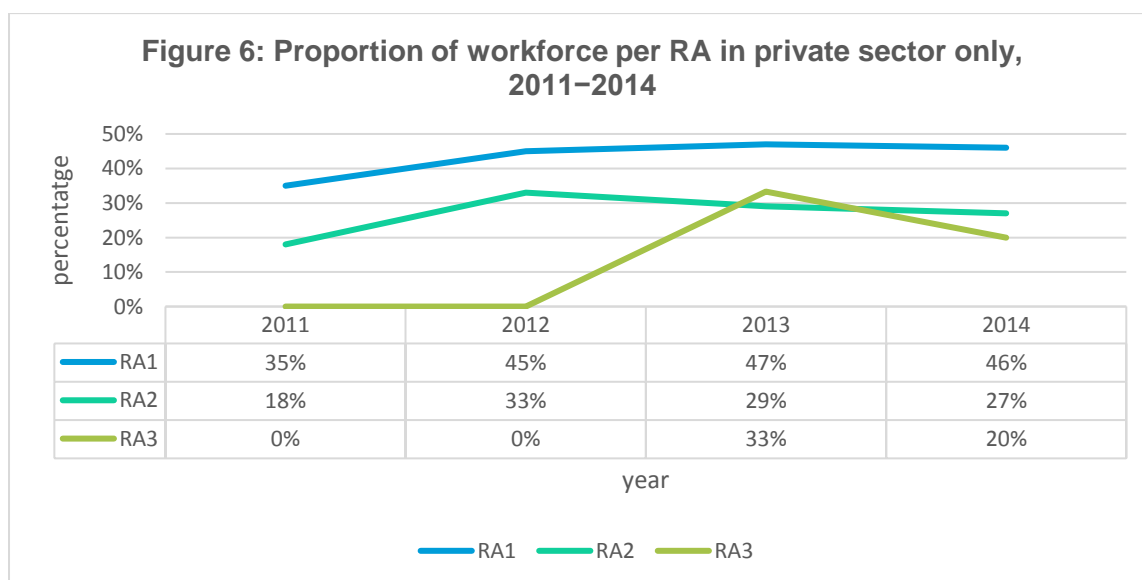
Distribution of consultant psychiatrists by Remoteness Area

Figure 5 below shows trends in the distribution of the Victorian psychiatry workforce by Remoteness Area (RA) between 2011 and 2014. While the proportion of the workforce in each RA remained constant, there was growth in absolute numbers in RA1 (Major Cities) and RA2 (Inner Regional Australia). During this time, the number of psychiatrists in RA1 increased by 78 from 738 to 816 (11% growth) while RA2 grew by 14 from 54 to 68 (26% growth). The number of psychiatrists in RA3 (Outer Regional Australia) remained relatively constant.



Source: AIHW (2016)

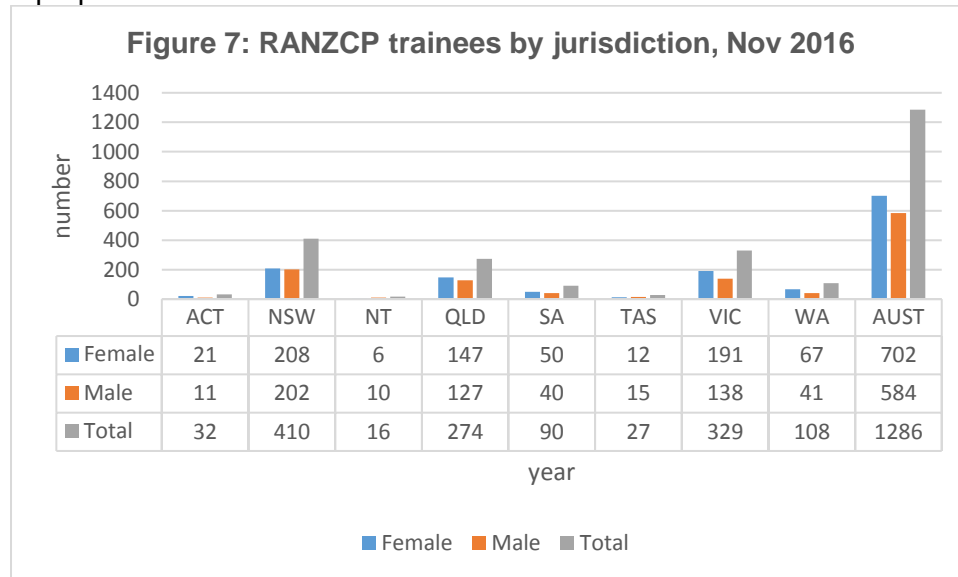
Figure 6 demonstrates trends in the private sector workforce by RA between 2011 and 2014. During this time, the number of consultant psychiatrists working only in the private sector in RA1 increased from 35% to 46% while the proportion in RA2 increased from 18% to 27%.



Source: AIHW (2016)

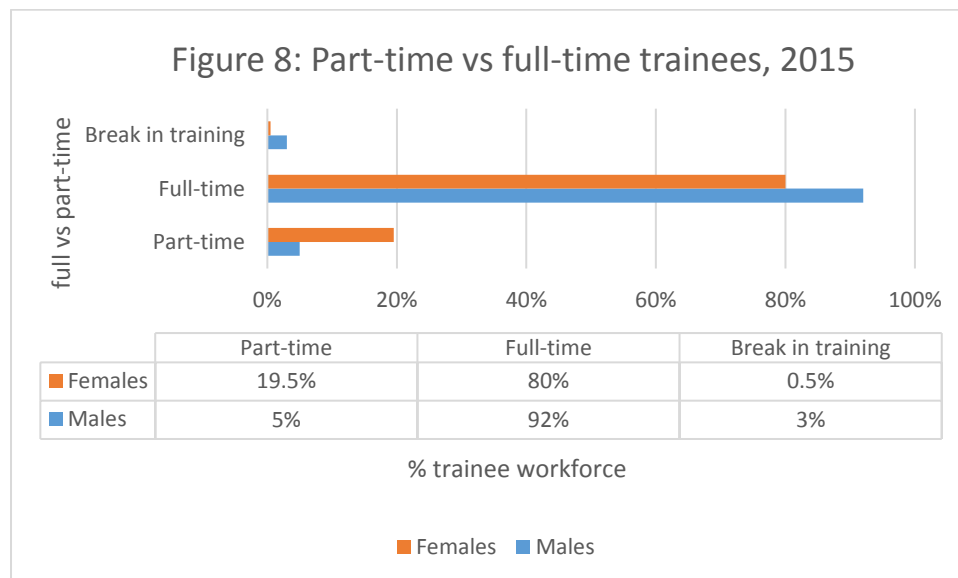
4.1.2 Trainee workforce

At 1 November 2016, the RANZCP had a total of 1,286 domestic trainees, 329 (26%) of whom were located in Victoria. Of these, 191 (58%) were female and 138 (42%) were male – proportions consistent with national trends.



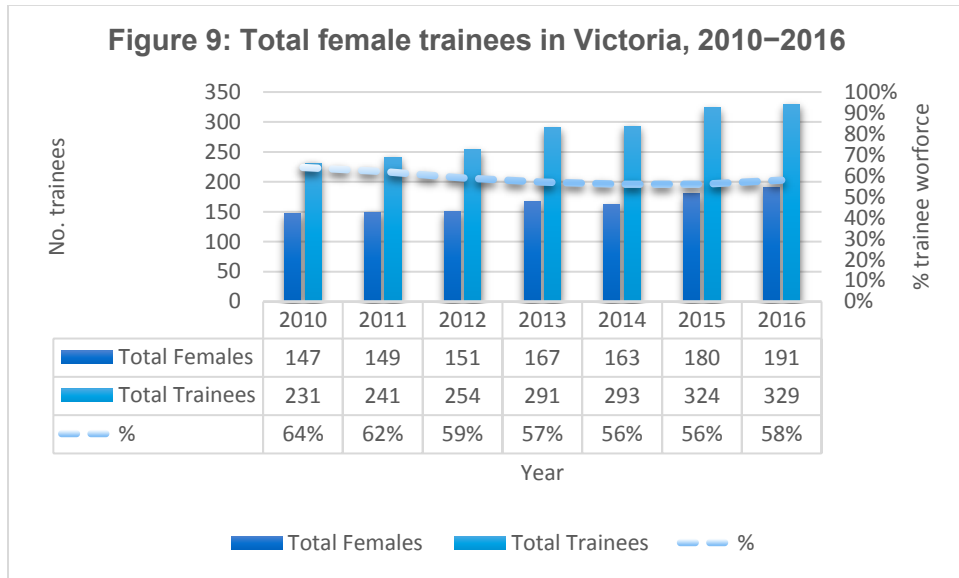
Source: RANZCP Data (2016)

The retention rate of trainees throughout all three training stages is relatively high. Trainees complete their training within 6.1 years on average. Approximately 47% will take a break and undertake a period of training on a part-time basis (AFHW, 2016). At June 2015, 20% of female trainees were undertaking their training on a part-time basis, compared to 5% for males, as shown in Figure 8 below.



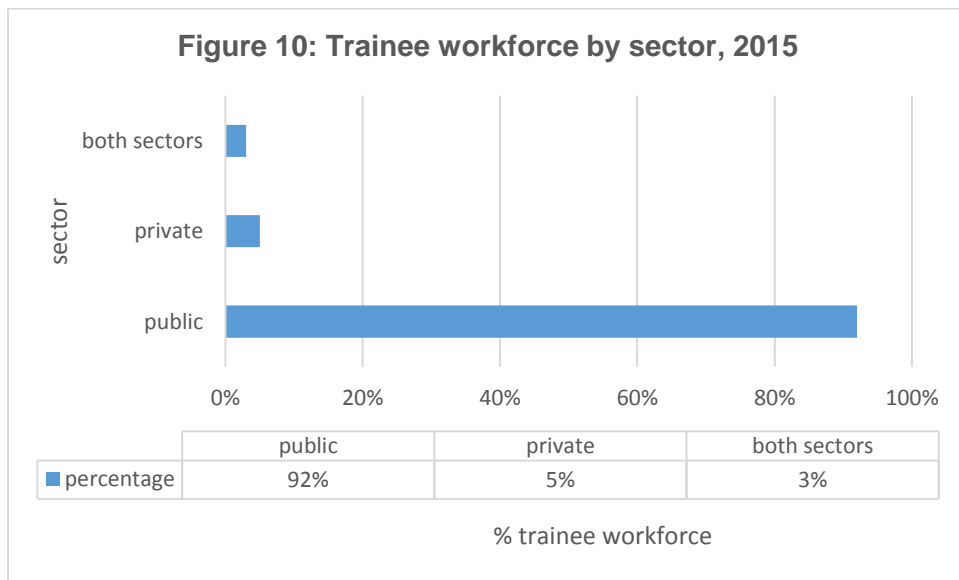
Source: RANZCP Data (2015)

In recent years, over half of the Victorian psychiatry trainee workforce has been female (Figure 9). This is a consistent and fairly stable trend, averaging approximately 59% over the past 7 years.



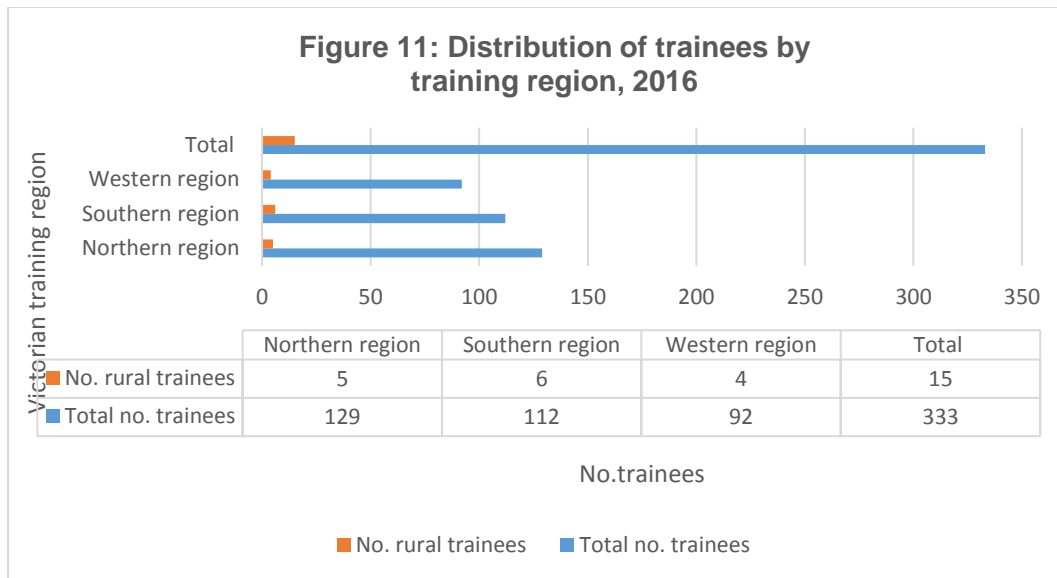
Source: RANZCP Data (2010–2016)

The majority of trainees work in the public sector, with just 5% working only in the private sector and 3% in both sectors (Figure 10).



RANZCP Data (2016)

Trainees in Victoria are distributed according to the three RANZCP training regions in the state: Western, Northern and Southern. Each region has a small number (4–6) of rurally-based trainees, while the majority are located in metropolitan or inner regional areas (Figure 11).

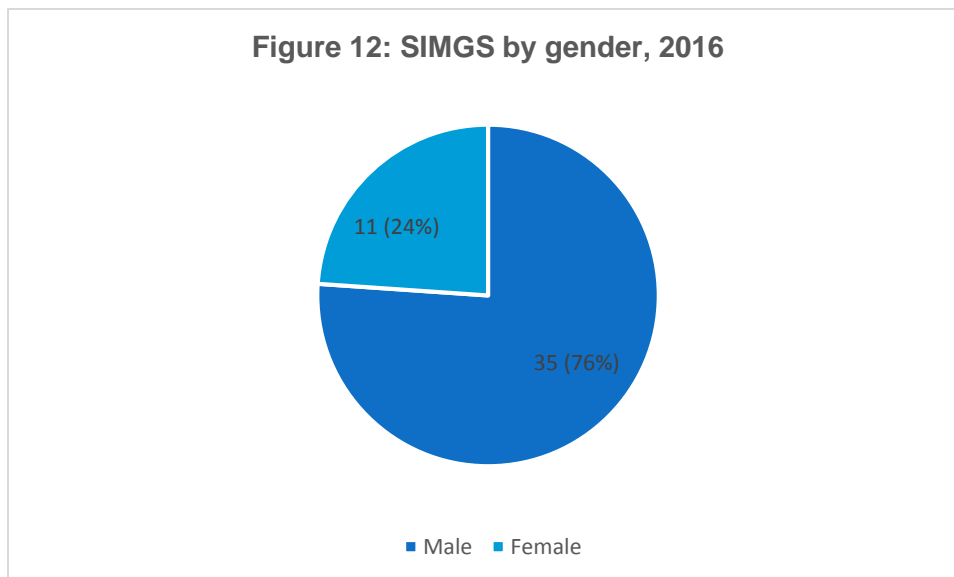


Source:

RANZCP Data (2016)

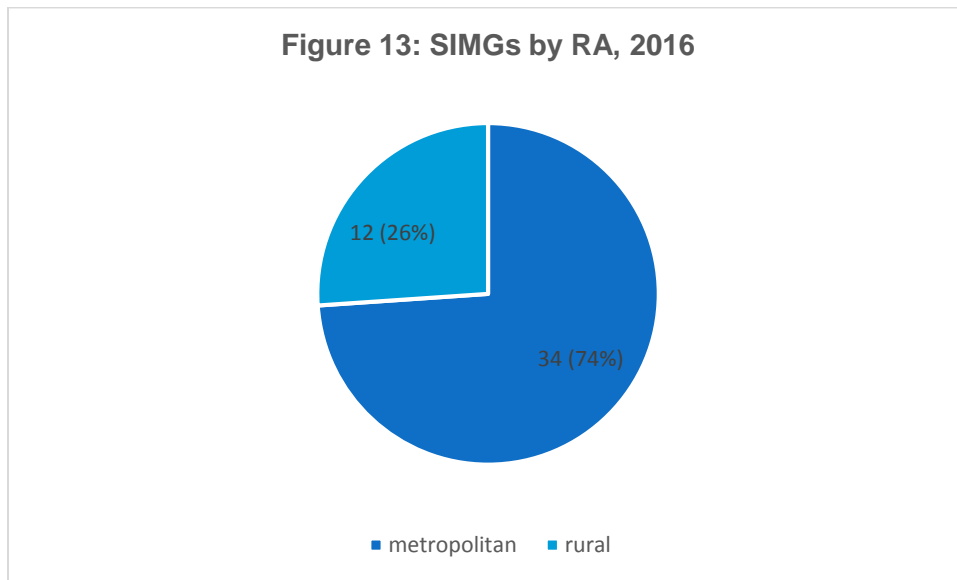
4.1.3 Specialist International Medical Graduates

Every year, Victoria receives an average of 8–10 new applicants for the SIMG pathway, which is greater than the number of applications received by Queensland or New South Wales. In 2016, the Victorian psychiatry workforce had 46 SIMGs, just over three-quarters (76%) of whom were male (Figure 12).



Source: RANZCP Data (2016)

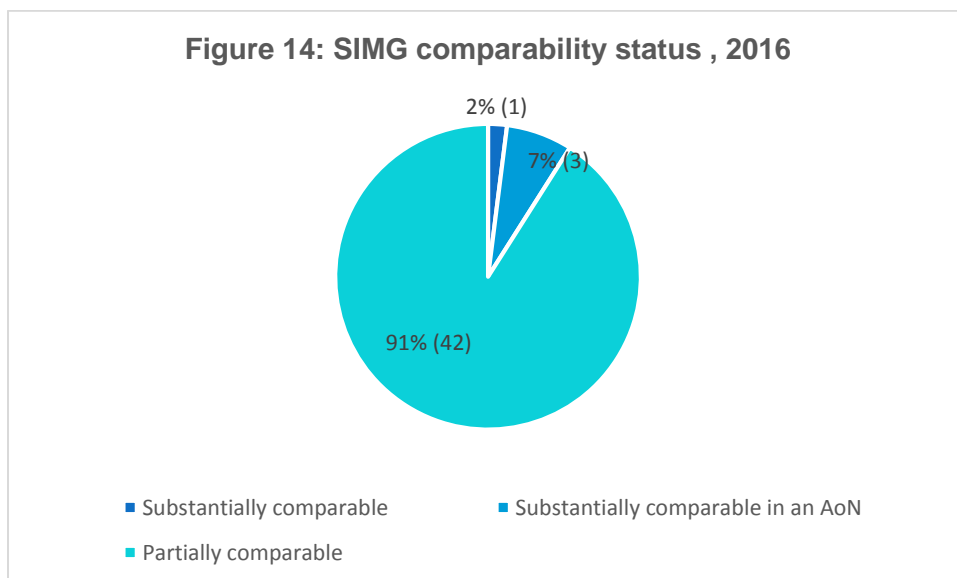
Approximately one-quarter (12) of SIMGs are located in regional or rural areas (Figure 13).



Source: RANZCP Data (2016)

The vast majority of SIMGs in Victoria (42; 91%) are on the RANZCP Partially Comparable Pathway. Four (9%) SIMGs are on the Substantial Comparability Pathway, three of whom are situated in an Area of Need (AoN) (Figure 14).

The AoN program is a state government strategy to provide temporary assistance to locations and services experiencing medical workforce shortages and difficulty recruiting medical practitioners to vacant positions. When a position is declared an AoN, the MBA can register a suitable SIMG into that position under the *Health Practitioner Regulation National Law* of the relevant jurisdiction, following assessment and approval of the SIMG by the relevant specialist medical college as suitably qualified for the position. This is on the proviso that the SIMG meets all other MBA medical registration requirements.



Source: RANZCP Data (2016)

4.2 Victorian psychiatry workforce subspecialties

This section discusses the Victorian psychiatry workforce within the framework of the internationally-recognised subspecialties of:

- adult psychiatry
- addiction psychiatry
- consultation–liaison psychiatry (CLP)
- forensic psychiatry
- child and adolescent psychiatry (CAP)
- psychotherapy
- old age psychiatry

Other areas include:

- Aboriginal mental health
- perinatal psychiatry.

Quotations from key informants are also included in the call-out boxes.

4.2.1 Adult (generalist)

Adult psychiatry is the most commonly-practiced subspecialty. It provides treatment for people with schizophrenia, bipolar disorder, depression, personality disorders, and a range of anxiety disorders. Adult psychiatrists lead multidisciplinary health teams, formulating and determining management plans for patients and their families.

Workforce shortages

Between 1985 and 2016, the Victorian population increased from 4,120,068 to 6,039,000, an increase of 47% (ABS). However, funding for the psychiatry workforce has not increased accordingly and this, along with increasing clinical demands and expectations, has resulted in a chronic shortage of psychiatrists for adult psychiatry services. Workforce shortages are reported across most metropolitan, regional and rural AMHS. Within metropolitan AMHS, the shortages are acutely felt in inpatient units and EDs, particularly during on-call periods (after-hours and weekends).

'During these times the clinical load doesn't slow down and the acuity of patients is severe.'

The greater acuity of patients is largely attributable to the use of crystal methamphetamines, which increases aggression and has led to an increase in staff assaults. Management of aggressive patients requires the presence of an adequate, skilled, and well-supported workforce, including other consultant psychiatrists, senior trainees (registrars), mental health nurses, and allied health. Despite this need, it is during the on-call periods that the psychiatry workforce is minimally-staffed and allied health staff are not available to provide support. The lack of treatment facilities and resources for mentally unwell patients with a higher risk of being violent frequently results in an unsafe environment for staff and other patients. Outer metropolitan AMHS in areas of socio-economic disadvantage are also experiencing an increase in the number of presentations of patients with a criminal history; prominent examples are Monash Health (Dandenong) and Sunshine Hospital. The latter is also receiving an increasing number of forensic patient referrals via the ED. Sunshine Hospital is being increasingly forced to operate like a forensic service, yet it does not have the resources to support these patients.

The presence of forensic patients in the mental health inpatient unit of a general hospital results in a disproportionate amount of resources being required for their management. This may compel the psychiatry workforce to make decisions resulting in other patients not receiving the required level of care, reducing outcomes for these patients and the service as a whole.

Weekend workforce shortages

Many of the metropolitan AMHS reported that meeting workforce demand at weekends approaches crisis levels. The large number of Friday night presentations in the face of workforce shortages affects the clinical workload over the remainder of the weekend by:

- reducing ability of the senior and junior psychiatry workforce to work together and make medical decisions
- slowing or stalling assessments, treatments, and/or transfers, which leads to systemic inefficiencies, causing frustration and additional stress for patients and their families, as well as clinical staff
- undermining ability for consultant psychiatrists to provide adequate support and supervision to the junior medical workforce.

For example, the Inner West reports workforce shortages during after-hours and weekends as its biggest problem. A junior registrar in the Inner West will work 11–12 hours each day on a weekend. On-call consultant psychiatrists would once have been called in on a Saturday or Sunday for about an hour; today they are regularly called in for about 9 hours, which is longer than a single shift.

‘Many consultant psychiatrists have complained about the taxing clinical load demands during on-call periods, and some have described these periods as unbearable.’

The current workforce model of five days per week, with staff on-call at the weekend, no longer meets the clinical requirements of hospitals and society. The urgent need to change to a 7 day week model was stated by many AMHSs. Some reported they were trialling new measures to overcome weekend shortages, however this is very challenging without available funds. For example, the Inner West is introducing regular shifts each Saturday and Sunday of 4–5 hours in duration plus on-call availability. The Alfred is starting a 3 month trial of a 7 days per week psychiatry workforce model to demonstrate that the increased workforce will decrease ED waiting times, reduce the backlog of clinical work, and improve efficiency of clinical work within inpatient units.

Leave requirements

Inadequate funding for workforce resources in the face of ever-increasing clinical demands has given rise to sensitivity regarding staff taking leave. Most inpatient units have an inadequate number of staff and, if just one staff member takes leave, a huge burden is created amongst the remaining staff due to the workload redistribution. Monash Health reports that at any one time, a staff member will invariably be on leave for one reason or another.

‘Clinical loads are in a continuous state of being distributed among a sub-optimal number of staff.’

Workforce shortages need to be addressed through analysis of correct workforce requirements per the catchment population, which can be defined as the correct:

- FTE of consultant psychiatrists

- FTE of junior medical staff
- mix and FTE of subspecialties
- junior to senior staff ratios
- FTE supervisors.

Staff–patient ratios should be introduced based on correct workforce requirements, taking into consideration all types of leave requirements.

‘The critical balance between training and service has tipped too far in favour of the service side of issues.’

These calculations must recognise that AMHS are essential training environments. They must therefore take into account training and supervision time in accordance with trainees’ level of experience. For more information on staff–patient ratios, refer to R51.

Key findings for adult psychiatry

- F1 Workforce levels are chronically inadequate.
- F2 The 5 days per week workforce model (with staff on-call after-hours and at weekends) is outdated and does not meet contemporary clinical and social demands.
- F3 Clinical loads are continually being distributed across a sub-optimal number of staff because leave and supervisory requirements are not factored into workforce requirements.
- F4 Chronic staff shortages are a welfare issue because they have created a chronically stressed workforce.
- F5 There are serious occupational safety issues because of inadequate resources and facilities to manage mentally unwell patients who are violent.

Recommendations for adult psychiatry

- R1 Improve transparency about the state-wide distribution of MHS funding.
- R2 Introduce a funding model that meets acute clinical demand 7 days per week.
- R3 Undertake an analysis of correct workforce requirements and introduce staff–patient ratios. Refer to R51.
- R4 Develop and implement safety measures for both patients and staff to address the unacceptable risks of aggression and violence.

4.2.2 Addiction psychiatry

An addiction psychiatrist focuses on the study, treatment, and prevention of a wide range of addictions. The aim is to limit the addictive behaviour of a person, address their vulnerabilities for addiction, and then provide help in maintaining their recovery. Addiction psychiatry requires a good knowledge of both physical health and psychological treatment, as well as an understanding of the social context and public health approaches to these problems. Addiction psychiatrists play a vital role in the development of community policies and programs to combat and manage alcohol, drug, and gambling problems.

Victorian funding model for addiction services

The current Victorian funding model for treating people with addictions is divided: addiction is classified under community health, and non-government organisations (NGOs) are contracted to manage patients with addiction issues. NGO services are not funded to provide clinical medical services (psychiatry), the funding for which come under acute health services.

Approximately 200 beds across the state are funded for the treatment of people with addiction issues. Most of these, however, are in the non-government sector and supported by general practitioners (GPs). By contrast, NSW Health, for example, has 600–800 beds for treating people with addiction issues.

Consultant psychiatry positions in addiction psychiatry

Despite general recognition of the urgent need to address problems raised by use of crystal methamphetamine, there is a marked lack of addiction psychiatrists available to address the number of patients with addiction problems. Very few addiction psychiatrist jobs exist because there are few clinical services funded for these positions. Current funding is approximately three EFT for addiction physicians/psychiatrists for the whole of Victoria.

Turning Point Alcohol & Drug Centre (part of Eastern Health and affiliated with Monash University) is the only health service in Victoria that has a professor of addiction psychiatry position. This highlights the fragile nature of academic appointments for addiction psychiatry in Victoria – although the funding is dedicated to a professorial position, it is not tied to a professor of addiction psychiatry position per se.

RANZCP addiction psychiatry training

Psychiatrists who work in addiction psychiatry in Victoria have undertaken their training in the subspecialty overseas or interstate. This is because there are limited opportunities to undertake training in addiction psychiatry in Victoria.

Turning Point is the only health service in Victoria that runs an addiction psychiatry training program. Trainees can undertake a RANZCP Certificate of Advanced Training in Addiction Psychiatry. The health service has only two training positions, however, and these are STP-funded.

Given the number of people in Victoria who require treatment for drug and alcohol problems each year, there is need to expand the addiction psychiatry workforce. Even if the number of addiction psychiatry training places in Victoria were increased – for psychiatrists as well as for GPs and physicians – there would still be an insufficient number of supervisors and educators. The catch-22 is that to train more addiction psychiatrists, there would need to be more addiction consultant psychiatrists to serve as supervisors for the trainees.

The dearth of addiction psychiatrists also means that medical students are not receiving exposure to or inspiration for the subspecialty because there are not enough of these consultant psychiatrists to teach them.

'There is little incentive for psychiatrists or trainees to undertake training in the subspecialty of addiction psychiatry due to the scant number of addiction psychiatry positions available once Fellowship is attained.'

Current opportunities for upskilling in addiction medicine

Currently dual diagnosis (mental health and addiction) consultants (1.6 EFT state-wide) provide didactic but not competency-based training for the workforce in addiction medicine. The teaching is, however, not aligned with medical training principles, and clinical placements are not included. The current investment in addiction medicine upskilling is grossly inadequate given the scale of addiction problems and their impact on mental health, acute hospital presentations, and the community.

Need for succession plan

The addiction psychiatry workforce is in need of root and branch reform. Without this, there will soon not be enough supervisors to support the RANZCP training program.

'Given the current low numbers of addiction psychiatrists and training places, there is currently no succession plan for the future workforce requirements to meet the demands of the population.'

Key findings for addiction psychiatry

- F6 The addiction psychiatry workforce is in acute need of root and branch reform.
- F7 There is a lack of training opportunities in addiction psychiatry/medicine.
- F8 There is a lack of incentive to train in addiction psychiatry because of lack of positions available.
- F9 The current funding model does not support clinical service delivery by psychiatrists.
- F10 Training to upskill in addiction medicine is inadequate.

Recommendations for addiction psychiatry

- R5 Undertake comprehensive review of the current Victorian funding model for addiction psychiatry services.

4.2.3 Consultation–liaison psychiatry

Consultation–liaison psychiatrists work with patients and other medical practitioners to manage the coexistence of physical and psychological issues. They provide patients with holistic health care, and can provide valuable training and advice for hospital colleagues managing common mental health problems encountered in day-to-day practice, such as depression, dementia, delirium, and anxiety.

Medical and surgical patients have higher rates of mental health problems than the general population. Patients coping with chronic diseases can also benefit from a consultation–liaison psychiatrist’s help if they are having difficulties managing their condition. CLP teams provide mental health care to general hospital patients and facilitate appropriate care after discharge. Adequate CLPs are required in Victorian general hospitals to ensure patient flow and quality care, and to maintain the safety of both patients and staff.

Extensive literature has been published on the benefits of CLP. For example, the outcomes of one CLP model tested in a 600-bed general hospital in the United Kingdom demonstrated:

- marked reductions in length of stay
- marked reductions in readmission rates
- substantial savings in terms of bed-days (estimated savings of ~14,000 bed-days over 12 months, or ~38 beds per day).

Most of the improvements in health and savings were observed in elderly patients, particularly in geriatric medicine wards (Tadros et al, 2013).

Historically, CLP has been funded by the DHHS mental health branch. Expansion of CLP services during this time has been infrequent and ad hoc, and funding has remained stagnant despite major growth in acute health service activity. For example, admissions to general hospitals have increased by at least 30% over the past 10 years, and yet there has not been compensatory expansion of CLP services (Queensland Health, 2010).

The failure to index CLP has resulted in grossly inadequate MHS in Victorian general hospitals, contributing to poor care, increased length of stay, preventable behaviour disturbance, and unsafe discharge planning. In addition, mental health funding is not included in the development of new services. Two recent examples of this are the expansion of obstetrics services at Sunshine Hospital and the opening of new intensive care beds at Melbourne Health. Without development and reform, CLP will no longer be available in Victorian general hospitals, with significant implications on patient flow.

The underdevelopment of consultation–liaison psychiatry services in Victoria is directly related to:

- the mental health branch and acute health branch of DHHS each having an expectation that the other will develop services. Decades of stalemate have resulted
- the lack of ‘visibility’ of CLP within key data sets whereby the increased service demands, decreased responsiveness and capacity limits remain hidden
- the absence of a model for service development involving both acute and mental health that demonstrates activity and quality and can respond to changes and growth within the acute health system (DHHS et al, 2016).

Block funding has discouraged the development of funding models from within acute health. It is assumed by general health units that the psychiatric care of an inpatient is funded by the mental health service. At the same time, mental health has deferred to acute health when faced with requests to index CLP. This stalemate, which has been ongoing since the 1990s, is the principal reason for the current unsustainable situation.

The closure of CLP clinics has over-stretched these services. CLP are unable to follow up patients they have cared for during their admission. In addition, patients with complex comorbid physical and psychiatric problems managed by the hospital – often using high levels of resources – cannot be seen. (These patients are *not* seen at community clinics.)

There has never been a framework that establishes the aims, role and scope of practice, performance criteria, or method of matching CLP to the growth in acute health. As a consequence, CLP services are unevenly distributed, inadequate and overstretched.

One positive development in CLP has been the introduction of CL nurse positions in response to local needs as well as political decisions setting the direction of mental health care. CL nursing has been effective in reducing 1:1 *nursing costs, developing mental health-related policies, processes, and educational programs (for example, aggression, 1:1 nursing, restraint and risk management), and improving the capacity of hospitals to deal with behavioural disturbance.*

CLP reform group

In response to the deterioration of CLP in Victorian hospitals, the RANZCP convened a CLP reform group in 2016. The group comprises representatives from the DHHS, RANZCP, Australian Psychological Association, and Australian College of Mental Health Nurses. The group undertook to develop a new model for CLP service delivery in Victoria.

The CLP model developed by the group establishes baseline staffing for service delivery proportional to hospital admissions supported by ABF and the achievement of KPIs. The model supports enhanced services in specialist settings and a framework by which local hospitals can develop individual programs within a cohesive multidisciplinary system. The model incorporates Queensland Health's benchmarking recommendations as stated in the 2010 *Consultation–liaison Model of Service* paper:

- 3.5 FTE per 100,000 people with 1.8 FTE per 100 beds
- higher CLP staffing rates in specialised settings.

The CLP reform working group proposes that a pilot be undertaken at a selection of Victorian hospitals in preparation for state-wide implementation.

Psychiatry workforce and CLP training

As CLP experience is compulsory during RANZCP training, all hospitals must necessarily maintain CLP. The services must, therefore, have a skilled consultant psychiatry workforce to provide supervision and support to trainees. Trainees must undertake a CLP rotation (6 months) during Stage 2 of their training when they are still relatively junior and on a steep learning curve. These rotations are completed on average between 28 and 30 months from the start of training. Training opportunities in CLP during Stage 3 of training are very limited across the state.

The insufficient CLP workforce has limited the number of CLP trainee posts in many locations thereby reducing the capacity for trainees to undertake CLP rotations. This is having flow-on effects for Advanced Training. Stage 3 trainees wanting to complete a subspeciality in CLP require the training post for a longer period of time than those in Stage 2, which compounds the access problem to CLP training posts. The future increase in the number of trainees will create further bottlenecks as the capacity to place them in training posts will continue to diminish (AFHW, 2016).

Key findings for consultation–liaison psychiatry

- F11 There is insufficient funding for CLPs and support staff to meet the clinical demand of patients in inpatient units and EDs across the state.
- F12 There is an absence of benchmarking to determine the correct requirements for CLP services within individual health care organisations.
- F13 There are insufficient number of CLP positions for trainees.

Recommendations for consultation–liaison psychiatry

- R6 Develop and implement an adequate CLP model for Victoria that incorporates:
- CLP teams situated within the AMHS
 - CLP teams to be multidisciplinary and proportional to the hospital size at clinical EFT of 1.8 per 100 beds, plus administration and management-supported by ABF and the achievement of KPIs
 - a framework with which hospitals can develop additional CLP resources for specialist programs within a cohesive system of mental health care
 - a uniform state-wide dataset for CLP
 - an evaluation of CLP services every 5 years. Evaluation should include changes in the general health care system, gap analysis, performance measures, and stakeholder surveys.
- R7 Undertake a pilot of this model at a selection of Victorian hospitals with a view to state-wide implementation (RANZCP, 2016).

4.2.4 Forensic Psychiatry

Forensic psychiatry covers areas where criminal and civil law meet psychiatry practice. Forensic psychiatrists help courts determine criminal responsibility. They are responsible for the assessment and treatment of mentally-disordered offenders both in custody and in the community. They also assess issues such as the risk of violence and reoffending. Aspects of forensic psychiatry include:

- involuntary treatment
- juvenile offending
- competence
- psychiatry injury and disability
- diversion of offenders from court to treatment
- provision of medico-legal opinions and expert evidence.

Forensicare is the state-wide specialist provider of forensic MHS in Victoria: the only agency in the state that provides clinical services spanning the mental health and justice sectors. Approximately 60% of Forensicare's consultant psychiatry workforce have qualifications in forensic psychiatry, with the balance of the workforce drawn from experienced generalist psychiatrists.

Most of the part-time consultant psychiatrists at Forensicare started on a full-time basis and eventually changed to part-time for reasons, such as family commitments, private practice work, or Mental Health Tribunal appointments.

RANZCP trainees

All trainees at Forensicare are at Stage 2 or 3 of their training program. Four trainees are at Stage 3 and Forensicare has the potential to establish more of these positions. An external assessor for SIMGs may be helpful.

SIMGs

Forensicare has close links with a Professor/Clinical Director in Ireland, which helps facilitate the recruitment of SIMGs, who are usually from England or Ireland. While the majority of SIMGs at Forensicare are trained in the UK and have comparable training standards, there remain factors – such as the AHPRA medical registration process and immigration processes – that affect when they are able to commence work in Australia. These factors have a temporary impact on workforce levels, which should be taken into consideration for workforce planning.

'Barriers to recruiting SIMGs to Forensicare include jurisdictional disparities, which affect whether Victoria will be their destination of choice. Queensland and NSW, for example, offer substantially better remuneration compared to Victoria, the differential being as much as \$100-150K annually.'

Forensicare's lack of an academic position reduces the organisation's attractiveness to SIMGs, particularly those with an academic portfolio. This also means Forensicare does not attract PhD students.

Forensic patients

Funding for forensic mental health beds has not kept pace with population requirements. The current forensic facilities in Victoria were built to cater for a catchment population of 3,000; this has increased to 6,000 but without an increase in bed numbers. Currently, at least 10 people at any one time are waiting for a bed at Forensicare, the length of wait varying between 30–50 days.

'The demand for forensic mental health beds would be reduced if patients' mental illness was assertively managed in the community. Better management in the community would reduce the likelihood of patients with mental illness becoming psychotic. If patients did not become psychotic, they would not commit a criminal offence and, therefore, they would not become a forensic patient.'

Civil forensic psychiatry

Training for civil forensic psychiatry, in WorkCover, for example, is almost exclusively undertaken in the private sector. Training opportunities for civil forensic psychiatry are almost non-existent in the public sector. Trainees get observational experience at best, and experience is acquired by on-the-job training.

Key findings for forensic psychiatry

- F14 The lack of academic appointments reduces the attractiveness of forensic psychiatry in Victoria.
- F15 There is a reliance on SIMGs to meet workforce requirements.
- F16 Victoria lacks competitive edge in the financial incentives it offers SIMGs relative to other jurisdictions.

Recommendations for forensic psychiatry

- R8 Establish clinical academic positions to improve the attractiveness of forensic psychiatry in Victoria.
- R9 Investigate incentives to attract SIMGs to Forensicare and give it a competitive edge over other jurisdictions.

4.2.5 Child and adolescent psychiatry

CAP focuses on infants, children, adolescents and their families. A psychiatrist dealing with children will typically see developmental disorders such as Attention Deficit Hyperactive Disorder, autism, or emotional and behavioural issues that have resulted from conflict or abuse. Issues that can lead to mental illness in adulthood are often first noticed in adolescence. A psychiatrist working with teenagers might encounter the onset of conditions such as depression, anxiety disorders, anorexia nervosa, or schizophrenia.

Psychiatrists working with children and adolescents draw on a wide range of skills, including psychopharmacology, psychotherapy, and family therapy. They often work alongside professionals such as teachers, school guidance officers, child safety workers, psychologists, and paediatricians.

There is a recognised shortage across Victoria of CAPs, and a shortage and maldistribution of CAP training posts.

CAP training program

RANZCP training includes subspecialist training in CAP. All psychiatrist trainees complete a mandatory 6 month rotation in CAP during Stage 2 training. During Stage 3, some psychiatry trainees will choose to undertake subspecialist training in CAP which involves two years in CAP rotations, including a mandatory 6 month inpatient rotation.

CAP training Entrustable Professional Activities (EPAs) require that Stage 2 trainees receive both child and adolescent experience during the rotation. To provide CAP training posts, AMHS must therefore have services that offer both of these. Completing two years of Stage 3 certificate training in CAP will provide a psychiatrist with a Certificate of Advanced Training in Child and Adolescent Psychiatry.

A psychiatrist with a Certificate of Advanced Training in Child and Adolescent Psychiatry is required to provide training and supervision to both Stage 2 and 3 trainees. A sufficient number of CAPs is therefore necessary to support the training. To be sustainable, this requires in turn the maintenance of sufficient Stage 3 CAP training posts. Despite this, there is pressure on AMHS to allocate CAP training posts to Stage 2, rather than Stage 3, trainees.

Stage 3 CAP trainees require a range of experience with children of all ages. For very young children (under 5 years), this is gained through training rotations in clinical services specifically funded by the Victorian government and managed by Mindful, the University of Melbourne's Centre for Training and Research in child and adolescent mental health. Gaining adequate exposure to children aged 5–12 years is much more problematic, for both metropolitan and rurally-based trainees. In 2017, accessing mandatory inpatient rotations may be difficult for the first time.

Experience in treating adolescents is gained at youth-based services such as Headspace, the Commonwealth Government-funded National Youth Mental Health Foundation which provides early intervention MHS to 12–25 year olds. (Headspace is not suitable for Stage 2 trainees unless it is matched with time in a child-focused service.) The greater exposure of Stage 3 CAP trainees to adolescents, as opposed to children aged 5–12 years, creates an imbalance in the CAP training experience.

There is also tension between developing expertise of psychiatrists in assessment and management (including medication treatment), and providing sufficient experience in psychotherapy modalities (individual, dyadic, and family therapies).

The latter experience is needed in Stage 3 training, so that CAPs will be able to give clinical leadership to multidisciplinary teams providing treatment.

CAP training at Victorian MHS

Stage 3 CAP inpatient training posts can be undertaken at:

- Metropolitan
 - Public – The Royal Children’s Hospital (RCH), Austin, Eastern Health, Monash, Alfred
 - Private – Albert Road Clinic (inpatient rotation)
- Rural
 - Goulburn Valley Area MHS (1 training post)
 - Warrnambool AMHS (1 training post, non-RANZCP trainee).

Bendigo AMHS does not currently have a Stage 3 CAP trainee, but could establish one. Potential also exists for a Stage 3 CAP training post to be established at other rural MHS including Latrobe Regional Hospital MHS (LRHMHS), Northeast and Border MHS (NBMHS) (Albury-Wodonga), and New Northern Mallee Area MHS (NNMAMHS) in Mildura. Barwon previously had a Stage 3 CAP trainee, but not currently. Rural MHS often find difficulty in increasing training posts because to do so requires additional funding, recruiting trainees can be difficult, and training is vulnerable to change of staff, such as departure of single CAP.

Child and adolescent psychiatry subspecialties

CAP has further subspecialties that require additional training and experience including:

- Child psychiatrists trained in forensic psychiatry to work in juvenile justice. There is a current need to train child psychiatrists in this area
- Child forensic psychiatrists trained in forensics to work in child protection and the family court system
- Child psychiatrists who specialise in CLP
- Child psychiatrists who specialise in addiction psychiatry. These psychiatrists can respond to adolescents with drug and alcohol problems.

The RANZCP allows trainees to do dual Certificates of Advanced Training in Stage 3, such as CAP and forensic or CAP and CLP.

Youth psychiatry

Recent years have seen a substantial increase in services to adolescences and young adults, both in the Victorian MHS sector (for example, expansion of CA MHS services to see young people up to 25 years of age), and through Headspace. While psychiatry resources to meet this expansion of youth services are not just CAP, many psychiatrists are CAP and there is an argument that the developmental training of CAP is well suited to the youth sector. Overall it has meant a greater need for CAP in the workforce, which is likely to increase.

CAP training in North Western Mental Health (NWMH) AMHS (RANZCP Western training region)

The number of Stage 1 RANZCP training places that an AMHS can offer depends on the number of Stage 2 CAP training places it has. This is based on the RANZCP requirement that an AMHS must be able to guarantee it can support the training requirements of a trainee for the lifetime of their training program.

A shortage of CAP training places creates bottlenecks, in that a limited number of Stage 2 CAP training places limits the number of trainees who can progress through the program to fill senior registrar positions within an AMHS.

This issue is particularly acute at NWMH AMHS, situated in the RANZCP Western training region. RCH, which cares for children up to 15 years of age, is the only organisation at which RANZCP trainees at NWMH can gain their Stage 2 CAP experience. The RCH has a limited number of CAP trainee positions, however, and some of these must be reserved for paediatric trainees of the Royal Australasian College of Physicians. Although Orygen Youth Health (OYH), situated in the same region, cares for children aged 15–25 years, there are no accredited Stage 2 training places at OYH (for the care of children aged 15–18 years).

The training bottleneck has significant consequences. Specifically, NWMH AMHS has to rely on SIMGs to fill many of the senior registrar psychiatry workforce positions. This measure creates workforce shortages, however, as the lead times to recruiting SIMGs are lengthy (6–9 months). SIMGs also place extra demands on consultant psychiatrists because SIMGs require more supervision and support than locally-trained registrars (also see SIMGs, section 5.1.3).

'If more child and adolescent training positions could be created in NWMH/Western training region, NWMH would be able to significantly increase its intake of first year trainees. This measure would eliminate the current trainee bottleneck.'

Correcting training bottlenecks is an imperative because, as the number of trainees entering the RANZCP program increases, the capacity to place them in training posts will diminish and create an even greater barrier for progressing through the program (AFHW, 2016).

Key findings for child and adolescent psychiatry

F17 There is a state-wide shortage and maldistribution of CAPs.

F18 A shortage of CAP training positions is restricting the intake of first year trainees each year, causing a reliance on SIMGs to fill senior registrar positions.

Recommendations for child and adolescent psychiatry

R10 Take measures to address the shortage and maldistribution of CAPs in Victoria.

R11 Explore ways in which the number of CAP training posts can be expanded across the state.

4.2.6 Old age psychiatry

The psychiatry of old age relates to the consequences of the ageing process and related medical factors, as well as social and cultural issues arising in later life. Old age psychiatrists collaborate with a variety of health professionals including colleagues, nurses, physicians, social services, occupational therapists, and volunteer organisations.

Despite the ageing population and the majority of hospital patients being over 65 years of age, there has been no growth in funding in Victoria for aged persons MHS. The shrinking service levels in the face of the ageing population has placed a burden on the old age psychiatry workforce.

Demand on CLP services in general hospitals for aged care assessments is growing. The Australian Bureau of Statistics reports that the proportion of the Australian population accessing Pharmaceutical Benefits Scheme-subsidised mental health-related prescription medications increases with age. In 2011, more than one-third (34%) of all people aged 75 years and over accessed one or more of these drugs. Despite these factors, funding for CLP services has not kept pace with clinical demands, nor is there dedicated funding for CLP aged care MHS.

On-call work periods for the old age psychiatry workforce have also become much busier. NWMH aged care AMHS reported that the cost of the on-call after-hours and weekend psychiatry workforce has doubled over the past 5 years.

‘Compounding the reduction in old age psychiatry services is the fact that the profile of aged care patients requiring medical care has changed. Specifically, two distinct patient cohorts have emerged: those who are often much more unwell with more comorbidities, and those who are physically fitter than their counterparts in previous generations. The latter cohort, owing to their fitness, can be much more difficult to manage when they become aggressive.’

These trends are affecting the staff-to-patient ratio requirements, and have created the need to review funding for aged care beds. Some overseas countries have introduced combined geriatrics–psychiatry models of care, which have been successful in creating efficiencies and improving quality of care.

While an adequate number of RANZCP trainees are interested in specialising in psychiatry of old age, a reduction in services (as well as a growing number of RANZCP graduates), means there are insufficient public sector jobs for them to be employed once they complete training.

A large proportion of old age psychiatrists are female. Those who take maternity leave generally wish to return to the public sector workforce but often do so on a part-time basis.

Key findings for old age psychiatry

- F19 Funding for aged care MHS has not kept pace with demand from the increasing ageing population.
- F20 Changes to the physical health of aged care patients have altered the requirements of the psychiatry workforce to patient ratios.

Recommendations for old age psychiatry

- R12 Explore the supports required to support expansion of aged care outpatients' services.
- R13 Undertake a needs analysis of the correct CLP workforce requirements for aged care AMHS.
- R14 Review the cost per psychogeriatric bed in light of the contemporary health profiles of the ageing population.
- R15 Investigate international combined geriatrics–psychiatry models of care.

4.2.7 Psychotherapy

Psychotherapy is the healing of a patient by establishing a therapeutic relationship with a psychiatrist who can guide them through understanding patterns of behaviour in their lives. In doing so, the psychiatrist seeks to bring about helpful changes in thoughts, feelings, attitudes, behaviours, relationships, or personality (Harari, 2014).

Psychotherapists combine biological, psychological, and social perspectives, while also considering factors such as physical conditions, the advice of medical colleagues, and risk. Some therapies are structured, logical, and take a problem-solving approach, while others use a more intuitive exploratory method. A psychotherapist may work with individuals or with couples, families, groups, therapeutic communities, or organisations.

Public sector and psychotherapy

Owing to underfunding in the public sector, there is no time or capacity in the system to influence a patient's recovery through the inclusion of psychotherapy in their treatment plans. It is reported that a paper culture has sprung up where public sector psychiatrists are spending copious amounts of time completing paperwork to address legalities instead of spending time with patients. The more the public sector is squeezed, the less time there is available for psychiatrists to develop a relationship with their patients, and to sit with them and undertake a therapeutic dialogue.

'The absence of psychotherapy undermines the biopsychosocial approach to recovery because it means the psycho and the social side of mental illness do not get addressed. More and more patients in the public sector are being pushed into the private sector for psychotherapy.'

Psychotherapy training

The diminution of psychotherapy in the public sector has reduced the number of psychiatrists who can teach, supervise, and assess trainees in psychotherapeutic interventions. This is affecting psychotherapy training for RANZCP trainees because they have reduced opportunities to gain psychotherapy experience. Some trainees report that, even when they receive psychotherapy experience, there are limited opportunities to meet with consultant psychiatrists to adequately discuss psychotherapy options/treatment. Trainees often have to travel to another institution to gain psychotherapy experience.

Investment in psychotherapy

By recognising psychotherapy as a central part of psychiatry, and investing accordingly in the capacity of psychiatrists to provide it in public sector inpatient units and clinics, readmissions can be reduced or avoided. Health care costs could thus be significantly reduced.

The desire to practice psychotherapy is reported as a key reason for junior psychiatrists to work in the private rather than the public sector once they obtain Fellowship. As such, investment in psychotherapy in the public sector may contribute to retention of psychiatrists in the public sector.

Key findings for psychotherapy

- F21 There is insufficient funding for psychotherapy services in the public sector.
- F22 There is a lack of recognition within the public sector of the value of psychotherapy in the healing process.
- F23 Diminution of psychotherapy services in the public sector is affecting trainee access to training and supervision in psychotherapy.

Recommendations for psychotherapy

- R16 Undertake a pilot of psychotherapy services in the public sector to determine the impact on patient outcomes, re-admissions and health care costs.
- R17 Undertake a feasibility study to explore the potential for establishing public–private partnership clinics, in which patients would be bulkbilled, in areas of disadvantage where it is difficult to attract private practice psychiatrists. The study would need to include the cost of start-up funding and whether there would be adequate interest by a sufficient number of psychiatrists.

4.2.8 Aboriginal outreach MHS

Victoria has several Aboriginal outreach services across the state, including Orbost, The Gathering Place (Maidstone, Werribee, and Highpoint) and at Plenty (outpatient community health of Northern Health). The roles of support staff vary from site to site and may include Aboriginal Health Workers and RNs.

Referral processes at the centres are inefficient and mechanisms for alignment with the general services are often lacking. For example, if a patient has already had psychiatric assessment but needs to be seen again, there is no capacity for longer-term care without starting the referral process all over again.

Services are reported as being vague in terms of what is required of the psychiatrist, and position description are lacking. There is no opportunity or expectation that psychiatrists can contribute to how the organisations operate.

'The services lack consultant psychiatrist input into service development, about what the structure should be, how they can work as a team. What are the resources required to enable teamwork? What is the role of the health worker? How can they best engage specialists? Services for follow-up, case review with patients is needed. Clear structure, how the organisations should run, and good communication mechanisms are required.'

There are also difficulties in recruiting consultant psychiatrists to work in Aboriginal outreach MHS. Despite this, measures are not taken to support those who have a substantial track record of working in the Aboriginal outreach services. To illustrate this, the frequency of renewal of employment contracts is increasing because the duration of contracts is being shortened. Significantly, contractual conditions are also being reduced with each renewal. These circumstances are naturally having an impact on retention.

Key findings for Aboriginal outreach MHS

- F24 There is a lack of recognition of how consultant psychiatrists can contribute to service development.
- F25 There is a lack of formal requirements for how consultant psychiatrists should contribute to Aboriginal outreach MHS.
- F26 Contractual conditions for consultant psychiatrists are diminishing.

Recommendations for Aboriginal outreach MHS

- R18 Evaluate systems for establishment of a model that ensures teamwork and structure, and streamlines and ensures continuity of care.
- R19 Undertake a needs analysis for a consultant psychiatrist role that can provide input into team structures, tertiary input, supervision, clinical leadership, service development and review.
- R20 Explore incentives to recruit and retain consultant psychiatrists to Aboriginal outreach MHS.

4.2.9 Perinatal MHS

Perinatal psychiatrists work with parents and infants to improve their interaction and attachment at an early stage of development, to help prevent children developing mental health problems later in life. The most common perinatal mental health problem is postnatal depression. Occurring in partners as well as the birth mother, it can affect parental bonds with the infant. These conditions can have severe long-term effects on relationships, families, and children, and may lead to a child having psychological issues later on in life.

There is a recognised shortage of perinatal psychiatry beds to meet population requirements. Victoria's birth rate is approximately 60,000 per year; around 30,000 of these occur within the Northern catchment area (northern and eastern Melbourne). This area also includes the Shepparton and the Albury-Wodonga regions, which are disadvantaged areas.

Perinatal units in Victoria

Three central public mother–baby units provide care for Victorian mothers: Monash (Southern), Werribee Mercy (Western), and Austin (North Eastern). These are supplemented by rural units planned or operating in Gippsland, Bendigo and Ballarat. The Austin Hospital has a parent–infant unit which includes services for both mothers and fathers who can be seen during pregnancy and the post-natal period. The three central inpatient units have six beds (plus six for babies). Austin also offers an outreach service supporting case managers.

One or both parents may be eligible for perinatal services if their baby is aged up to 12 months. The types of illnesses treated include severe schizophrenia, bipolar, personality disorders and depression. Those who require the services of perinatal psychiatrists often cannot afford to pay for the service. This inaccessibility leads to poor outcomes, including ongoing abuse, parent–child separations, or situations developing where children need to be removed from their parents. Longer term problems can also arise when children are not provided with the support they need, such as conduct disorder, educational problems, physical and mental health issues, and even behavioural problems which result in involvement with the justice system.

Shortage of perinatal psychiatrists

There is a great need to train more perinatal psychiatrists for community public sector services. There is also a shortage of perinatal psychiatrists for the Children's Court Clinic, which the parent–infant units support. The services of psychiatrists are needed for complex cases, but access to them is very difficult because of insufficient numbers. Rural Victoria also has a shortage of perinatal psychiatrists.

'The cessation of Federal perinatal funding and the low priority the AMHS receives from successive state and Federal Governments means there is not enough funding to attract metropolitan-based consultant psychiatrists who specialise in perinatal services to rural public sector positions.'

Recruitment

Many female trainees are interested in becoming perinatal psychiatrists. This has implications for availability of part-time work, flexible working arrangements, and planning for regular periods of maternity leave.

Key findings for perinatal psychiatry

- F27 There is a critical shortage of perinatal psychiatrists to meet the clinical demand state-wide.
- F28 There is difficulty accessing perinatal psychiatrists to support the work of the Children's Court Clinic.

Recommendations for perinatal psychiatry

- R21 Undertake an analysis of correct workforce requirements to support the Children's Court Clinic.
- R22 Analyse the incentives required to attract perinatal psychiatrists to rural public sector positions.

4.3 Trainee workforce

4.3.1 Overview

The RANZCP oversees the training and qualification of psychiatrists in Australia and New Zealand. Trainees who successfully complete the RANZCP program are eligible to become Fellows of the RANZCP (FRANZCP). Fellowship qualifies psychiatrists to practise independently as consultant psychiatrists in Australia or New Zealand. While undertaking the training program, trainees work as registrars in hospitals and clinics, where they are supervised by experienced psychiatrists. Prerequisites for applying to enter the Fellowship program are:

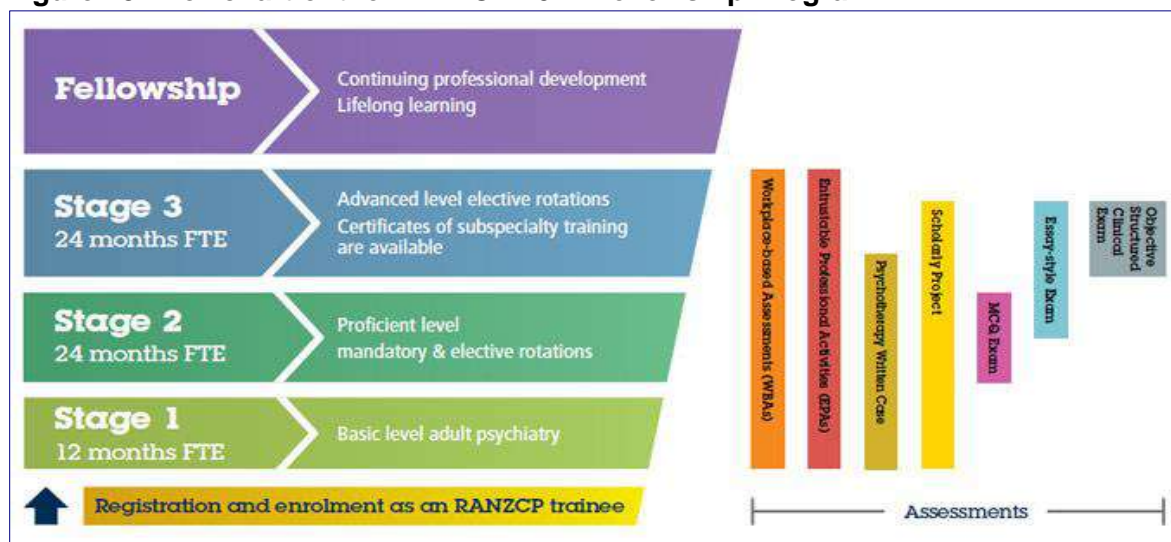
- successful completion of a medical degree
- at least one year FTE of general medical training
- current general registration as a medical practitioner in Australia or New Zealand.

Fellowship program

In January 2013, the RANZCP implemented a revised competency-based training regime: the 2012 Fellowship program. This program has a modified training structure with three stages completed over a minimum of 60 months (Figure 15).

(The previous 2003 Fellowship program was phased out in 2016, when trainees were fully transitioned into the 2012 program.)

Figure 15: Flowchart of the RANZCP 2012 Fellowship Program



The 2012 Fellowship program has a modified assessment structure with Entrustable Professional Activities (EPAs) and Workplace Based Assessments (WBAs). A number of exams and assessments are required to be completed for the attainment of Fellowship.

Stage 3 (years four and five) involves two years FTE supervised experience of generalist training, or trainees may undertake a Certificate of Advanced Training in one of the following subspecialties: addiction, adult, child and adolescent, consultation–liaison, forensic, psychiatry of old age, and psychotherapies. The majority of trainees elect to undertake the generalist pathway. On completion of the certificate stream, trainees graduate with a Certificate of Advanced Training in their chosen subspecialty. Fellows of the RANZCP can also undertake a Certificate of Advanced Training after attaining Fellowship.

In 2014, 17 trainees in Victoria were undertaking the Approved Program in Advanced Training (APAT) pathway. More than half (9; 53%) had elected to undertake the CAP training pathway. (Figure 16).

Figure 16: Advanced trainees in Victoria by subspecialty, 2014

Advanced subspecialty	Training numbers in Victoria, 2014
Addiction psychiatry	–
Adult/generalist	–
Child and adolescent	9 (53%)
Consultation–liaison	2 (12%)
Forensic psychiatry	3 (18%)
Psychiatry of old age	2 (12%)
Psychotherapies	1 (6%)
Total	17

Source: Department of Health (2016)

Supervisory capacity requirements

The RANZCP sets the regulations and provides guidance regarding supervision requirements. Patient and trainee welfare and safety is the priority. Supervision conditions are reviewed and assessed at accreditation visits; however, the allocation of supervision time/capacity is driven by workplace needs. Although the RANZCP can make recommendations and set standards, it cannot enforce supervision, because this is the role of the relevant workforce authority. The RANZCP can, however, monitor and review how supervision requirements are being met (Department of Health, 2016).

The RANZCP sets a number of standards and regulations about the physical infrastructure provided for trainees and supervisors. The sites' capacity to meet these standards is assessed during accreditation visits. The RANZCP does not have the capacity or authority to request that further physical infrastructure be implemented to meet the standards, and can only recommend or suggest that changes be made to improve the workplace conditions. Notwithstanding, in accordance with governance arrangements, the RANZCP has power to de-accredit sites if standards are not met (Department of Health, 2016).

As the number of trainees increases, the number of supervisors required will increase and this will affect supervisor training and support requirements. New supervisors themselves need to be adequately supported. Development of resources, such as online modules and peer support activities, would contribute to provision of support, especially valuable for trainees in rural and remote areas (Department of Health, 2016).

Directors of training

Each of the Victorian RANZCP training regions has a DoT, whose role is to ensure, as far as practicable, the quality of training and that all aspects of the training program run efficiently. Key accountabilities include:

- awareness of the functioning of clinical facilities involved in the program and maintenance of a relationship with them, so that modifications related to the training experience can be made as necessary
- ensuring that training centres take responsibility for trainees' development, including the provision of appropriate clinical experience, supervision of the quality of the trainees' work, and opportunities to make formal presentations of their work in clinical meetings
- approving each of the trainee's rotations/training experiences
- ensuring that consultant responsibility is taken for each trainee (clear lines of clinical responsibility from the trainee to the consultant at all times) and that the required level of supervision is provided
- responsibility for a process of evaluation of the training
- meeting each trainee at least once every six months to review progress with training experiences and tasks.

The VPTC can liaise with health services (employers) in the administration of advertising and selection processes for DoT positions and related support. The required minimum resourcing formula for DoTs to trainees in the RANZCP program (Stages 1, 2, and 3) is:

- 0.5 FTE DoT time per 20 trainees for training, support, teaching, and remediation (0.4 FTE if there is a separate Masters Formula Education Course. This formula takes no account of geographical size or complexity).
- 0.4 FTE Administrative assistant staffing per 20 trainees.
- a minimum (even in small programs) of 0.3 FTE DoT time¹ and 0.5 FTE administration time. This is the minimum administrative staffing needed to run a training base (RANZCP, 2011).²

In 2016, the VPTC recognised that the recommended DoT time is manifestly inadequate because of the size and complexity of the RANZCP training regions. With trainees dispersed across multiple sites, total FTE should be increased from the current 1.7 FTE to least 2.5 to 3.0 FTE. Given that the administrative burden for DoTs has also increased significantly, the VPTC has also recommended that each DoT needs full-time clerical assistance (RANZCP; VPTC, 2016).

Trends in expressions of interest and first year trainee intake in Victoria

RANZCP applicants are selected for psychiatry training based on their suitability, skills, and experience. First year trainees need to apply to the hospitals in which they wish to work as well as to the VPTC (RANZCP, 2015e). Figure 17 provides a breakdown of the annual number of applicants between 2010 and 2017 versus the number of available places and actual intake. While the annual number of first year training places has remained reasonably stable, the number of expressions of interest in and the actual number of applications submitted for the Fellowship Program annually has increased significantly with a concomitant increase in the size of the pool of quality applicants (i.e. selected).

Figure 17: RANZCP first year trainee intake, 2010–2017

Year	2010	2011	2012	2013	2014	2015	2016	2017
No. positions available	46	42	47	50	50	47	50	53
Expressions of interest	n/a	n/a	68	88	106	n/a	133	159
Total applicants	n/a	n/a	47	52 (1 st round) 13 (2 nd round)*	79	78	89	106
No. selected applicants	43	33	36	48 (1 st round) 8 (2 nd round)*	77	47	67	70
No. selected applicants who received a position at a hospital	43	33	33	46	49	47	48	50

¹ Refers to all funded DoT/Coordinating sessions.

² This formula takes no account of program geographical size or complexity, and more sessions should be allowed for such factors. If the DoT is employed to support SIMGs, these should be added to the trainee numbers.

Year	2010	2011	2012	2013	2014	2015	2016	2017
No. selected applicants who did not receive a position at a hospital	3	9	3	7	27	31	19	17
% positions filled	94%	79%	70%	94%	98%	100%	96%	94%
No. Rural positions available	n/a	n/a	1	6	8	4	8	8
Matched 1 st year rural positions	n/a	n/a	0	3	7	4	6	8
% rural filled	n/a	n/a	0%	50%	89%	100%	75%	100%

Source: Victorian Psychiatry Training Committee, 2016

*Number of applicants may be duplicated from 1st round (two selection rounds in 2013).

As Figure 17 reveals, much of the desired data is unavailable because formalised and consistent data collection processes are not in place.

Figure 18: Distribution of first year training places in Victoria according to training region and HCO, 2016

VPTC training region	Hospital/AMHS	No. of first year training positions, 2016	Total
Northern	Austin Health	5	17
	Eastern Health	6	
	St Vincent's Hospital	4	
	Bendigo Health	2	
Southern	Peninsula Health	4	21
	Monash Health	9	
	Goulburn Valley	1	
	The Alfred	6	
	Latrobe Regional Hospital	1	
Western	Barwon Health	4	12
	North West Mental Health	8	
Total		50	50

Vocational training capacity

Training capacity has a serious impact on vocational medical training. Pressure on training capacity increases as larger cohorts of medical graduates move from intern to prevocational to vocational training positions. The Commonwealth has continued to support the expansion of training capacity through the STP, which provides funding for specialist training positions in expanded settings for 900 training rotations a year (AFHW, 2016).

The responsibilities for funding and organising vocational training lie with many parties: the Commonwealth (which funds STP posts), jurisdictions (for postgraduate and specialist training in the public sector), and Colleges (which operate across Australia and New Zealand). Adding to the complexity is that medical practitioners will often cross jurisdictional, sectoral, specialty college, and international boundaries throughout their training pathway. As a result of this division of responsibilities and the myriad of individual medical practitioner pathways, imbalances in the vocational training process can be complex to manage and resolve (Department of Health, 2016).

RANZCP trainees' perspectives on the workforce

Career aspirations upon graduation

Only after trainees sit final exams do most start to get a sense of what they want to do after graduation. A general sense prevails, however, that the majority of trainees want a position (at least part-time) in the public sector. This is because of a perception they would receive better support, including teaching and professional development opportunities, as a junior consultant in a public setting. Full-time private sector work immediately after graduation is perceived by trainees as potentially isolating.

'The drawbacks to working in the public sector are the copious red tape, high degree of paperwork, dealing with bureaucracy and the lack of administrative support. Only about 30% of a registrar's time is spent doing clinical work with patients because of the amount of administrative work they have to do whereas, historically, clinical work used to account for about 90% of a registrar's time.'

Some trainees express concern that it is difficult to find public sector consultant positions in an inner city location. Sometimes new graduates aim to initially obtain employment as a junior consultant at an outer metropolitan public hospital because these positions are perceived as being easier to get, as are positions in inpatient units, until they can move into a CLP or clinic-type role.

There is also a cohort of new graduates who choose to work as locums in the public sector as a way of shopping around and see where they want to work. For others working as a locum is a lifestyle choice to provide balance with other life pursuits.

'Some trainees aspire to begin work in the private sector on a part-time basis immediately upon graduation. These graduates are usually those interested in working in psychotherapy.'

Inpatient units, workforce shortages and burnout

Inpatient unit experience is mandatory as a RANZCP trainee only during the first year of the program. The general preference for first year is to undertake six months in an inpatient unit and the other six months in a community clinic because this provides a different perspective of the types of patients and how they are managed, and of how the system works. The camaraderie generated by the teamwork within the inpatient unit is appreciated. Most trainees actually enjoy their inpatient unit experience when there is adequate staffing. This is because they receive greater supervision and the necessary support, which is particularly important for a junior trainee or a JMO, especially when dealing with difficult patients.

In the final years of the training program, trainees do on-call work which enables them to get exposure to high acuity patients which is an important aspect of their training. The experience senior trainees receive at Barwon Health is reported as being particularly valuable. Barwon delegates some of the *Mental Health Act 2014* powers to these trainees and has a consultant psychiatrist available on-call to provide back up and support.

A widespread negative perception of working in inpatient units prevails because they are high pressure environments. The pressure is created by the mix of high acuity patients, physical and verbal violence from patients, constant pressure to discharge patients to meet NEAT targets, and workforce shortages, particularly during on-call periods. The amount of on-call work has steadily increased and is now a problem – registrars (trainees or HMOs) are now working 8–9 hours per day on the weekend. The sum of these factors militates against being able to receive adequate support and the cumulative effect results in burnout.

Burnout is more likely to occur when there are staff shortages. Inpatient units have a minimal number of staff already so, if just one staff member takes leave, a huge burden is created because the workload becomes distributed amongst the remaining staff who then have to carry an even greater clinical load.

What suffers under these circumstances is the ability for trainees to receive adequate supervision and support. To keep up with the clinical load, trainees end up doing a large amount of unpaid overtime and are often rendered unable to attend scheduled teaching sessions. The heavy workload culminates in the need for sick leave, which further exacerbates staff shortages and low morale.

'When there is adequate supervision and support there is less burnout and people are more likely to choose psychiatry as a specialty training. Perceptions of busyness are influenced by the amount and support of supervision a trainee receives – good support means they can cope better with a heavy workload.'

Occupational aggression

Reported trainee experiences of reduced personal safety include:

- Not all facilities provide trainees with a duress alarm to carry. This is despite it being a requirement for the nursing staff
- The duress alarm they were issued did not work
- Working in CAP inpatient units in which there were no windows on the internal doors. Such windows contribute to safety in that they provide other staff with the opportunity to observe human activity, which is necessary in the event of physical assault or threat of one
- No security support or availability of duress alarms in community clinics. If strife occurs, police are called to manage the situation.

An important conclusion based on observation and experience is that all trainees should receive aggression management training at each facility in which they work during their first year of training because the environment and available supports at each facility differs. More drill practice for duress alarms would also be helpful.

Mental Health Act

A consequence of the updated *Mental Health Act 2014* is an increased demand on trainees' time by creating a greater:

- administrative burden, by the number and length of reports and discharge summaries that need to be prepared
- expectation that registrars will know the patients more thoroughly, a consequence of which is that mental health tribunal hearings are taking longer.

The longer tribunal hearings also increase the potential for a patient to decompensate and direct their anger towards the psychiatry staff who are representing their case at the hearing.

Private practice experience

'Experience in the private sector is helpful and appreciated because trainees learned about the private sector, how to collaborate, and what services are available. There is definitely a market for more private rotations.'

Psychotherapy experience

Accommodating psychotherapy experience when working in settings that don't offer it can be difficult, however. This is because trainees also have to factor in travel time to and from the location where the psychotherapy experience will be provided. The provision of psychotherapy services in the public sector may reduce the burden of ED presentations and patient admissions, particularly in areas of socio-economic disadvantage.

'Psychotherapy experience during training makes psychiatry more appealing. Barwon Health has established a public clinic in which registrars are able to gain psychotherapy experience.'

STP positions

STP positions have created a revolutionary opportunity for trainees to be exposed to specialist areas of psychiatry that would otherwise be difficult to access – for example, in Headspace and research positions in public hospitals.

Key findings for RANZCP trainee workforce

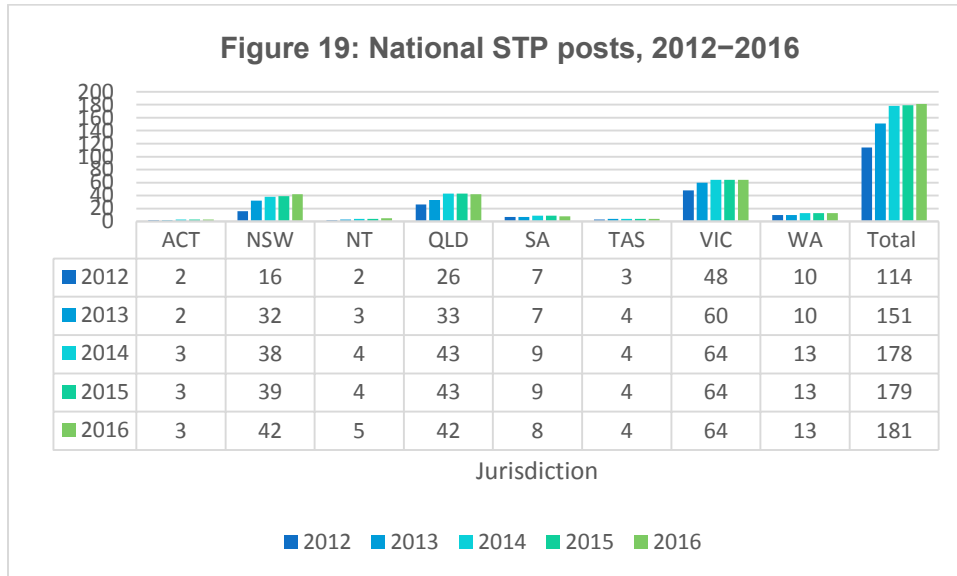
- F29 Funding for DoTs and DoATs is inadequate.
- F30 On-call work has steadily increased and is now a welfare problem – workforce shortages are undermining the capacity for adequate trainee support which is leading to burnout.
- F31 The amount of time devoted to meeting *Mental Health Act 2014* requirements has created a workforce burden.
- F32 There is a lack of psychotherapy opportunities in the public sector.
- F33 Inconsistencies exist between AMHS for personal safety mechanisms.
- F34 There are an inadequate number of senior registrar positions state-wide.
- F35 Data collection systems for trainee workforce are inadequate.

Recommendations for RANZCP trainee workforce

- R23 Review the required FTE for DoTs and DoATs.
- R24 Review the administrative requirements for DoTs and DoATs.
- R25 Assess the adequacy of current occupational safety requirements. Introduce regular duress alarm drills and, for first year trainees, AMT at each Victorian hospital in which they undertake a rotation.
- R26 Undertake an analysis of correct workforce requirements in inpatient units to ensure that trainees receive adequate and supervision.
- R27 Explore how psychotherapy services can be introduced in public outpatient clinics.
- R28 Explore how the number of trainee placements in the private sector can be expanded to increase the opportunity for trainees to get experience in these settings.
- R29 Undertake a needs analysis for more administrative staff in public settings to increase efficiencies in the psychiatry workforce.
- R30 Undertake a needs analysis of the correct senior registrar workforce requirements for inpatient units.
- R31 Develop and implement formal data collection processes relating to the trainee workforce, ranging from expressions of interest to rotations.

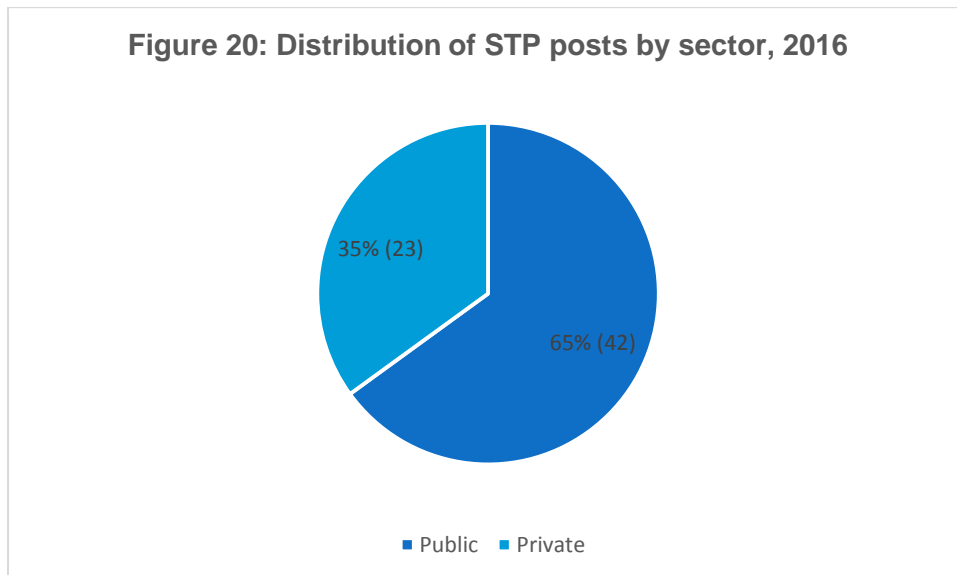
4.3.2 Specialist Training Program

The STP program was born of a workforce need, and has grown substantially since its inception in 2010. Funded by the Commonwealth Government, the STP provides an important contribution to the total number of training places available nationally. The national target of 900 FTE training places was met in 2015. One-fifth (160 FTE; 18%) of these places are dedicated to specialist psychiatry training. More than a third (64; 36%) of these specialist psychiatry training posts are situated in Victoria (Figure 19).



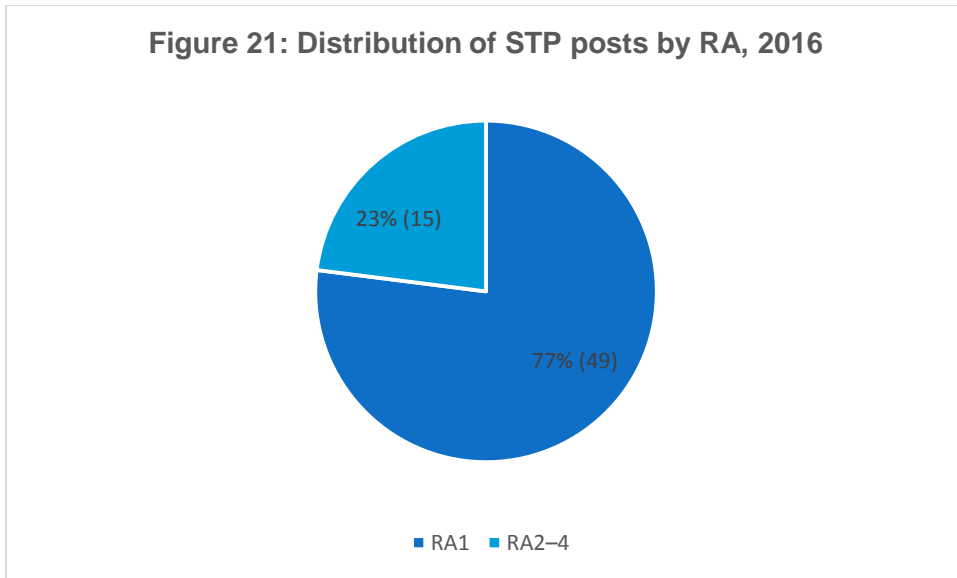
Source: RANZCP Data (2016)

Almost two-thirds of Victorian STP training posts (65%) are situated in public sector settings, with 35% in the private sector (Figure 20). Three-quarters (77%) are located in metropolitan areas, and the remainder (23%) are in regional and rural locations (Figure 21).



Source: RANZCP Data (2016)

Figure 21: Distribution of STP posts by RA, 2016

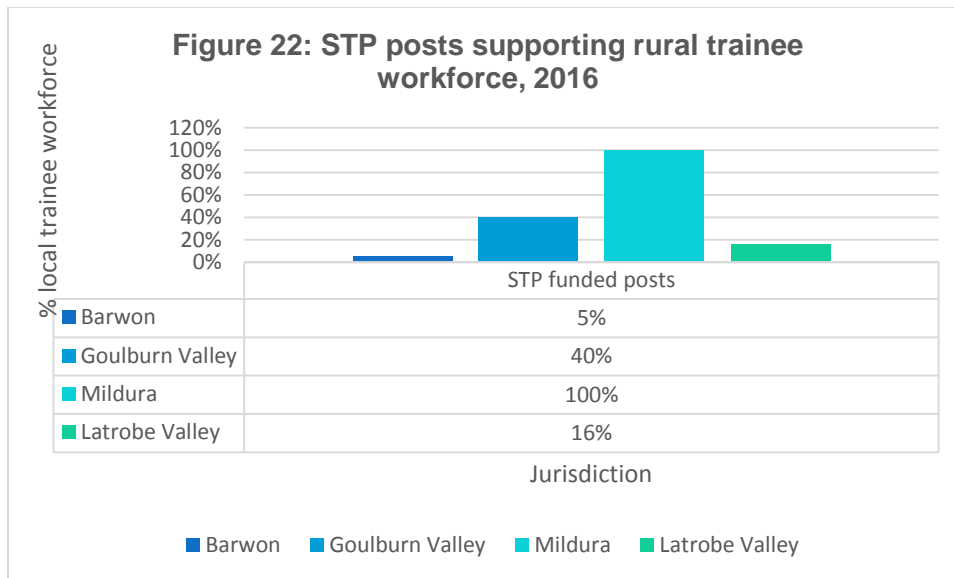


Source: RANZCP Data (2016)

STP posts are important because they provide trainees with exposure to high prevalence/low acuity disorders, which may not be as available in public hospital settings. The majority (55; 86%) of Victoria's STP specialist psychiatry training posts have a single subspecialty focus (see Appendix 3 for STP single focus subspecialties) while 9 (14%) have a combination focus – for example, CAP and forensic psychiatry (Appendix 4).

Health services that receive funding must first go through an expression of interest process; the RANZCP then distributes the funding provided by the Commonwealth to successful applicants. Appendix 5 provides a breakdown of Victorian health services funded for STP specialist psychiatry posts.

STP positions support rural training programs to a significant degree. For example, STP posts support 40% of the local trainee workforce at Goulburn Valley MHS (GVAMHS) (Figure 22). Without STP funding, some rural psychiatry training programs and workforces would collapse. This is because, if just one workforce member were to leave, the clinical load would have to be distributed amongst those that remain. The individual load would become too burdensome, leading to burnout and resignations. Critical mass would be lost and supervisory requirements for trainees could not be met. The training program would then be unsustainable.



Source: RANZCP Data (2016)

* Note: Barwon has another 7 STP-funded training posts that are classified as being located in RA1.

STP funding

The funding for each training post is a salary contribution of \$100,000 (ex GST) per FTE per year. Posts in rural locations may also be provided with rural loadings of up to \$20,000 (ex GST) per FTE per year (Australian Department of Health, 2016). This funding does not, however, cover the actual costs to the health service of maintaining the posts. As the funding is not indexed annually, health services are increasingly subsidising the salary costs. AMHS currently subsidise each STP-funded post by \$30–40K per annum. From 2018, this funding formula is expected to change, and targets for rural FTE and private FTE will be set by the Commonwealth.

STP support program

The STP program also provides funds for a range of support activities. RANZCP supports projects for psychiatry training include:

- a) Support for SIMG and rural trainees (mentoring, webinars, exam preparation, and rural grants) to improve equity of access to training and enhance the rural experience, to encourage the uptake of rural training posts and post-Fellowship employment.
- b) Recruitment into Psychiatry initiatives:

The RANZCP established the Recruitment into Psychiatry project in 2012 to attract medical students and postgraduate medical practitioners into psychiatry. Project initiatives include:

- Introduction to psychiatry short courses
- Psychiatry Interest Forum (PIF)
- PIF ambassadors
- PIF delegates to the RANZCP annual scientific congress.

i. Introduction to Psychiatry Short Courses

A two-day course targeted at postgraduate medical practitioners and medical students in their clinical years. Course objectives are to:

- provide an extended view of psychiatry and demonstrate the diversity of psychiatry subspecialties
- create an opportunity for attendees to network with RANZCP Fellows, psychiatry trainees, medical students, and other medical practitioners interested in psychiatry
- address negative misconceptions about psychiatry, and promote the training and career pathways in psychiatry.

Since 2015, the RANZCP has held nine Introduction to Psychiatry courses at locations around Australia. In April 2015, a DHHS-funded course was held in Ballarat, attended by 26 participants, with an emphasis on the role of the psychiatrist in a rural setting.

The RANZCP recognises the value in continuing to hold Introduction to Psychiatry Short Courses and notes the importance of a rural focus within the course curriculum. Increasing interest in training in a rural location by reaching both medical students and postgraduates in such locations is seminal to increasing the psychiatry workforce in rural Victoria.

ii. *Psychiatry Interest Forum*

Launched in 2014, the aims of PIF are to provide interested medical students, junior and other medical practitioners with the chance to engage with the profession of psychiatry, with the aim of increasing recruitment. PIF members are provided with opportunities to increase interaction with the RANZCP and to network. PIF also delivers psychiatry career information to medical students.

PIF has been a success when measured by popularity. Since 2014, membership has continually increased. At May 2016, the current national membership was 1,419. Of these, almost a quarter (332; 23%) are Victorians. Thirty-seven (22%) of the 168 members who have transitioned to traineeship are Victorian.

iii. *PIF Ambassadors*

A new initiative was introduced in 2015 whereby PIF members can elect to become a PIF Ambassador and join the PIF Reference Group, the purpose of which is to:

- provide a link between PIF members and the RANZCP
- ensure greater awareness and responsiveness to PIF members' requirements
- ensure greater awareness of psychiatry information, events, speakers, and education
- take the lead in organising local events and promotions (via social media) in collaboration with the RANZCP.

There are currently 14 PIF Ambassadors in Australia and New Zealand.

iv. *PIF delegates at RANZCP Congress*

Since 2012, medical students and junior doctors have had the opportunity to attend the RANZCP annual scientific congress. While at Congress, PIF delegates take part in a dedicated program with guest speakers and networking opportunities to discuss Congress sessions, or to seek advice and wisdom about their career trajectory. Feedback about this initiative has been extremely positive. Attendees reported the opportunities were inspirational, highlighting that they were able to gain a better understanding of psychiatry and create networks with trainees and Fellows. Other PIF initiatives have included abstracts at Congress, essay competitions, a Facebook page, and sponsorship of events, such as university psychiatry societies' meetings.

The Commonwealth Government recently announced that, from 2018, it will be reducing funding for STP support projects from 2018. This decision will:

- Affect the ability of the RANZCP to provide recruitment initiatives to medical students and JMOs
- Decrease the ability of the RANZCP to provide support for SIMGs to access:
 - exam preparation workshops
 - cultural and linguistic workshops (for those new to Australia)
 - coaching grants to address specific issues, such as coaching and linguistic case formulation.

Key findings for the Specialist Training Program (STP)

- F36 STP training posts have not been linked to strategic workforce planning.
- F37 AMHS are heavily reliant on STP funding to maintain critical mass for the RANZCP training program.
- F38 Health services are increasingly having to subsidise the cost of STP posts because they are not indexed.
- F39 Substantial reduction in funding from 2018 for the delivery of STP support projects for SIMGs.

Recommendations for the Specialist Training Program (STP)

- R32 Advocate to the Commonwealth for ongoing funding for the STP program.
- R33 Explore how STP training places can become formally incorporated into strategic workforce planning.
- R34 Review the impact on supervisors in the public sector of the STP positions and develop strategies, including funding to address issues.
- R35 Investigate the pre-requisites to increase the amount of training undertaken in the private sector, in primary care, and in rural and regional locations.
- R36 Investigate the required assistance for DoT-SIMGs in rural training locations.
- R37 Consider strategies to recruit and support supervisors in private practice and rural locations and/or to trial remote supervision of trainees. Blended models of supervision may be considered to ensure that trainees can receive appropriate supervision to train in regional/rural areas.

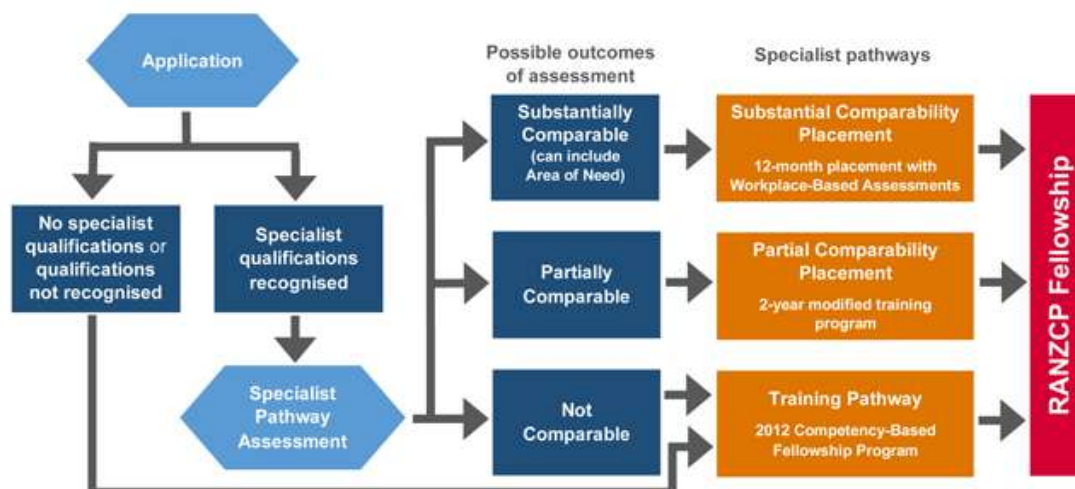
4.3.3 Specialist International Medical Graduate workforce

A SIMG is a medical specialist who has undertaken specialist training overseas and is seeking registration to practice as a specialist in Australia or New Zealand. The RANZCP uses the term SIMG to recognise medical graduates who are trained overseas in the speciality of psychiatry, and that some or all of their training is recognised by the College after an assessment process.

In accordance with RANZCP policy, SIMGs must have a confirmed job offer before being eligible for specialist assessment. A SIMG must then apply to the RANZCP for assessment of their training and experience to become eligible to work in Australia in a specialist capacity. The outcome of this assessment will determine the training pathway they will enter to achieve Fellowship (RANZCP, 2016). Refer to Appendix 8 for more information on the RANZCP eligibility criteria, assessment outcomes, and training pathways for SIMGs.

Overseas candidates eligible to enter the specialist pathway are termed SIMG candidates. The duration of training of each SIMG varies according to whether the psychiatry training they received overseas is considered 'Partially Comparable' or 'Substantially Comparable' to the RANZCP training requirements. SIMGs whose training is not comparable may still choose to enter the Training Pathway and are supported by their regional DoT.

Figure 23: SIMG training pathways



SIMGs generally function at senior roles – as a Senior Registrar (Stage 3 training) in metropolitan AMHS or as a Consultant Psychiatrist in rural AMHS. They may also work in an AoN position. Typically, SIMGs in metropolitan AMHS will have Partial Comparability status. Those in a rural AMHS may have Partial or Substantial Comparability, while those in an AoN will have Substantial Comparability.

The majority (55%) of SIMGs in Victoria undertook both their basic medical training and specialist psychiatry training in India. Other trending nationalities included Iran (13%) Sri Lanka (13%), and Egypt (6%). All SIMGs assessed as 'substantial comparable' by the RANZCP obtained their specialist psychiatry training in the UK (Figure 24).

Figure 24: Country in which basic medical and specialist psychiatry training were obtained

Country in which basic medical training qualification obtained	Country in which specialist psychiatry qualification obtained	Comparability status	Number
India	India	Partial	22 (48%)
India	UK	Substantial	3 (7%)
Iran	Iran	Partial	6 (13%)
Sri Lanka	Sri Lanka	Partial	6 (13%)
Egypt	Egypt	Partial	2 (4%)
Egypt	UK	Substantial	1 (2%)
Turkey	Turkey	Partial	1 (2%)
Germany	Germany	Partial	1 (2%)
South Africa	South Africa	Partial	1 (2%)
Nigeria	Nigeria	Partial	1 (2%)
Mexico	Mexico	Partial	1 (2%)
China	China	Partial	1 (2%)
		Total	46

Source: RANZCP Data (2016)

SIMGs and AoN positions

The 2012 report by the House of Representatives Standing Committee on Health and Ageing, *Lost in the Labyrinth: Report on the inquiry into registration processes and support for overseas trained doctors*, recognised that confusion occurs between AoN and the other system of classification of workforce need, DWS. The latter, which are administered by the federal government, are geographical areas in which the local population has less access to Medicare-subsidised medical services when compared to the national average.

The Standing Committee acknowledged that AoN and DWS support two distinct mechanisms of addressing medical workforce shortages, and there is scope for a national approach to improve alignment between them.

Recommendation 26 of the report states:

‘the Australian Government Department of Health and Ageing consult with state and territory government departments of health to agree on nationally consistent and transparent approach to determining AoN status based on agreed criteria. Consideration should be given to improving the alignment between the AoN and the DWS’.

For SIMGs to work in an AoN-Specialist position, they must be assessed as ‘Substantially Comparable’. A SIMG must then undergo an AoN assessment by the RANZCP. The SIMG must be found to have the necessary skills and experience to work independently, competently, and safely as a consultant psychiatrist in the designated AoN position.

For these reasons, the RANZCP introduced a policy on 1 June 2015 whereby ‘Partially Comparable’ candidates are no longer eligible for AoN-Specialist positions. The policy states that:

- Partially Comparable candidates have not been eligible for AoN-Specialist positions
- Partially Comparability placement candidates who are already in AoN positions are no longer eligible to move to other AoN positions
- Existing Partially Comparable candidates who wish to apply for a new AoN position must be re-assessed with a Substantially Comparable outcome to be eligible to apply for a new AoN position.

Prior to the introduction of this policy, Partially Comparable SIMGs who worked in an AoN found it harder to sit the Fellowship examinations (a requirement of Partially Comparable SIMGs) because they usually experienced inadequate support from the health service in which they worked. As such, these SIMGs spent a long time in AoN positions but without completing the Fellowship requirements.

RANZCP policy stipulates that Substantially Comparable SIMGs on the specialist pathway in an AoN must be assigned a RANZCP accredited supervisor who will assist them in completing the requirements of Fellowship within the specified time (12 months FTE). The health services where these SIMGs are employed are keen to provide this support as it is short term and the SIMG is not required to sit any summative examinations.

Workforce issues

Compared to locally-trained psychiatrists or registrars, SIMGs require more supervision and support while they adjust to the Australian healthcare system and culture. They are the most vulnerable cohort within the psychiatry workforce for a number of reasons, principally:

- language differences
- acculturation issues, in particular:
 - unfamiliarity with the Australian culture
 - lack of social, cultural, and family support networks
 - unfamiliarity with the Australian healthcare system
- variation in medical knowledge/clinical skills resulting from different types of training
- different views on approaches to treatment from having received different types of training
- immigration issues
- limited supervision and feedback processes
- difficulties in passing RANZCP exams.

When working in rural locations, SIMGs face additional challenges, including:

- professional isolation
- difficulty in accessing professional development opportunities
- decreased opportunities to meet RANZCP training, education, and supervision requirements, and to network.

Some rurally-based SIMGs also have responsibilities to supervise trainees, which can be unsatisfying for the trainees if the SIMGs are not well supported themselves in that role.

SIMG Support Program

Through the jurisdictional Psychiatry Training Committees, local RANZCP trainees receive systematically-organised and well-governed support structures. Support for SIMGs vary between jurisdictions, however. (For example, NSW integrates SIMGs into their Training Network, and Queensland has a SIMG DoT.)

In 2011, the RANZCP established the SIMG Support Program, funded by the STP. The broad aims of the program are to:

- increase SIMG access to appropriate training and support to maximise their workforce contribution
- assist SIMGs to obtain Fellowship through the provision of activities that complement existing training opportunities and support structures.

The SIMG Support Program is comprised of four projects:

- Coaching grants
- State-based programs for exam preparation
- Australian Clinical Practice Skills workshops
- Centralised resources (e-learning modules).

The Commonwealth Government has advised that, from 2018, funding for STP support projects will be significantly reduced. This will seriously affect the RANZCP's ability to provide support to SIMGs.

SIMG Directors of Training

Despite the value of the SIMG Support Program, SIMGs still need support through the presence of DoTs, as their training pathways have evolved over time. Support for those for Partially Comparable SIMGs are now similar to those for local RANZCP trainees, yet funding for DoTs is only provided for the latter.

Eastern Health was previously funded a small amount for a DoT-SIMG position. This was of great benefit because it helped bring trainees together, increase educational opportunities, and reduce the sense of professional isolation that SIMGs experience. Despite this, the position did not work as well as it might, because funding was insufficient to provide adequate support and did not cover administrative support. Funding for the position eventually ceased.

The position was reinstated in a fashion between February and June 2016, when DHHS provided funding (0.2 EFT) for a needs analysis for a DoT-SIMG. Since July 2016, the funding for the role has been 0.1 EFT (\$38,000). Adequate ongoing funding is, however, indispensable for a DoT-SIMG position to be effective. This could be funding for 1.0 EFT position or, alternatively, two 0.5 EFT positions, each being responsible for metropolitan-based and rurally-based SIMGs. A significant amount of travel would be a requirement of the latter and this should be reflected in the funding. Funding for administrative support would also be essential.

RANZCP policies and SIMGs

Some SIMGs can work in Australia for up to two years in a Specialist Specified Training (SST)³ position to gain specific experience. In line with recent AHPRA guidelines for limited medical registration, RANZCP now provides SIMGs in an SST position with the option of applying to enter the specialist training pathway while they are still in the SST position if the SIMG meets eligibility requirements.

Commonwealth legislation that affects the SIMG psychiatry workforce

Section 19AB of the *Health Insurance Act 1973* does not help the distribution of the psychiatry workforce to improve access to services in rural and remote areas.

For example, certain suburbs of Melbourne readily-accessible by public transport (such as Brighton, Chelsea and Berwick) are considered DWS while the regional city of Ballarat is not. While the ideal distribution of the GP workforce is one of ready access to a GP within each suburb, this is not necessarily the ideal distribution for the psychiatry workforce as a psychiatrist may not be necessary or even appropriate in each suburb.

³ Specialist Specified Training (SST) allows SIMGs in the final two years of their overseas specialist training to undertake supervised workplace-based training in Australia with the aim of enhancing practical skill in a particular area of expertise. Also eligible to apply for SST training are SIMGs who have a specialist qualification in psychiatry and are looking to gain short-term training which is not available in their home country. SST is not a pathway to RANZCP Fellowship. The maximum time granted for an SST post is two years. On completion of the SST post, the applicant will usually return to their home country to resume work or finish specialist training.

The formula used to determine DWS may not be relevant to the psychiatry workforce.

‘Section 19AB of the Health Insurance Act 1973 (the 10-year moratorium) was introduced by the Howard government almost 20 years ago to address medical workforce issues. While it may have application to certain crafts of medicine, the restriction may not be relevant to psychiatry, or used properly to address the maldistribution of the psychiatry workforce. The Commonwealth Government grants exemption from the moratorium if the psychiatrist applies to practice in a DWS.’

For the purposes of DWS determination, Medicare considers psychiatry as a single speciality and does not distinguish between psychiatry subspecialties. As such, an area may become oversubscribed by general psychiatrists and an exemption for psychiatrists with a different subspecialty, such as CAP or old age, will not be granted. Psychiatrists need to request special consideration for their application to practice in a DWS that is replete with general psychiatrists but undersubscribed in certain subspecialties.

‘Section 19AB restrictions have not addressed the shortage of private psychiatrists in socio-economically disadvantaged areas where there is an expectation by the patient that their psychiatrist will bulk bill them. A better way of managing this by Medicare would be increasing rebate to 100% of schedule fees in those areas rather than attempting to attract SIMGs subject to the moratorium to work there. This proposal is consistent with the RANZCP recommendations to the MBS Review Taskforce in November, 2015.’

Key findings for Specialist International Medical Graduate (SIMG workforce)

- F40 The majority of SIMGs fill positions that are otherwise hard to fill by locally trained psychiatrists.
- F41 SIMGs are the most vulnerable members of the psychiatry workforce and require extra support in acculturation, education, training and supervision.
- F42 The restrictions created by Section 19AB of the *Health Insurance Act 1973* may not be relevant to psychiatry, or used properly to address the maldistribution of the psychiatry workforce.
- F43 DWS determination for the purposes of Medicare does not distinguish between psychiatry subspecialties, which means these areas can be oversubscribed in one subspecialty and undersubscribed in others.
- F44 There is no link between AoN and DWS determination and methods.

Recommendations for Specialist International Medical Graduate (SIMG workforce)

- R38 Investigate the required assistance for SIMGs in rural training locations.
- R39 Establish ongoing funding for a DoT-SIMG position:
 - The DoT-SIMG requires 1.0 EFT with at least 1.0 EFT administrative support, based on current needs, to support Victorian SIMGs. Alternatively, two part-time SIMG DOTs (0.5 EFT each) could be appointed, one each for metropolitan-based and rurally-based trainees. The estimate of 1.0 EFT is based on current numbers, 46 in total, and with consistent average of 8–10 new applicants every year.
 - The objectives and role of DoT-SIMGs can be in line with RANZCP expectations of DoTs and work within similar governance (VPTC in case of Victoria).

- R40 Make proposals to the Commonwealth government to:
- Consider increasing the Medicare rebate to 100% of schedule fees in socio-economically disadvantaged DWS areas rather than attempting to attract SIMGs who are subject to the 10-year moratorium to work there
 - Review the applicability of DWS requirements for the psychiatry workforce
 - Consider the psychiatry subspecialty of a SIMG when granting exemptions.

4.3.4 Private Psychiatry Sector

Although this report focuses on the public sector psychiatry workforce, given the overlap and synergies between the public and the private sectors, senior management from some of Victoria's private psychiatry hospitals were invited to participate to gain a more balanced and overall perspective of workforce issues.

Key findings for training in the private psychiatry sector

- F45 Undertaking trainee experience in the private sector is beneficial for trainees because it gives them the opportunity to learn:
- about services offered in the private sector
 - how the private sector works
 - the differences between the private and public sectors
 - the appropriate mental health conditions for which to refer patients in the public sector to the private sector
 - whether they would like to work in the private sector
 - the differences in infrastructure and environment between the private and public sectors. For example, in the private sector there are no security guards and patients cannot be subject to a Compulsory Treatment Order without being transferred to a public unit.
- F46 There is a misconception that only the public sector treats acutely mentally unwell patients. This is not the case, however, as the private sector is increasingly treating acutely unwell patients. While these patients will generally have private health insurance (PHI), this does not mean they are necessarily wealthy.
- F47 Patients without PHI have difficulty accessing drug and alcohol services.
- F48 When working in the private sector, the role of the psychiatrist includes undertaking case conferences, family meetings, and telephone consultation and liaison services. These skills aren't used in the public sector to the same extent.
- F49 Regular formal meetings by a psychiatry subspecialty unit, such as adult psychiatry, must be in place to meet the requirements of the RANZCP training program for the subspecialty.
- F50 The outer south-eastern area of Melbourne has an undersupply of public and private psychiatrists.
- F51 Formal linkages between the public and the private sectors may increase efficiencies in the process of transferring patients between them.
- F52 The private sector has the capacity to better assist rural areas, with access to psychiatry services through the provision of outreach services.

Recommendations for training in the private psychiatry sector

- R41 Investigate the possibility of introducing formal linkages and pathways between public and private hospitals to increase efficiencies when transferring patients.
- R42 Explore the possibility of facilitating joint meetings between the public and private sectors to increase communication and learning opportunities.
- R43 Investigate incentives that could be introduced to attract psychiatrists to work in areas of socio-economic disadvantage.
- R44 Investigate how relationships between public and private sector psychiatrists can be strengthened, such as networking and educational opportunities.
- R45 Determine options for how people in rural areas can better access private psychiatry services including:
- establish more formalised links between large rural areas and the private sector
 - raise awareness of private psychiatry services amongst rural medical practitioners
 - establish seamless referral processes between rural areas and private psychiatry clinics with services such as telehealth, FIFO and other outreach services.

- R46 Investigate opportunities for RANZCP trainees to rotate through the private sector to increase the understanding of the private psychiatry sector.
- R47 Consider if public–private partnerships would support the creation of day programs for which the public sector may not have the resources. Such programs could draw on the expertise of psychiatrists in the private sector and would be designed to support the public sector by helping to reduce the burden of repeat admissions.

5 Discussion and recommendations regarding attraction, recruitment, and retention

5.1 Attraction

The number of applicants applying for the RANZCP training program has exceeded the number of training places available in recent years. All first year places were filled because a sufficient number of applicants have been of high quality. In 2015, the RANZCP received applicants from around 85 applicants for the 50 first year training places available in 2016. The likely reasons for the increased number of applicants are the greater number of local medical graduates and an increased interest in psychiatry training.

Psychiatry has not always been a popular choice as a vocational medical specialty. A key influence on whether it will be the vocational choice of a junior medical practitioner is whether they receive exposure to the specialty. The option for JMOs to undertake a psychiatry rotation early in their careers is beneficial – a trend has emerged that the more JMOs are exposed to psychiatry, the more that want to specialise in it. Despite this, there are an insufficient number of positions available in Victorian public hospitals for JMO psychiatry rotations.

During a PGY1, JMOs must undertake one medical, one surgical, and one ED rotation, but a psychiatry rotation is not compulsory. It was traditionally thought that JMOs needed one to two years of general medical experience before they were ready for psychiatry experience. In recent years, this view has shifted. JMOs can now undertake a psychiatry rotation during their PGY1 if they wish. Some MHS also offer one year HMO psychiatry positions (six months inpatient unit; six months community clinic work). These experiences help individuals to decide if they would like to enrol in the RANZCP training program. They also positively influence a candidate's application to the RANZCP training program.

The degree of support a JMO receives during a psychiatry rotation may also influence whether they choose psychiatry as a vocational pathway. Workforce shortages may contribute to a negative experience for JMOs because inadequate staffing undermines the amount of support and supervision senior registrars and consultant psychiatrists can provide.

'When there are workforce shortages, junior doctors are less likely to receive adequate supervision and the support they require, which reduces the likelihood that their psychiatry experience will be a positive one.'

Positive role models during JMO rotations – both within the context of a clinical rotation and outside that experience – are powerful determinants for whether medical students and JMOs will decide on a field of specialty.

As discussed earlier, the RANZCP has been delivering the Recruitment into Psychiatry project since 2012 (see section 5.3.3: Specialist Training Program). Part of the STP, the various initiatives within the project have been deemed a success. The Commonwealth Government's recent announcement that it will be reducing funding for STP support projects from 2018 will affect the ability of the RANZCP to provide recruitment initiatives to medical students and JMOs.

5.2 Recruitment

5.2.1 Consultant psychiatrists

Recruitment of consultant psychiatrists was reported as a problem by both metropolitan and rural services and reflects an overall workforce shortage. Recruitment to inpatient units is particularly difficult. This is problematic because, in addition to being the most acute area of mental health services, inpatient units have the most junior medical and nursing staff. Inpatient units, therefore, require sufficient levels of consultant psychiatrists to provide adequate training, supervision, and support to the junior staff.

Recruitment becomes more difficult the further hospitals are from the CBD. For example, Peninsula Health MHS reported difficulty in recruiting for community positions in the outer areas of the Mornington Peninsula. Most services reported the need to recruit SIMGs to meet workforce requirements. In recent years, Monash Health recruited several consultant psychiatrists to meet the expanded workforce requirements for new and larger facilities at Dandenong. Although the full complement of staff was achieved, recruitment of two SIMGs was necessary to do this.

Recruitment of SIMGs has inherent problems. The process includes many hidden costs (time and money for both the organisation and the SIMG), and processes with unexpected delays owing to the requirements of the various organisations involved, including the RANZCP, AHPRA, and Australian Department of Immigration and Border Protection). The lengthy process creates temporary workforce shortages. This has flow-on effects, including a more burdensome clinical load for those in the workforce and the use of locums in the interim, which is expensive.

5.2.2 Rural areas

All rural services reported difficulty in recruiting locally-trained psychiatrists, increasing with the distance from Melbourne. For example, problems were reported in recruiting consultant psychiatrists to the cities of Warrnambool, Albury-Wodonga, and Mildura. As one key informant stated:

'Recruitment to rural areas is usually not about recruiting a person but an entire family which complicates matters in that the needs not just of one person have to be met but all the family members'.

Attracting a family flows on to non-workforce that may be barriers to recruitment. For example, desired educational opportunities for children may not be available locally, opportunities for a partner's career may not be present, and opportunities for career development are limited. For example, there is little opportunity for a psychiatrist to take leave for professional development leave because backfill is difficult to arrange.

A key disincentive to attracting metropolitan-based consultant psychiatrists in private practice to rural areas is the disparity in income. These psychiatrists would need to work twice as much to maintain income parity – that is, the income earned for four days' work in the rural public sector can be generated in two days of private practice in a city. To transition from a metropolitan private practice to a rural public sector position may therefore mean halving one's income.

To demonstrate this disparity, one psychiatrist who has moved to a rural area reported being better off economically by maintaining their metropolitan practice and commuting to Melbourne once per week. Paradoxically, even Medicare telepsychiatry incentives for patients located in a regional, rural, or remote area are a financial disincentive to rural practice. Psychiatrists can consult with their rural patients via Skype from their Melbourne-based practice at a higher rate for some MBS items than they can by seeing them face-to-face in the country area where they both live. (See MBS item numbers: telepsychiatry – 353, 359 and 361; consulting rooms – 291, 293, 296 and 300.)

These remuneration issues are applicable to non-procedural specialists (such as psychiatrists); procedural specialists can continue to generate the income they would earn in the city as long as their patients have private health insurance. The problem has been made worse by the recent changes in salary packaging arrangements announced in 2015, despite a strong opinion from the AMA on this matter.

Lastly, recruitment issues relate not simply to recruiting psychiatrists but to recruiting those with the correct subspecialty to meet the local needs. An absence of incentives to attract psychiatrists with the required subspecialties to rural areas is reported. While general psychiatry positions are more readily available, those who specialise in an area of psychiatry do not necessarily want to give this up if they move to a rural location. See also section 6.2.4: Difficult- to-fill positions.

5.2.3 Academic positions

Both metropolitan and rural AMHS reported that academic psychiatry appointments are helpful from both a recruitment and a retention perspective for several reasons including that they:

- add prestige and lend credibility to a service because they are affiliated with a university
- expand the scope and variety of work and learning experiences – for example, teaching and research – which makes the work much more interesting and rewarding
- attract psychiatrists who want to become academics or already work in academia
- enhance the meaningfulness of jobs because they enable consultants to give back by teaching students
- assist with translating research findings into physical care.

Academic positions are also important from a health care perspective because of the long-term benefits such as better quality research, increased volume of research, and better education. According to Henderson et al (2015), despite the knowledge base of psychiatry currently undergoing unprecedented expansion, recruitment to academic psychiatry has declined. In Australia, this decline in recruitment will have a serious impact on undergraduate teaching, postgraduate training, and continuing contribution to research. The presence of an academic position at Forensicare contributed to it gaining an international reputation. The loss of this appointment mitigates against the recruitment of psychiatrists because it has undermined the attractiveness of the organisation to SIMGs, particularly those with an academic portfolio. The absence of an academic position also means Forensicare can no longer attract PhD students.

Reported factors that influence the organisation where a trainee wishes to train include prestige, inner city location, and reputation for a high-quality training program. For example, the Royal Melbourne Hospital (RMH) has no trouble filling its training places because of its location and cachet. Eastern Health (EH) has also established a robust training program and developed a reputation for being a very good place to train. For trainees, academic positions may be perceived as significant in terms of influencing the development of their own career.

5.2.4 Difficult-to-fill positions

All the rural AMHS report great difficulties in recruiting consultant psychiatrists. For example, the NBMHS has been advertising for a psychiatrist at Wangaratta Base Hospital without success for over a year. NBMHS also has difficulties in attracting SIMGs to the region, irrespective of the availability of funding. The NNM AMHS experiences similar problems; for more than 2 years, it has been unsuccessful in advertising for consultant psychiatrists to establish a permanent workforce in Mildura.

While financial, social, and family factors contribute to difficulties in recruiting to rural services (see section 6.2.2: Rural areas), there are also issues of professional isolation that discourage consultant psychiatrists from choosing a rural position. These include:

- joining a workforce they know is acutely understaffed
- not necessarily having junior medical staff backup
- frequent rostering for on-call and after-hours work
- potentially needing to work 7 days a week
- limited opportunities for career development
- difficulty in taking leave, for either personal or professional reasons, because of the difficulty in finding backfill
- the risk of being 'last man standing', should one or more colleagues leave.

5.2.5 Workforces gaps

CAP training places

Some workforce gaps reported were peculiar to certain AMHS. For example, NWMH AMHS has gaps in its CAP training places, which has created a bottleneck in the local RANZCP trainee program. NWMH reports that increasing the number of CAP training places would have the twofold effect of removing the bottleneck and supporting the local trainee workforce. This is because NWMH could:

- increase its first-year trainee intake significantly
- reduce its reliance on SIMGs to fill senior registrar positions, which could be filled by local RANZCP trainees as they progress through the training program.

Scope exists within NWMH to increase CAP training places. For example, Sunshine Hospital does not have a CAP but needs one, which is a gap in its own right. Should this need be met, a CAP training place could be created at Sunshine Hospital. OYH may also have the potential to create CAP training places given that a large proportion of its patients are aged 15-18 years.

CL Psychiatrists

A significant workforce gap reported by all AMHS was insufficient CLPs. This shortage with its flow-on effects is highlighted in particular at Sunshine Hospital. The transfer of Footscray Hospital's general medical services to Sunshine Hospital over the past year has increased the demand for CLP services. Despite this, there has been no increase in resources for Sunshine Hospital, so there are insufficient CL psychiatrists to meet the clinical demand. Patients who require CLP services are consequently not being assessed while in hospital; all that can be done is to advise them to follow up with their GP after discharge.

Compounding the shortage of resources for CLP resources at Sunshine Hospital is the recent cessation of funding for CLP maternity services. This is significant given that Sunshine Hospital has approximately 5,000 births each year and is situated in an area of socio-economic disadvantage. The new 200-bed maternity hospital being built in the area will further increase the need for maternity CLP services.

Forensic psychiatrists

Northern Hospital has a large number of patients with non-custodial supervision orders whose care is shared with forensic services. The hospital would benefit from having a psychiatrist with a forensic background or interest.

Psychotherapy psychiatrists

Proper community management of mentally unwell patients includes psychotherapy, which is central to the biopsychosocial approach to treatment of mental illness. However, the public sector lacks an adequate psychotherapy workforce, which means the psychosocial aspects of mental illness are not addressed. Increased public sector psychotherapy resources would help reduce or offset ED presentations and hospital admissions of mentally unwell patients and reduce health care costs. The diminution of psychotherapy within the public sector is having an impact on psychotherapy training because it has significantly reduced access for trainees to teaching, supervision, and assessment of psychotherapeutic interventions.

Addiction psychiatrists

The Victorian addiction psychiatry workforce is not only lacking in academic appointments, but in a sufficient number of addiction psychiatrists and training places across the state. Given the prevalence of addiction problems, there is acute need to expand the addiction psychiatry workforce to address clinical demand and create a succession plan for future workforce requirements. If measures are not taken to increase the addiction psychiatry workforce in the foreseeable future, there will eventually not be enough supervisors to support the RANZCP training program.

Junior medical workforce

Trainees are more confident in their knowledge and skills by the time they are in their senior stages of training. In transition to consultant status, they hold senior registrar positions and are skilled in dealing with the complexities of patient care in hospitals. As senior registrars, they have responsibility for the low-risk clinical day-to-day work in hospitals, and are teachers and role models for the junior trainees.

'Senior registrars in hospital wards are pivotal in forging important relationships with ward staff and with trainees and consultants in disciplines other than psychiatry. They also have a distinct clinical and educational influence upon junior doctors and medical students because they are teachers and role models for them.'

Senior registrars provide support to consultant psychiatrists in particular. In rural AMHS, senior registrars are the key to a sustainable psychiatry workforce because of their ability to provide support during on-call periods. Their presence allows consultant psychiatrists more time to handle high-risk cases and provide training and supervision to junior registrars. First year registrars, in particular, find inpatient work tough and need greater support. Senior registrar positions have decreased, however, which has increased the burden on consultant staff and decreased support and learning opportunities for junior registrars.

Junior and senior registrars together comprise the junior medical workforce, which is an integral component of succession planning. For this planning to be adequate, the number of trainee positions available each year must be in accord with current and future clinical demand and population growth. As Stage 1 trainees have less experience and require a greater amount of supervision and support, increasing the number of Stage 1 RANZCP training posts only will not alleviate workforce shortages. Increasing training posts to solve workforce shortages can only be effective if there is an equivalent increase in the number of Stages 2 and 3 training posts. The required number of training places for all training stages should be established according to local AMHS needs.

'An adequate junior workforce is fundamental to the succession planning of health services. The current junior workforce requires a greater number of senior registrars to support a self-sustaining psychiatry workforce.'

5.3 Retention and migration

5.3.1 Challenges to retention

Retaining experienced psychiatrists in the public sector is important because it helps with knowledge sharing. Yet attracting and retaining consultant psychiatrists, more so than registrars, is reported as a problem by many metropolitan services. The reasons include:

- lack of financial rewards. Compounding this, the *Public Sector Medical Specialists Enterprise Agreement 2013* does not encourage full-time work as the hourly rate is much less than fractional appointments
- overwork and stress due to workforce shortages, including excessive weekend on-call work when there is little support
- feeling undervalued relative to the commitment and amount of service provided
- increasing red tape, bureaucracy, and paperwork including unnecessary duplication
- lack of support for basics such as maintaining clinical records
- insufficient administrative support which reduces time for clinical work
- increased risk of experiencing serious adverse events through violence and abuse, and the associated unpleasantness of dealing with aggressive patients.

'Consultant psychiatrists in public mental health are grossly underpaid, constrained by petty bureaucracy, and have an increased risk of experiencing serious adverse events through violence and abuse. The only reason senior consultants do the work is because they are committed to helping people and yet they are undervalued.'

The degree of aggression and violence to which the psychiatry workforce is subjected, particularly in inpatient units and EDs, is reported by many AMHS as a reason for disenchantment with the public sector. Inpatient units, in particular, are taxing and challenging environments, with physical assaults, spitting, and extreme verbal abuse being common. Occupational violence at Sunshine Hospital extends to the relatives of patients assaulting staff and giving death threats. Recent Monash Health statistics reveal that 25% of adverse events were due to physical assault of staff, while 9% related to verbal abuse. The need for police intervention to help manage situations (code black) is also increasing in frequency. As one Clinical Director expressed, 'There are limits to how much violence one can endure'.

Occupational aggression is a key reason reported as to why consultant psychiatrists migrate from the public to the private sector, in either a full-time or part-time capacity. The most common reason reported, by both metropolitan and rural AMHS, is lack of incentives – financial, in particular.

A less common but significant reason for migration from the public to the private sector is the Commonwealth Government's 10-year moratorium on provider numbers for SIMGs working in a DWS. To highlight the issue, the moratorium obstructed the Harvester Clinic in Sunshine from expanding its workforce.

Owing to the moratorium, a SIMG who had trained overseas but had achieved FRANZCP and was working locally for five years, was refused a provider number so they could work at the Harvester Clinic. As a result, the Mid-West lost a committed, highly experienced psychiatrist, who then moved to the eastern suburbs to work in private psychiatry.

Incentives reported that would encourage psychiatrists to remain in full-time positions in the public sector include, but are not limited to:

- financial incentives
- penalty payments
- career development
- career progression
- collegiate development
- professional development leave
- presence of an academic position within the local AMHS.

5.3.2 Rural areas

Retention issues differ between metropolitan and rural AMHS. Ballarat AMHS reports that once SIMGs gain their Fellowship, many leave the region for better remuneration opportunities. Some may stay in Ballarat but move into private practice. Many rural AMHS reported there is a need to increase full-time salaries substantially to improve the long-term retention of consultant psychiatrists.

Regarding retention of rural trainees, the decision to stay in a rural area once they have obtained Fellowship is primarily influenced by individual and family needs, and/or professional development and career progression opportunities. Notwithstanding these, a satisfying training experience has the potential to extend the period of time they might provide service to a rural area once they have obtained Fellowship. Rural trainees need extra support during training, relative to metropolitan counterparts, to have a satisfying experience.

5.3.3 Workforce distribution

The vast majority of psychiatrists and psychiatry trainees are located within metropolitan areas relatively close to where they live. RANZCP data shows that 93% of are based in metropolitan Melbourne. As previously discussed, the metropolitan–rural maldistribution is because:

- professionals usually prefer to work in areas closer to where they reside
- rural practice is unpopular for the many reasons previously discussed (see sections 6.3.1 and 6.3.2).

Within metropolitan Melbourne, there is a maldistribution of CAP trainee positions, with a particular shortage within the NWMH AMHS (RANZCP Western Training Region). Also reported is a maldistribution of RANZCP trainees compared to SIMGs, with a greater number of the latter working in outer metropolitan hospitals compared to local trainees. This is significant as SIMGs require more supervision than local trainees, and this places greater time pressures on consultant psychiatrists.

The RANZCP has had no requirement for trainees to undertake a rural placement since 2013. In 1996, the RANZCP introduced into its bylaws a requirement that trainees undertake a rural placement as part of their training. RANZCP trainees were required to have at least three months' experience in a rural area or with populations that were socially or economically disadvantaged. The RANZCP General Council voted to de-mandate this requirement in 2013, however, because rural training rotations were unpopular among trainees.

Lastly, the Commonwealth Government's 10-year moratorium on provider numbers for SIMGs working in a DWS – who can do after-hours and weekends only – is yet another factor which inhibits recruitment and equitable workforce distribution.

5.4 Issues affecting service provision

5.4.1 Workforce shortages

The majority of AMHS reported a workforce shortage, which was the primary factor undermining service provision. Weekend workforce shortages, in particular, affect service provision.

Firstly, RANZCP trainees have to take over the unfinished, often routine, work of the senior trainee on the previous shift. To keep up with the clinical load, trainees are compelled to do a large amount of unpaid overtime.

Secondly, workforce shortages reduce synergies and communication between consultant psychiatrists and registrars, leading to inefficiencies and skewing the division of work. This situation is highlighted in particular at hospitals within NWMH AMHS. For example, on weekends, the junior doctor is increasingly being called away to deal with patients elsewhere in the hospital, leaving the consultant psychiatrist to do tasks that a registrar normally undertakes. The consultant psychiatrist is often left without the input and assistance of the junior doctor to assess patients. This reduces the thoroughness of patient assessments as it limits the information the consultant would otherwise be able to draw on.

Lastly, workforce shortages impinge on the quality of training of the future consultant workforce because they compromise the ability for trainees to receive adequate supervision and support. As one Clinical Director stated, 'The critical balance between training and service has tipped too far in favour of the service side of issues'.

Workforce shortages and professional development

Although funding is available to cover sabbatical leave, most AMHS report difficulties finding someone interested in backfilling positions on a short-term basis. Sabbatical leave cannot then be approved. This means that organisations are missing out on the important benefits that sabbaticals bring to organisations, particularly the introduction of new ideas and knowledge that enable renewal.

Current factors exacerbating workforce shortages

Factors reported as contributing to the workforce shortages are recent changes within mental health care include:

- requirements of the updated Victorian *Mental Health Act 2014*. These have placed a greater demand on trainees' time through:
 - a greater administrative burden in the number and/or length of reports and discharge summaries that need to be prepared
 - longer Mental Health Tribunal hearings because of the expectation that registrars/consultants will know the patients more thoroughly compared to the requirements of the former Mental Health Act
- emerging health policies, including consumer engagement. As consumers and carers are more health literate, more time must be devoted to discussions with them
- increasing administrative requirements and red tape within the public sector

- increasing complexity of patients' conditions. An increasing number of patients have comorbidities and a large proportion have a dual diagnosis. These patients require longer psychiatric assessments and consultations.

Workforce shortages and floating registrar

One option proposed to support staffing levels during periods of leave is the creation of a 'floating' registrar position. For example, the home ward may be the ED and the registrar would otherwise 'float' across various wards to provide leave cover, as required. Many disadvantages are associated with this proposal, however. One is that floating registrar positions are unsupervised and unsupported, and therefore unaccredited. A trainee's experience in such a role could not contribute towards their training.

Although floating accredited trainee positions would not be impossible to create, they would be difficult to arrange. Such positions would also be costly because the supervisor's clinical work would need to be aligned to the trainee's movements. Significantly, without supervision and support, such positions introduce an unacceptable level of clinical risk to both the patients and the registrars.

A better and more sustainable approach to provision of leave cover for trainees is to ensure that the number within a pool of trainees is sufficient. The pool size must take into account the natural ebb and flow of clinical demands and leave requirements. In addition, the clinical load of each trainee should be less than 100% so they can comfortably accommodate extra clinical work when one of their colleagues is on leave.

Workforce shortages and locums

Workforce shortages may lead to AMHS relying on locums to meet workforce requirements, which has disadvantages compared to an ongoing staff member. The short-term duration of locum placements of 3–4 weeks has an impact on continuity of care which leads to reduced quality of care. Given that a large amount of time and energy goes into recruitment processes, this affects Clinical Directors because it offsets time they could otherwise devote to clinical work, supervision, leadership, and administrative duties.

5.4.2 Best practice approaches to address workforce issues

A range of best practice and innovative approaches has been identified to attract, recruit, and retain medical students, JMOs, trainees, and/or consultant psychiatrists to the Victorian workforce relating to:

- attraction strategies
- recruitment/retention for:
 - all AMHS
 - metropolitan AMHS
 - regional and rural AMHS.

Each of these approaches is discussed below.

Recommendations for attraction, recruitment, and retention

Attraction strategies

- R48 Maintain the STP-funded Recruitment into Psychiatry projects to attract medical students and JMOs. As Commonwealth funding for the STP support projects will cease in 2018, consideration should be given to establishing such projects tailored to Victoria.
- R49 Explore how the number of JMO positions can be increased and how JMOs can be encouraged to undertake a psychiatry rotation during their PGY1 or PGY2. Adequate supervision and support should be in place for these JMOs during their rotation.

Recruitment and retention strategies applicable to all AMHS

- R50 Develop long-term incentives for consultant psychiatrists in the public sector. To improve the recruitment and retention of psychiatrists in the public sector, an array of long-term incentives should be developed. This should include exploration of other countries with good public service retention rates. Incentives should address in particular:
- remuneration
 - professional development opportunities
 - career pathways
 - administrative support to optimise psychiatrists' time for undertaking clinical work.
- R51 Establish staff-patient ratios. Staff-patient ratios should be established. Inpatient unit benchmarking should be the first priority, and then the entire system. The algorithm used for benchmarking should take into account both supply and demand of services including:
- socio-economic disadvantage
 - clinical demand
 - current and future demographics
 - Aboriginal populations
 - culturally and linguistically diverse requirements
 - private and community resources available
 - senior-to-junior staff ratios
 - supervision requirements
 - type and number of support staff available – for example, RNs and Allied Health Professionals
 - all types of leave requirements including annual, sick, study, travel time associated with study, sabbatical and long service leave.

Other factors to consider when determining correct workforce requirements are:

- *Mental Health Act 2014* requirements
- health policies such as consumer engagement and NEAT targets
- administrative requirements
- complexity of patients' conditions – for example, comorbidities and dual diagnoses which requires longer psychiatric assessments and consultations.

The following issues should also be taken into consideration when determining the unique needs of regional and rural AMHS:

- FTE loading
- Greater mental health mortality and morbidity (for example, ABS suicide data) experienced by rural communities (which are vulnerable to mental health problems related to natural disasters, financial hardship, lack of or inaccessibility to health services, and geographical and social isolation)

- Long distances that need to be covered across large geographical areas which affect:
 - travelling time for the delivery of outreach services
 - transit time for patients/families
 - availability of public transport
 - availability of ambulance services
 - community support services used, such as police.

Documents to consider for establishing staff-to-patient ratios for the Victorian psychiatry workforce include:

- Department of Health (2016). *Australia's Future Health Workforce – Psychiatry*. www.health.gov.au/internet/main/publishing.nsf/Content/Australias-future-health-workforce%E2%80%9393psychiatry
- Andrew G and Tolkien Team & World Health Organisation Collaborating Centre for Classification in Mental Health (2007). *Tolkien II: a needs-based, costed, stepped-care model for MHS: recommendations, executive summaries, clinical pathways, treatment flowcharts, costing structures*.
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Recruitment/retention strategies for metropolitan AMHS

R52 Resolving weekend workforce shortages is an imperative for retaining psychiatrists in the public sector. To address this, consideration should be given to workforce models that meet acute clinical demand 7 days per week for metropolitan AMHS. Any such model would need to be acceptable to the members of the psychiatry workforce.

The Alfred Hospital 3 month trial of a 7 days per week psychiatry workforce model could be used as a prototype and, once evaluated, adapted for AMHS elsewhere to determine the correct weekend psychiatry workforce requirements.

Recruitment and retention strategies for rural AMHS

To recruit and retain psychiatrists to rural areas, the local workforce needs to be self-sustaining. A self-sustaining workforce is one that has critical mass, meaning a sufficient number of staff to share the clinical load and able to support each other. The recommendations to achieve this are:

R53 Develop a range of substantial and competitive incentives.

The first step is to establish an adequate FTE consultant psychiatry workforce, with the correct level and mix of subspecialties, which can meet RANZCP requirements for trainee supervision. This could be achieved through offering an array of incentives including:

- supporting employers to offer competitive salary packages to attract locally-trained psychiatrists to rural areas. Remuneration could be graded according to the distance from Melbourne
- relocation costs

- development of rural health services information packages by regional and rural AMHS for prospective and new employees covering:
 - local services and amenities (for example, childcare, schools, accommodation, social, recreational and cultural activities, public transport, safety issues, supermarkets, cafes)
 - rural health services, including a snapshot of local demographics and public health profile, local health workforce, support services, and referral pathways (RANZCP, 2015e).

The RANZCP guide - *Preparing orientation information for psychiatry trainees: a guide for rural health services* (2015e), could be used as a prototype and adapted by regional/rural AMHS for the broader psychiatry workforce.

As highlighted by the NNM AMHS, attracting part-time staff to rural areas may be less difficult than attracting full-time staff. In this case, contracts for part-time consultants could require that they work a minimum number of hours in the rural location to meet RANZCP supervision requirements. Each rural AMHS should also be funded for an academic appointment because these contribute to better recruitment and a retention.

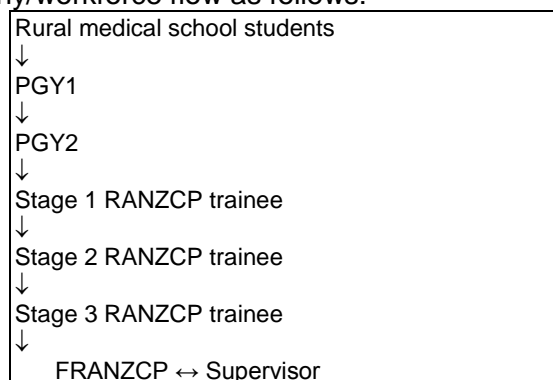
An alternative to all consultant psychiatrists living locally is the provision of adequate funding for flexible models of service provision that include a part-time fly-in-fly-out FIFO/ drive-in-drive-out (DIDO) consultant psychiatry workforce. Once again, these psychiatrists would need to agree to work a minimum number of hours in the rural location to ensure RANZCP supervision requirements are met.

One possible initiative to support a self-sustaining rural workforce may be the establishment of a local public-private partnership outpatient clinic.

R54 *Establish RANZCP training program in towns with a rural medical school*

For regional and rural services with a significant medical school and continuing student presence, the 'grow your own' approach offers a sustainable solution whereby students remain and work in areas where they have trained. This approach captures a workforce that has already experienced and enjoyed a regional or rural health service and lifestyle. To help with recruitment to the RANZCP training program, enrolment targets and weighting of enrolment criteria in favour of regional/rural students could be established.

Another benefit of rural clinical schools is that they provide the opportunity for vertical integration/hierarchy/workforce flow as follows:



This approach accords with the Commonwealth Government's *Integrated Rural Training Pipeline*. Announced in December 2015, the initiative is designed to help retain medical graduates in rural areas.

One component of the initiative is a targeted national expansion of the STP in rural areas – 50 in 2017 and further 50 in 2018 (The Hon Sussan Ley MP, 2015).

Other initiatives that would help sustain a rural psychiatry workforce are funding to:

- support a medical education psychiatrist/registrars position to facilitate support programs and increase psychiatry conversion rates
- increase the numbers of JMOs and HMOs allocated to psychiatry for rural AMHS.

R55 Address professional isolation.

Owing to the tyranny of distance between rural towns and metropolitan Melbourne, professional isolation is a key issue that needs to be addressed for both consultant psychiatrists and trainees. There are many effective initiatives that can help with this:

- Videoconferencing resources for Masters of Psychological Medicine (MPM) that are interactive and online friendly. Good quality technology would enable rural trainees to attend classes face-to-face on an occasional, rather than a weekly, basis. This would offset welfare issues of trainees travelling while fatigued as well as offset the weekly workforce shortages created by their need to attend classes in person.
- Grants to attend professional development events/conferences.
- Educational webinars.
- Mentoring program via the internet. The program could enhance clinical leadership and management skills and provide a variety of opportunities including practice visits, networking, peer support groups and supervisor access.
- Face-to-face workshops for both trainees and SIMGs that:
 - provide exam preparation/fellowship, e.g. coaching
 - provide education for clinical practice skills
 - create opportunities for networking with peers and senior psychiatrists, and engaging with the RANZCP to learn more about professional opportunities.
- Rural DoTs to coordinate training for both trainees and SIMGs.
- Psychiatrist Councils within each rural Local Hospital Network (LHN). These Councils were a successful component of the RANZCP NSW Rural Psychiatry Project. The Councils were the only mechanism for all psychiatrists from rural LHNs to regularly meet as a collective group. Most councils met once per year and 25–50% of all psychiatrists in the region attended. The preference for face-to-face meetings was much stronger than those via videoconferencing.
- The most valued aspect of the Council meetings was the opportunity for networking and information sharing from a range of areas including public, private and academia. A by-product of the meetings has been greater collaboration because of the psychiatrists becoming aware of and familiar with other personnel, programs and resources. From an evaluation of the NSW Rural Project, it was concluded that the ideal number of meetings was 3 per year including one face-to-face, an annual video conference and an all-inclusive rural meeting.
- Locum assistance for improved access to professional and personal leave. The availability of backfill while psychiatrists take leave is an important factor in supporting self-sustaining rural workforces. A best practice option to facilitate quality locum psychiatry services could be the establishment of a locum scheme dedicated to the psychiatry workforce.

A model that could be adapted for such a scheme is the Rural Locum Assistance Program (Rural LAP) (formerly the Rural Obstetric and Anaesthetist Locum Scheme). Federally funded, Rural LAP is especially designed to support the rural health workforce to *inter alia*:

- support staff in taking leave and undertaking CPD activities
- improve retention
- improve the attractiveness of rural practice.

Rural LAP offers locum travel, accommodation and financial incentives, and can provide locum coverage for up to 14 working days per financial year for recreation and CPD leave. For more information, visit: www.rurallap.com.au.

6 Conclusion

Population needs for mental health services in Victoria are not being met. The public sector mental health service has barely the capacity to respond to severely ill patients, placing critical demands on services across most subspecialties. Chronic underfunding has created both a shortage and a maldistribution of the psychiatry workforce – not only across the state but also within metropolitan Melbourne. Workforce shortages in regional/remote locations are compounded by well-known difficulties in attracting medical practitioners to work in these areas. While these areas may rely on SIMGs and/or a FIFO/DIDO workforce to an extent, these are not long-term solutions to workforce shortages. Critical to the maintenance and expansion of the training programs and posts, particularly in rural settings and the private sector, is the funding provided by the Commonwealth-funded STP, however, this is not guaranteed beyond the 2017 training year.

Inadequate staffing levels and occupational violence are key reasons why psychiatrists find public sector work unattractive. Staff are too stretched to be able to support and/or supervise each other, which is particularly needed in the light of increasingly high-acuity patient presentations. Clinical workloads are burdensome, leading to low morale and burnout, increased sick leave, resignations, and a vicious cycle of staff shortages. Senior consultants do the work because they are committed to helping people. Under current circumstances, public sector psychiatry will become even less attractive – as a career choice or a long-term career – because of the combination of workforce shortages, safety issues, lack of recompense and satisfaction, and feeling undervalued.

The introduction of a range of incentives – financial, in particular – can improve recruitment and retention to the psychiatry workforce in both metropolitan and regional/rural areas. Self-sustaining local workforces also need to be generated through the expansion of the RANZCP training program both in terms of the number of AMHS that offer a training program and the number of training places for each stage of training.

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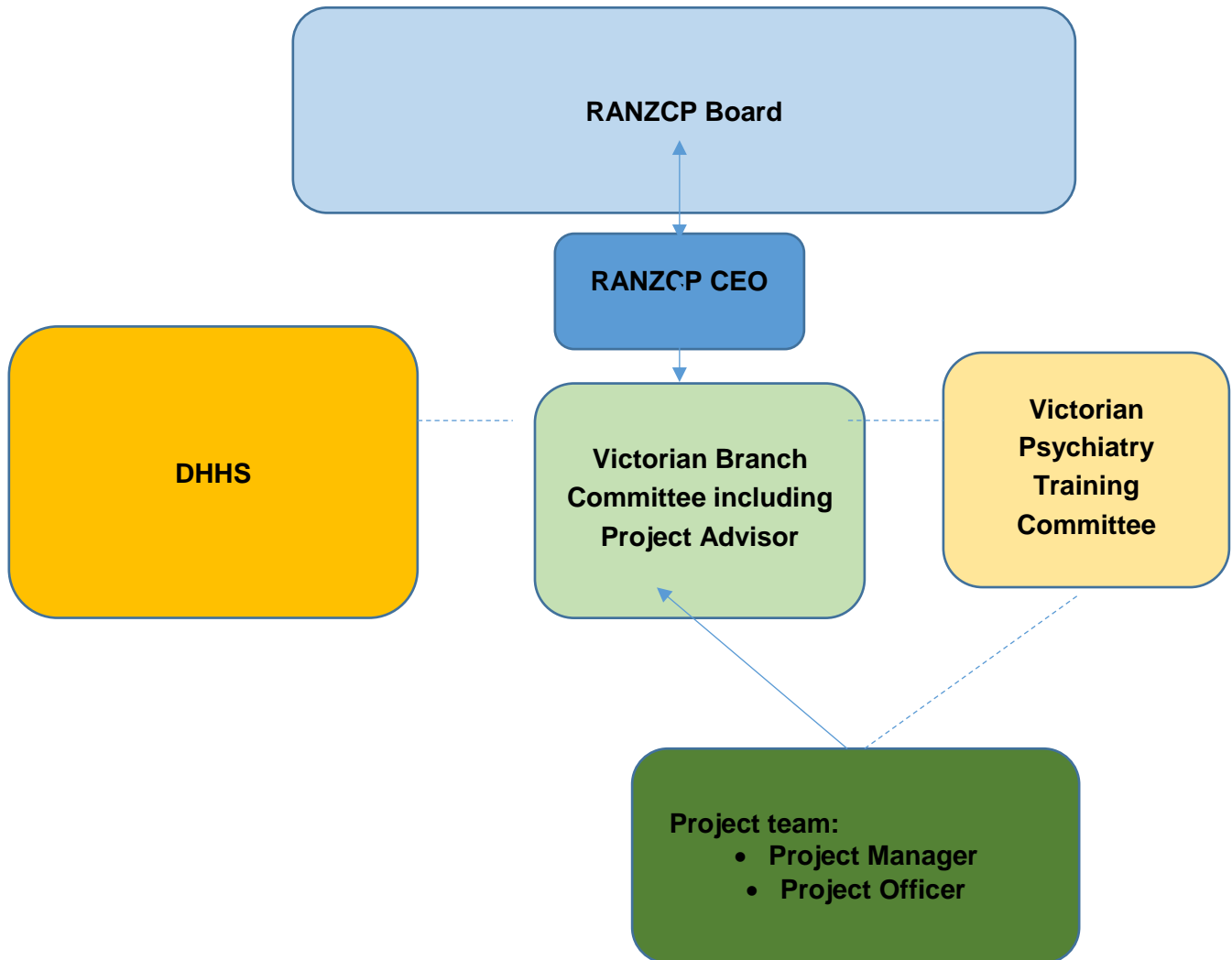
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RANZCP Data (2010-2016)

8 Appendices

Appendix 1 Project Governance Structure



Appendix 2 RANZCP Victorian Training Regions

VPTC training region	Hospital/AMHS	No. of first year training positions, 2016
Northern	Austin Health	5
	Eastern Health	6
	St Vincent's Hospital	4
	Bendigo Health	2
Southern	Peninsula Health	4
	Monash Health	9
	Goulburn Valley	1
	The Alfred	6
	Latrobe Regional Hospital	1
Western	Barwon Health	4
	North West Mental Health	8
Total		50

Appendix 3 STP training posts with a single subspecialty focus

STP training post – single focus	No.
Aboriginal and Torres Strait Islander mental health	3
Acute care	0
Addiction	6
Adult day service	0
Child and adolescent	12
Clozapine	1
Consultation–liaison	3
Drug and alcohol	2
Eating disorders	2
General adult	7
GP liaison	0
Homelessness	1
Intellectual disabilities	0
Mood disorders	0
Neuropsychiatry	1
Old age	3
Perinatal and infant	5
Personality disorder	2
Primary mental health	2
Private	0
Psycho-oncology	1
Psychotherapy	2
Refugee mental health	1
Trauma	1
Total	55

Source: RANZCP data May 2016

Appendix 4 STP training posts with a combination subspecialty focus

STP training post – combination focus	No.
Aboriginal and Torres Strait Islander/GP liaison	0
Aboriginal and Torres Strait Islander/primary mental health	0
Acute care/community mental health/general practice surgeries	0
Cardiac psychiatry/CLP	0
Child and adolescent/youth drug and alcohol	0
Child and adolescent/forensic	1
Consultation–liaison/addiction/Aboriginal and Torres Strait Islander	0
Consultation–liaison/general	0
Consultation–liaison/old age	0
Community/CLP	0
Dual diagnosis (mental health and substance use/addiction)	0
First onset and youth psychosis/perinatal	0
Forensic/addiction	0
General adult/addiction	2
General adult/addiction/psychotherapy	0
General adult/CA	0
General adult/research	1
General adult/research/early psychosis	0
General adult/rural/Aboriginal and Torres Strait Islander	0
General adult/rural/acute	1
Hospital in the home and intermediate care	0
Neuroimaging/clinical academia	1
Old age/community	0
Old age/general and consultation–liaison	0
Rural/general adult	2
Rural/general adult/consultation–liaison	0
Combination focus sub-total	9
Single focus sub-total	55
TOTAL	64

Source: RANZCP Data (May 2016)

Appendix 5 STP positions by health care organisation and Remoteness Area (RA)

Health Care Organisation	RA	No. STP posts
Mildura Base Hospital	4	1
Goulburn Valley Health	2	1
Barwon Health	1	6
Barwon Health	2	2
Barwon Health - Dennis Street, Colac, VIC and McKellar Centre, North Geelong	2	1
Latrobe Regional Hospital	2	1
Yarra Ranges Community Health Service	2	1
St John of God Healthcare, Raphael Centre Berwick	2	2
Casey Community Care Team Casey Hospital	2	1
South West Healthcare MHS Division Warrnambool Campus	2	1
St John of God Pinelodge Clinic	1	2
Mental Health Research Institute	1	1
Austin Health	1	2
Northpark Private Hospital	1	1
The Melbourne Clinic	1	3
Craigieburn Health Service	1	1
Albert Road Clinic	1	1
Harvester Clinic	1	1
St Vincent's Mental Health Family Counselling Service, Victorian Aboriginal Health Service	1	1
St Vincent's Mental Health	1	1
St Vincent's Mental Health Victorian Transcultural Psychiatry Unit	1-4	1
St Vincent's Mental Health Adolescent Forensic Health Service	1	1
Headspace – Western Melbourne	1	1

Headspace – Southern Melbourne	1	1
Headspace – Peninsula	1	1
Headspace – Shepparton	2	1
Headspace – Melbourne Outer East	1	1
Royal Children's Hospital Melbourne	1	1
Royal Children's Hospital Integrated MH Program/Broadmeadows Community Health Centre	1	1
Southern Health	1	6
Uniting Care Moreland Hall and Northern Melbourne Headspace	1	1
RMH	1	2
RMH, Neuropsychiatry Unit	1	1
Mercy Mental Health – Mother Baby Services	1	1
Eastern Health – Turning Point Alcohol & Drug Centre	1	1
Eastern Health – Alcohol & Drug Service	1	1
Eastern Health –Spectrum - The Personality Disorder Service for Vic	1–4	2
The Victoria Clinic	1	1
The Melbourne Clinic	1	1
Alfred Child & Youth Mental Health Service (CYAMHS)	1	1
Austin Health Mental Health CSU, Drug Dependency Clinic Austin Health, Austin Hospital	1	1
Austin Health Mental health CSU, Brain Disorders Program	1	1
Delmont Private Hospital	1	2
Harvester Building (Moving to Royal Park Campus end of 2014)	1	1
Gertrude Street Clinic	1	1

Source: RANZCP Data (May 2016)

Appendix 6 RANZCP SIMG assessment criteria

A SIMG is a medical specialist who has undertaken their specialist training overseas and is seeking registration to practice as a specialist in Australia or New Zealand. To achieve specialist recognition of equivalence to Australian/New Zealand training standards, SIMGs apply directly to the relevant specialist medical college to have their existing training and experience assessed. RANZCP has specific criteria that SIMGs must meet before they can be considered eligible for the assessment.

RANZCP eligibility criteria for SIMG assessment

To be eligible to apply for assessment of existing qualifications, training and experience, SIMGs must:

- Hold the highest psychiatry qualification obtainable as a specialist clinical psychiatrist in their country of origin at the time of qualification
- Have gained that qualification through an appropriately supervised specialist training program which was at least:
 - 3 years in duration
 - 12 months general adult training, of which 6 months was acute inpatient.
- Have attained registration as a specialist psychiatrist in that country
- Want to live and work in Australia permanently
- Have a job offer in Australia or New Zealand
- Have applied to the Australian Medical Council for primary source verification of their primary and specialist psychiatry qualifications. All specialist psychiatry qualifications which constitute the highest specialist psychiatry qualification in the country of qualification need to be verified
- Provide evidence of English language proficiency.

Specialist assessment outcome

Depending on the outcome of the assessment process, RANZCP will provide SIMGs with one of three possible determinations:

- Substantially Comparable – involves 12 months of workplace-based assessments, as well as some additional requirements depending on gaps in their training and experience compared with Australian training standards.
- Partially Comparable – involves 2 years of workplace-based assessments, the clinical exam (OSCE) and the essay style written examination, as well as any gaps identified in training and experience as compared with Australian training standards.
- Not Comparable – applicants whose qualifications, training and experiences are not considered equivalent to Australian training standards have the option to apply for the RANZCP Fellowship pathway.

Appendix 7 Abbreviations list

Acronym	Full name
ABF	Activity-Based Funding
ABS	Australian Bureau of Statistics
AFHW	Australia's Future Health Workforce
AHPRA	Australian Health Practitioner Regulatory Agency
AMA	Australian Medical Association
AIHW	Australian Institute of Health and Welfare
AMC	Australian Medical Council
AMHS	Approved Mental Health Service
AMT	Aggression Management Training
AOD	Alcohol and Other Drugs
AoN	Area of Need
APAT	Approved Program in Advanced Training
ARC	Albert Road Clinic
BHSMHS	Ballarat Health Services Mental Health Service
CA	Child and Adolescent
CAMHS	Child and Adolescent Mental Health Service
CAT	Crisis Assessment Team
CBA	Competency Based Assessments
CBFP	Competency Based Fellowship Program
CBT	Cognitive Behavioural Therapy
CCST	Certificate of Completion of Specialist Training
CCTV	Closed-Circuit Television
CD	Clinical Director
CEO	Chief Executive Officer
CL	Consultation–liaison
CLP	Consultation–liaison psychiatry
CME	Continuing Medical Education
CPD	Continuing Professional Development
CSU	Charles Sturt University
CYAMHS	Child and Youth MHS
DBAMS	Dementia Behavioural Advisory Management Service
DHHS	Department of Health and Human Services
DIDO	Drive-in-drive-out
DoT	Director of Training
DoAT	Director of Advanced Training
DWS	Districts of Workforce Shortages
ECAT	Emergency Crisis Assessment Team
ECT	Electro-convulsive therapy
ED	Emergency Department
EFT	Effective Full-time
EH	Eastern Health
EPA	Entrustable Professional Activities
FIFO	Fly-in-fly-out
FRANZCP	Fellow of the Royal Australian and New Zealand College of Psychiatrists
FTE	Full-time Equivalent
GP	General Practitioner
GPS	Global Positioning System
GSAT	Generalist Stream Advanced Training
GST	Goods and Services Tax
GVAMHS	Goulburn Valley Area Mental Health Service
LRHMHS	Latrobe Regional Hospital Mental Health Service
HDU	High Dependency Unit
HMO	Hospital Medical Officer
ICT	Intensive Community Team
ICU	Intensive Care Unit
IMG	International Medical Graduate
JMO	Junior Medical Officer
KPI	Key Performance Indicator
LAP	Locum Assistance Program

LHN	Local Health Network
LV	Latrobe Valley
LRHMHS	Latrobe Regional Hospital Mental Health Service
MBA	Medical Board of Australia
MBS	Medicare Benefits Schedule
MHS	Mental Health Service
MH-HARP	Mental Health Hospital Admission Reduction Program
MPM	Masters of Psychological Medicine
NBMHS	Northeast and Border Mental Health Services
NCSO	Non-Custodial Supervision Orders
NEAT	National Emergency Access Target
NEVIL	North East Victoria Innovative Learning
NGO	Non-Government Organisation
NHWDS	National Health Workforce Data Set
NMTAN	National Medical Training Advisory Network
NNMAMHS	New Northern Mallee Area Mental Health Service
NSW	New South Wales
NWMH	North Western Mental Health
NZ	New Zealand
OCA	Observed Clinical Activity
 OCD	Obsessive Compulsive Disorder
OSCE	Objective Structured Clinical Exam
OTD	Overseas Trained Doctor
PD	Project Director
PGY	Postgraduate Year
PhD	Doctor of Philosophy
PHI	Private Health Insurance
PHN	Primary Health Network
PIF	Psychiatry Interest Forum
PO	Project Officer
PPP	Practice, Policy and Partnerships
RA	Australian Geographic Classification, Remoteness Area
RACF	Residential Aged Care Facility
RACP	Royal Australasian College of Physicians
RANZCP	Royal Australian and New Zealand College of Psychiatrists
RCH	Royal Children's Hospital
RMH	Royal Melbourne Hospital
RN	Registered Nurse
SBRT	Severe Behavioural Response Team
SECU	Secure Extended Care Unit
SIMG	Specialist International Medical Graduate
SST	Specialist Specified Training
STP	Specialist Training Program
SUMITT	Substance Use and Mental Illness Treatment Team
SVMH	St Vincent's Mental Health
SWSAMHS	South West Sydney Area Mental Health Service
TMS	Transcranial Magnetic Stimulation
UK	United Kingdom
UoM	University of Melbourne
VBC	Victorian Branch Committee
VIC	Victoria
VMO	Visiting Medical Officer
VMST	Victorian Medical Specialist Training
VPTC	Victorian Psychiatry Training Committee
WBA	Workplace Based Assessments
WG	Working Group
WHO	World Health Organisation
WIES	Weighted Inlier Equivalent Separation

Victorian Psychiatry Attraction, Recruitment, and Retention Needs Analysis Project Report



Report: Victorian Psychiatry Workforce

Part B

Psychiatry Attraction, Recruitment, and Retention Needs Analysis Project Report

Profile of each Victorian AMHS, including issues and
recommendations to address these.

August 2017

Authorising Committee	RANZCP Board RANZCP Victorian Branch Committee
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Introduction

Part B of the Victorian Psychiatry Workforce report contains a profile of each AMHS in Victoria, including the issues affecting them. All general recommendations, as proposed in Part A apply to all AMHS discussed in Part B. Key issues and recommendations specific to individual AMHS are also proposed, where relevant, and are in addition to the general recommendations outlined in Part A.

Summary of recommendations specific to an individual AMHS

AMHS	Recommendations
Royal Children's Hospital	<ul style="list-style-type: none"> • Explore possibilities for funding an increased number of academic positions in child psychiatry.
NWMH aged care AMHS	<ul style="list-style-type: none"> • Explore the supports required to support expansion of outpatients' services. • Explore options for a combined/joint/partnership model of care between geriatrics and aged care mental health. • Undertake an analysis of the actual cost per psycho-geriatric bed in light of the healthier old age population. • Undertake a needs analysis of the correct consultant–liaison psychiatry (CLP) requirements for aged care mental health.
Forensicare	<ul style="list-style-type: none"> • Undertake an evaluation of incentives that would attract SIMGs to Forensicare and give it a competitive edge over other jurisdictions.
Warrnambool & District Base Hospital Psychiatric Services	<ul style="list-style-type: none"> • Explore opportunities for linking the old age consultant psychiatrist position with an academic appointment. Funding could be shared between Deakin University and the AMHS.
Latrobe Regional Hospital MHS	<ul style="list-style-type: none"> • Explore the potential to establish an academic appointment.
North Eastern Border/Albury Wodonga AMHS	<ul style="list-style-type: none"> • In conjunction with NSW Health, develop a range of incentives to attract consultant psychiatrists to the area. • Until a self-sustaining local workforce is established, undertake an evaluation of the supports required for a FIFO/DIDO psychiatry workforce to support the community in the interim.

Summary of key issues

AMHS	Issues
Royal Children's Hospital	<ul style="list-style-type: none"> • Child adolescent psychiatry (CAP) training posts are insufficient – RACP paediatric trainees must be accommodated in addition to RANZCP trainees. • Insufficient academic positions. • Inadequate on call weekend workforce relative to clinical demands. • Inadequate CLP workforce relative to clinical demands.
Orygen Youth Health	<ul style="list-style-type: none"> • Difficulty in recruiting and retaining senior consultant psychiatrists because of: <ul style="list-style-type: none"> ○ high level of violence in inpatient unit ○ high caseloads because of workforce shortages ○ inadequate leave entitlements ○ need for an increased workforce to meet the acute clinical demand seven days per week ○ perceived inadequate remuneration. • Reliance on SIMGs to meet workforce requirements, which involves a lengthy recruitment process that, in turn, creates workforce shortages. • Insufficient CAP training posts.
Inner West AMHS	<ul style="list-style-type: none"> • Skeletal weekend on call workforce is totally inadequate to meet clinical demands – current on call weekend workforce model is outdated in the face of increased ED presentations and inpatient admissions. • Unsafe working environment for psychiatrists because of inadequate workforce.
Mid West AMHS	<ul style="list-style-type: none"> • Insufficient support and incentives to retain psychiatrists in the public sector. • Inadequate funding for CLP services, particularly in light of Footscray medical units being transferred to Sunshine Hospital. • Absence of funding for an experienced child psychiatrist. • Unsafe environment in inpatient unit owing to high levels of violence. • Insufficient resources to manage increasing number of patient presentations. • Inadequate workforce to comfortably accommodate leave requirements. • Outmoded workforce model/inadequate staffing levels to meet weekend clinical demands.

<p>North West AMHS</p>	<ul style="list-style-type: none"> • Insufficient financial incentives to readily attract newly graduated psychiatrists to full-time public sector positions. • Inadequate psychiatry workforce relative to clinical load. • Violence in inpatient units and a recognised need for a skilled workforce to manage aggressive patients well. • Insufficient affordable private practice resources to support public workforce demands. • Inadequately staffed community team.
<p>Northern AMHS</p>	<ul style="list-style-type: none"> • Need for a forensic psychiatrist. • Imbalance in the proportion of SIMGs to local trainees. • Workforce shortages caused by need for Overseas Trained Doctors (OTD) to resign to gain experience elsewhere. • Growing Aboriginal population. • Retention issues for consultant psychiatrists.
<p>NWMH aged care AMHS</p>	<ul style="list-style-type: none"> • Significant increase in costs for weekend workforce over last few years. • Increased complexity of patients not reflected in funding per bed. • Inefficiencies caused by separate models of care for geriatric and psychiatry. • Expansion of bulk-billed outpatient clinic requires start-up funding.
<p>Monash Health AMHS</p>	<ul style="list-style-type: none"> • High level of occupational violence in inpatient units. • Constant pressure on psychiatry workforce to discharge patients before they are clinically ready. • Increasing number of presentations to ED of mentally unwell patients with a criminal history. • Continuous understaffing owing to lack of recognition of leave requirements in funding model.
<p>The Alfred AMHS</p>	<ul style="list-style-type: none"> • Need for addiction psychiatrists. • Limited opportunities for trainees to get defined psychotherapy experience.
<p>Peninsula Health MHS</p>	<ul style="list-style-type: none"> • Inadequate psychiatry workforce to meet clinical demands including: child psychiatry, perinatal psychiatry, addiction psychiatry, old age psychiatry and CLP. • Inadequate psychiatry workforce on weekends to meet clinical demand.

<p style="text-align: center;">SVMHS</p>	<ul style="list-style-type: none"> • Insufficient funding for CLP workforce to meet clinical demands. • Difficulty in retaining full-time consultants owing to insufficient financial incentives and occupational violence. • Accommodating leave requirements burdens the workforce. • High level of occupational violence. • Inadequate after hours and weekend workforce to meet clinical load.
<p style="text-align: center;">North Eastern AMHS</p>	<ul style="list-style-type: none"> • Difficulty in retaining full-time consultant psychiatrists owing to perceived insufficient financial incentives and occupational violence. • Accommodating leave requirements places a strain on the workforce.
<p style="text-align: center;">Eastern Health AMHS</p>	<ul style="list-style-type: none"> • No academic position. • High level of occupational violence. • Inadequate leave cover arrangements. • Inadequate CLP workforce to meet clinical demand. • NEAT KPIs creating pressure to discharge patients before they are clinically ready.
<p style="text-align: center;">Forensicare</p>	<ul style="list-style-type: none"> • Difficulty in attracting SIMGs because of lack of academic appointment and lack of competitive financial incentives relative to other jurisdictions. • Reliance on SIMGs to meet workforce requirements. • Little supervisor time for pastoral feedback and formative training. • Forensic patients are becoming an increasing burden on peripheral hospitals.
<p style="text-align: center;">Barwon AMHS</p>	<ul style="list-style-type: none"> • Uncertainty of STP funding which supports a large proportion of trainee workforce.
<p style="text-align: center;">Warrnambool & District Base Hospital Psychiatric Services</p>	<ul style="list-style-type: none"> • Difficulty in attracting locally trained psychiatrists owing to distance. • Inadequate consultant psychiatry workforce. • Absence of a permanent Clinical Director of MHS. • Unhealthy workplace culture. • Absence of a RANZCP training program.

<p>Latrobe Regional Hospital MHS</p>	<ul style="list-style-type: none"> • Difficulty in recruiting locally trained consultant psychiatrists. • Difficulty in attracting full-time consultants which undermines capacity for clinical leadership. • Over-reliance on SIMGs which creates workforce gaps because of long recruitment lead times. • Weekly workforce shortage on trainee's day of study leave. • Occupational violence. • Difficulty recruiting consultants for short-term positions to cover leave. • Lack of recognition of the unique ways in which the rural geographical expanse impacts upon the psychiatry workforce.
<p>Goulburn Valley Health AMHS</p>	<ul style="list-style-type: none"> • Fragile critical mass such that the departure of one staff member would bring about the eventual collapse of the workforce including the RANZCP training program. • Reliance on STP funding, which is not guaranteed, to achieve critical mass. • Shortage of senior registrars to help create a self-sustaining workforce. • Workforce shortage one day per week owing to trainee's day of study leave. • Poor videoconferencing network for online attendance of MPM classes.
<p>Ballarat Health Services AMHS</p>	<ul style="list-style-type: none"> • Difficulty in retaining SIMGs in the region once they obtain Fellowship. • Perceived financial disincentives to working full-time in the rural public sector. • Frequent on call weekend work owing to small psychiatry workforce. • No RANZCP training program because difficulties in retaining SIMGs is undermining ability to achieve critical mass of consultant workforce.

<p>Bendigo Health Psychiatric Services</p>	<ul style="list-style-type: none"> • Workforce shortages, particularly old age, CLP and youth psychiatry. • Weekly workforce shortage because of trainees needing to take study leave to attend MPM classes. • Trainee welfare compromised because of their need to travel to Melbourne to attend MPM classes one day per week while tired. • Poor videoconferencing services making the option for rural students to attend MPM classes online unviable. • Cessation of rural–metropolitan links has led to negative flow on effects including much more inexperienced junior psychiatry workforce with concomitant greater burden on consultants.
<p>North Eastern Border/Albury Wodonga AMHS</p>	<ul style="list-style-type: none"> • Critical workforce shortage. • Difficulty in attracting consultant psychiatrists. • Insufficient funding to expand FIFO/DIDO workforce. • Insufficient workforce impacting upon service provision. • No RANZCP training program because of workforce shortage.
<p>Mildura Base Hospital AMHS</p>	<ul style="list-style-type: none"> • Difficulty in attracting locally trained consultant psychiatrists. • Reliance on SIMGs to meet workforce requirements. • Workforce gaps owing to lengthy recruitment process for SIMGs. • Absence of RANZCP training program.

Approved Mental Health Services

Royal Children’s Hospital

The RCH is the major specialist paediatric hospital in Victoria, whose care extends to children from Tasmania, southern New South Wales and other states around Australia and overseas. The hospital is the designated state-wide major trauma centre for paediatrics. It also provides the state Victorian forensic paediatric medical service (with Southern Health and Victorian Institute of Forensic Medicine) in which assessment and care for abused, assaulted and neglected children and adolescents is provided.

The RCH has a strong training and research focus. Campus partners for these include the Murdoch Children’s Research Institute, The University of Melbourne Department of Paediatrics, and the RCH Foundation.

Psychiatry workforce profile (as at 2016)

Position	Number	Details
Consultant psychiatrists	8.5 EFT	
SIMGs	0	
HMOs	0	
Trainees	8–10	<ul style="list-style-type: none"> • 4–5 Stage 1 RANZCP trainee positions each semester • 2 Stage 1 positions – STP funded • Up to 2 Stage 3 RANZCP trainee positions <ul style="list-style-type: none"> ○ 1 inpatient unit ○ 1 academic/CLP position • Up to 3.5 positions are for paediatric trainees from The Royal Australasian College of Physicians (RACP) as they need to do a 6 month rotation as part of their training requirements
Academic positions	2	<ul style="list-style-type: none"> • Professor of child psychiatry (0.3 EFT) <ul style="list-style-type: none"> ○ New position – commenced February 2016 ○ 3 clinical sessions/week ○ Joint position between the Department of Paediatrics and the Department of Psychiatry of the University of Melbourne. Funding is philanthropic • Professor of Psychiatry (0.4 EFT) <ul style="list-style-type: none"> ○ 4 clinical sessions/week ○ Jointly funded by the University of Melbourne and the RCH

Workforce issues

Maldistribution of child psychiatrists

The north and western regions of Melbourne have a large under-privileged population and higher psychiatry needs yet there are fewer private practices in these regions relative to other metropolitan Melbourne regions. A maldistribution of child psychiatrists, therefore, exists in Melbourne, which creates challenges for providing necessary services.

Insufficient academic positions

The RCH is internationally renowned for its medical excellence and research yet has only two academic positions in child psychiatry. Also, few, if any, other similar positions exist in Victoria. Yet academic positions provide many important short and long-term benefits including better quality research, increased volume of research and better education.

Inadequate ED staffing levels after hours and on weekends

On call work is onerous due to the frequency of being rostered on call because of steadily increasing activity in the hospital over the last decade and, in particular, since the opening of the new hospital in 2011. Funding for ED out-of-hours mental health care in EDs is limited. The growth of funding has been inadequate as it has not kept pace with demand for services.

Insufficient funding for CLP services

The funding for inpatient psychiatry services at the RCH is insufficient to cover running an inpatient unit, the costs for which are cross-subsidised with community care funding. CLP funding is also reported as limited and inadequate to meet clinical demand.

Specific issues for RCH

- CAP training posts are insufficient – RACP paediatric trainees must be accommodated in addition to RANZCP trainees.
- Insufficient academic positions.
- Inadequate on call weekend workforce relative to clinical demands.
- Inadequate CLP workforce relative to clinical demands.

Recommendations for RCH

- Explore possibilities for funding an increased number of academic positions in child psychiatry.

North Western Mental Health

NWMH, which is part of Melbourne Health, operates out of all hospitals in north west metropolitan Melbourne and at a number of independent locations. The formation of NWMH has seen the redistribution of inpatient mental health facilities from the inner city to meet the needs of the growing populations in the outer west and north – a catchment area of over 1.2 million people with four population growth corridors.

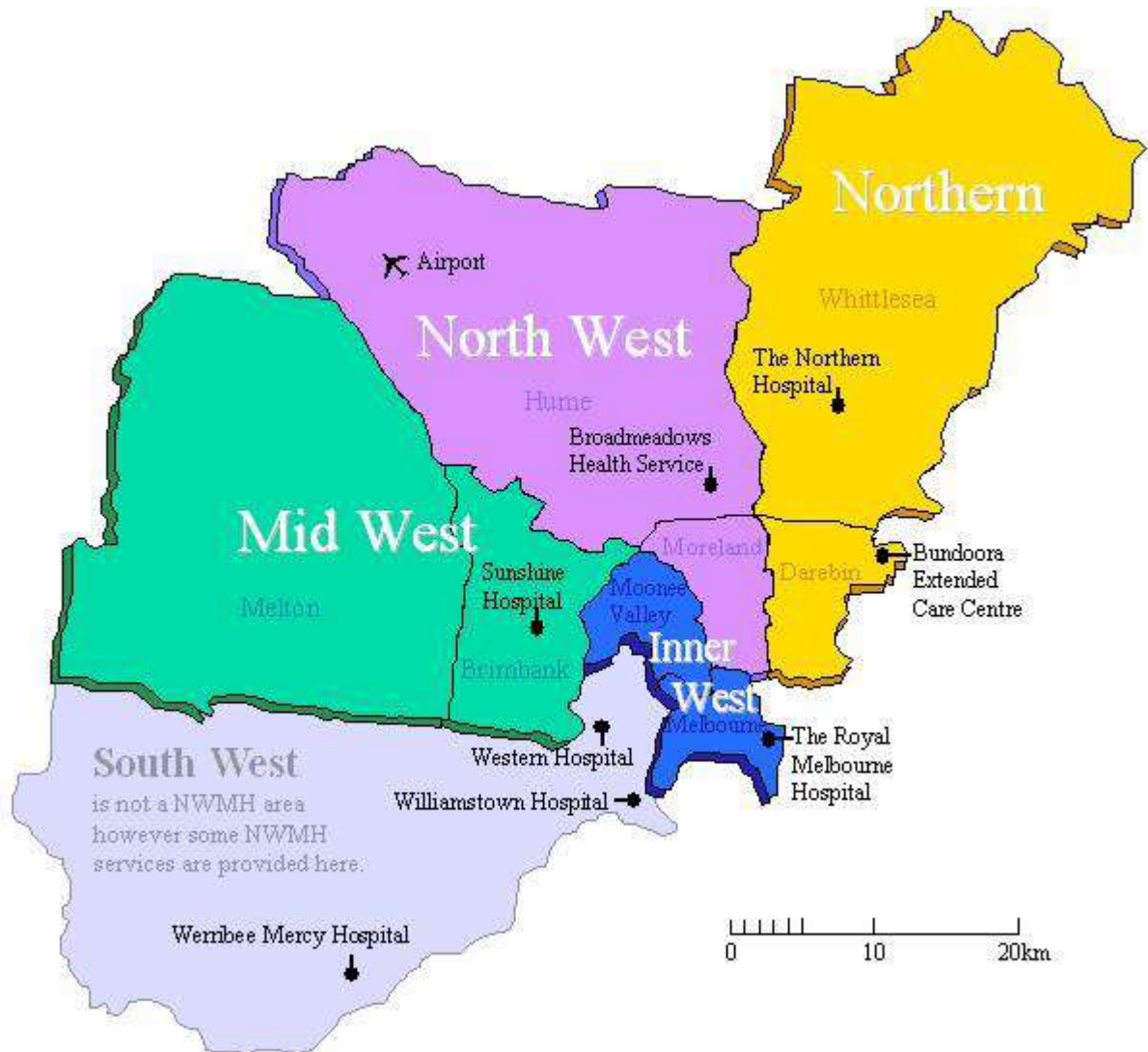
NWMH has six mental health programs:

- 1 youth health service – ORYGEN
 - covers the Inner West, Mid West, North West and South West areas
- 1 aged persons' mental health program
 - covers all five areas of the map (only parts of South West)
- 4 adult MHS (AMHS):
 - Inner West – Cities of Melbourne and Moonee Ponds
 - Mid West – Cities of Brimbank and Melton, including Sunbury
 - North West – Cities of Hume and Moreland
 - Northern – Cities of Whittlesea and Darebin.

Within these services there are general adult inpatient and community roles, plus more specialised consultation–liaison roles and subspecialty roles (for example, within neuropsychiatry and eating disorders units).

NWMH employs on average 60 local RANZCP trainees (Stages 1, 2 and 3). The trainees rotate to Forensicare, Werribee Mercy mental health service, The Albert Road Clinic, The Melbourne Clinic, Western Health drug health service, substance use and mental illness treatment team (SUMITT)/alcohol and other drugs (AOD) service, The Royal Children's Hospital – to undertake child and adolescent psychiatry training. NWMH trainees are also regularly appointed to the Royal Women's Hospital psychiatry service.

NWMH also employs about 35 SIMGs (on the RANZCP specialist and SST pathways across all sites), and has a number of HMO positions. At October 2016, the junior medical workforce of NWMH AMHS totalled 110 EFT.



Orygen Youth Health

Orygen Youth Health (OYH) is an internationally renowned leader in youth mental health programs. OYH has a specialised youth mental health clinical service, an integrated training and communications program and is an active research centre. OYH sees young people aged 15 to 25, with a focus on early intervention and youth specific approaches.

OYH's inpatient unit is a standalone unit at the Western Hospital and is not attached to an ED or a medical ward. The unit is part of Melbourne Health but its location is within the boundaries of Western Health. OYH also has an outpatient clinic, and a crisis assessment and treatment team (CATT).

Workforce profile

Orygen			
		Number	Comment
Consultant psychiatrists (8 EFT)	Full time	2	
	Part time/Visiting Medical Officer (VMO)	14	
Junior medical workforce	RANZCP trainees	7	<ul style="list-style-type: none"> • 1 STP position at Headspace • Tend to be full-time • 3.5 have research positions (the no. expands and contracts according to the no. of active projects)
	SIMGs	5	
	HMOs	2.5	

Workforce issues

Difficulty in retaining senior consultant psychiatrists

Retention of senior medical staff is a more acute problem than is the retention of registrars. Yet retention of experienced psychiatrists in the public sector is important because it helps with knowledge sharing. A valuable benefit of working full-time in the public sector is that the Continuing Medical Education (CME) allowance is substantial. Notwithstanding this, full-time work in the public sector has become very unattractive because there are not many other incentives and attracting staff who wish to work full-time is very difficult. This creates difficulties from a workforce planning perspective.

Lengthy SIMG recruitment process

As OYH is internationally renowned, it is attractive to some SIMGS who come specifically to Australia to work at the organisation. Some come on Fellowships then return to their home country while others come as a career move. Those that stay on enter the SIMG training pathway. The recruitment process for SIMGs is highly bureaucratic and very long, being fraught with uncertainty and lengthy delays. Thus a guaranteed workforce for OYH is difficult to achieve. A more efficient process for the recruitment of SIMGs is required. As all SIMGs must now enter a RANZCP training pathway to obtain Fellowship, a dedicated Director of Training (DoT) is required to provide support.

NWMH needs to recruit SIMGs to fill senior registrar positions. This creates temporary workforce shortages because of the length of time involved in recruiting SIMGs. The recruitment processes for SIMGs involves the requirements of the Department of Immigration and Border Protection, the Australian Health Practitioner Regulatory Agency and the RANZCP being met, which can take six to nine months.

Insufficient CAP training places

NWMH has an insufficient number of CAP training positions at the RCH for Stage 2 trainees, which severely limits the intake of first year trainees each year. The number of first year trainee places NWMH is able to offer annually is predicated on the number of CAP places. Currently, the number of CAP positions at NWMH AMHS varies between eight and ten each year. This creates a bottleneck in that it restricts the number of trainees progressing through the training program who can eventually fill senior registrar positions.

An increase in the number of CAP training positions would mean NWMH could take on more first year RANZCP trainees, who would progress through the training program and eventually fill the accredited senior registrar positions. NWMH would, therefore, be able to rely much less on SIMGs, which would increase stability in the workforce and increase opportunities for local trainees. NWMH reported it could significantly increase its first year trainee intake by increasing its number of CAP training places.

Weekend workforce shortages

The inpatient units operate fully seven days per week but is only staffed for Monday to Friday with an inadequate and skeletal workforce on the weekends. Decision making about patients' care, therefore, slows down on weekends which creates inefficiencies. Given the clinical workload on weekends, OYH needs a seven days per week staffing profile for the inpatient unit and the CATTs to manage acutely unwell patients.

The staffing ratios between the medical workforce and patients is inadequate. Staff-patient ratios have been established for nurses but not for doctors and this needs to be addressed.

Occupational aggression

Owing to the large proportion of young male inpatients, many of whom who use methamphetamines, the OYH inpatient unit has the highest level of violence in Victoria. The unpleasantness to which the health workforce is subjected – assault, verbal abuse, spitting – has created difficulties in attracting psychiatrists and the burnout rate is high. Junior medical staff find it difficult to cope in the inpatient unit because of the high level of acuity and the burdensome workload in the face of minimal training and supervision.

Leave requirements

Leave cover, particularly for sabbaticals, is a perpetual problem because of inadequate funding. Sabbaticals are very important because they enable people to bring in new ideas and knowledge which is how the workforce renews itself. Despite this important benefit, no one at OYH is able to take sabbaticals because the organisation finds it impossible to provide backfill.

Inadequate cover during periods of leave is exacerbated by underfunding for staffing levels. This has many flow on effects included an overburdened and stretched workforce in which consultants are needing to do the work of registrars. The staff shortages also reduce the flexibility to move people around to cover leave, as required. Staff taking leave reduces workforce levels even further and, therefore, reduces the number of available staff to undertake medical decision-making. This slows down or stalls patients' assessment, treatment and transfer and leads to systemic inefficiencies.

Specific issues for OYH

- Difficulty in recruiting and retaining senior consultant psychiatrists because of:
 - high level of violence in inpatient unit
 - high caseloads because of workforce shortages
 - inadequate leave entitlements
 - need for an increased workforce to meet the acute clinical demand seven days per week
 - perceived inadequate remuneration.
- Reliance on SIMGs to meet workforce requirements, which involves a lengthy recruitment process that, in turn, creates workforce shortages.
- Insufficient CAP training posts.

Inner West AMHS

The Inner West AMHS has a 29 bed inpatient unit, which is the busiest unit in Victoria. It also has a community clinic and an eating disorders clinic. Subspecialties include adult/general and neuropsychiatry psychiatry.

Psychiatry workforce profile

Inner West AMHS			
		Number	Details
Consultant psychiatrists	Full time	3	
	Part time/VMO	21	
Junior medical workforce	RANZCP trainees	10.5	
	SIMGs	0	
	HMOs	7	On rotation from RMH
	SIMG	0	

Workforce issues

Recruitment

Owing to its inner city location, the Inner West has no difficulty in attracting trainees. The AMHS is also aligned with the RMH, which has prestige. Notwithstanding these factors, the AMHS has to rely on SIMGs to fill senior registrar positions.

Weekend workforce shortages

The biggest issue for the Inner West is the on call work afterhours and on weekends. Many years ago, an on call consultant psychiatrist would have been called in for about one hour on a Saturday or Sunday. These days they are called in for about nine hours, which is greater than a single shift. A junior registrar will work 11–12 hours **each** day on a weekend.

Adding to the burden of long hours by on call staff is that the large volume of high acuity of patients and yet other psychiatry or allied health staff are not available to provide backup. For example, an average of five new patients will be seen on a Friday night, which has a flow on effect in terms of clinical workload over the weekend.

Another reported pressure is the need to discharge patients from the ED within four hours¹. Given that many of these patients will need a bed in the inpatient unit, a concomitant of the four hour ED rule is an extremely high turnover in the inpatient unit to make room for the patients in the ED waiting for a bed.

The inadequate workforce has introduced issues of safety. The work environment is unsafe for psychiatrists because the patients may be extremely unwell and disturbed yet the on call psychiatrists must work by themselves all day. The demanding clinical load brought about by inadequate staffing levels is leading to burnout for some psychiatrists.

¹ Commonwealth Government's National Partnership Agreement on Improving Public Hospital Services includes the National Emergency Access Target (NEAT) to improve access. NEAT requires that 90 per cent of all patients presenting to a public hospital ED will be admitted, transferred or discharged within four hours.

In light of the above points the Inner West is in great need of a weekend workforce and this need will become even greater in the future. To help reduce the clinical workload of current staff, the Inner West is reported to be introducing in the near future regular shifts of four to five hours in duration plus on call availability each Saturday and Sunday.

Key issues for Inner West AMHS

- Skeletal weekend on call workforce is totally inadequate to meet clinical demands – current on call weekend workforce model is outdated in the face of increased ED presentations and inpatient admissions.
- Unsafe working environment for psychiatrists because of inadequate workforce.

Mid West AMHS

Workforce profile

Mid West AMHS			
		Number	Details
Consultant psychiatrists (8.5 EFT)	Full time	7	<ul style="list-style-type: none"> • Subspecialties: <ul style="list-style-type: none"> ○ adult ○ CLP (0.3 EFT) ○ 1 academic position (0.4 Sunshine MH services, 0.6 UoM)*
	Part time/VMO	9	
Junior medical workforce (15 EFT)	RANZCP trainees	3	<ul style="list-style-type: none"> • 3 month rotation from Footscray • 2 psychiatry HMOs would like to enter training program
	SIMGs	8	
	HMOs	4	

The academic position is held by a psychiatrist who has an international reputation for research in schizophrenia.

Workforce issues

Recruitment

The AMHS is successful in attracting locally trained doctors to work in psychiatry, i.e. psychiatry HMOs.

Local private sector services

The high number of people of low-socioeconomic status in the NWMH AMHS catchment area militates against psychiatrists setting up private practice in the area. As such, the AMHS has very few private practice psychiatrists and, therefore, limited capacity for public sector psychiatrists to refer patients who may otherwise be appropriate for treatment in a private practice setting. As there is no public sector funding for psychotherapy services, these patients have a much greater likelihood of being readmitted. Harvester Private Consulting Suites has been established in Sunshine to provide an opportunity for psychiatrists working in the area to set up private practice in the west.

Eleven consultant psychiatrists provide services at the clinic, which is managed by Melbourne Health in conjunction with Glen Cairn Consulting Suites in Coburg.

Commonwealth Government 10-year moratorium

The Commonwealth Government's 10-year moratorium on provider numbers for OTDs working in an Area of Need (AoN) – who can do after hours and weekends only – has obstructed the Harvester Clinic from expanding its psychiatry workforce. For example, the Commonwealth Government has refused to provide a SIMG, who had trained overseas but had achieved FRANZCP and was working locally for five years, a provider number for the Harvester Clinic because of the 10-year moratorium. As a result the Mid West lost the otherwise committed, highly experienced psychiatrist who moved to the eastern suburbs to work in private psychiatry.

Services in Western suburbs need psychiatrists who are committed to the public. Werribee and Melton are struggling enormously to meet the demand for service. There needs to be support for psychiatrists to stay in the Western suburbs once they finish their training.

CLP services

Over the last 12 months Footscray Hospital's general medical services have shifted to Sunshine Hospital. This has given rise to an increase in the demand for CLP services, however, there has been no increase in resources. As a result, upon discharge, patients who need CLP services are not being followed up and instead are being advised to see their GP. Concurrent with the increase in demand for adult CLP services has been cessation of funding for CLP maternity services. Yet the approximate 5000 births each year at Sunshine Hospital creates a need for CLP-perinatal psychiatry services. The new 200-bed women's and children's hospital being built in the area by Western Health will increase the need for maternity CLP services. Despite this, the hospital is being established without planning or provision for psychiatry services to address the needs of the socio-economically deprived population to which it provides services.

CAP services

Sunshine Hospital has a paediatric ward but no CAP cover. As such, aggressive children who present to the ED may need to be transferred to the RCH or another hospital. The appointment of a child psychiatrist to Sunshine Hospital has the potential to create a CAP training post within NWMH. To do this, however, funding for an experienced child psychiatrist who can provide trainee supervision is required. A benefit of such an appointment would be that NWMH could increase its annual intake of first year RANZCP trainees.

Occupational aggression

Violence is an issue at Sunshine Hospital, which extends to relatives of patients assaulting staff and giving death threats. The Mid West AMHS is within the catchment area for Dame Phyllis Frost Centre, Victoria's maximum female correctional facility. The hospital is looking after an increasing number of patients with a criminal history, including forensic referrals via the ED, and being forced to operate like a forensic service but it does not have the resources to support these patients.

Sniffer dogs comb the inpatient units once per month to search for illegal drugs. Patients found in the possession of illicit drugs are discharged but are very often readmitted at some point. The AMHS is currently reviewing the need to install CCTV.

Leave requirements

Funding for sabbaticals is available but they cannot be approved because there is not the ability to backfill the role. There is no backfill for annual leave. Once, the sharing of the clinical workload amongst staff when a staff member took leave was not a problem, however, this is no longer the case. As the workforce is now overburdened by the clinical workload, when a psychiatrist takes leave the burden becomes even greater.

Weekend workforce shortages

Staffing is funded as a five days per week service but the clinical load has increased to the point where the hours provided by staff on weekends means the service is now operating as a seven days per week service. Formerly, on call work on the weekends was, on average, one to two hours per day. These days Saturday on call work constitutes a full shift and Sunday hours are variable. On both Saturday and Sunday the psychiatry workforce is overstretched and compromised.

The workforce model is supposed to be one in which the on call psychiatrist and junior registrar work together to assess a patient. This is not happening very often, however, since the shift of general medical services from Footscray to Sunshine. The two medical practitioners cannot work synergistically to assess patients because the junior doctor is increasingly being called away to deal with patients elsewhere in the hospital. This creates a more inefficient service because, with limited information to draw on, the ability to assess patients thoroughly becomes limited. In addition, the time available for consultant psychiatrists to undertake assessments is limited because they also have to do the tasks that a junior doctor would normally do.

Key issues for Mid West AMHS

- Insufficient support and incentives to retain psychiatrists in the public sector.
- Inadequate funding for CLP services, particularly in light of Footscray medical units being transferred to Sunshine Hospital.
- Absence of funding for an experienced child psychiatrist.
- Unsafe environment in inpatient unit owing to high levels of violence.
- Insufficient resources to manage increasing number of presentations of mentally unwell patients with a history of violence and criminal offences.
- Inadequate workforce to comfortably accommodate leave requirements.
- Outmoded workforce model/inadequate staffing levels to meet weekend clinical demands.

North West AMHS

North West has a catchment population of greater than 300,000 people. The catchment population is expected to grow as it contains growth corridors.

Workforce profile

North West AMHS			
		Number	Details
Consultant psychiatrists (10 EFT)	Full time	6	1 academic position (was 0.5 EFT but will be reduced to 0.3 EFT because person was appointed full professorial position)
	Part time/VMO	8	
Junior medical workforce	RANZCP trainees (4–7 EFT)	2	1 STP funded position
	SIMGs	9	
	HMOs	5	

Workforce issues

Recruitment

Recruitment is an issue at North West. A reported observation is that many new graduates prefer the private to the public sector because of the better remuneration and the lack of jobs in the public sector. Part-time psychiatrists in the public sector earn more per hour than full-time psychiatrists, which may contribute to why some psychiatrists prefer part-time public sector work. It is better to have newly graduated psychiatrists working in the public sector, however, where they will get better support and professional development. This improves clinical outcomes.

Workforce shortages.

Funding has not grown in line with the increasing clinical load which translates to inadequate staffing levels relative to meet clinical demand. The distribution of mental health funding is inequitable because it should reflect:

- population need
- level of socio-economic disadvantage
- number of available private psychology and psychiatry services in the area.

Wherever possible, North West transfers patients to the private sector. This measure is limited, however, as there are no private practices north of Coburg and affordability is an issue because of the area's low socio-economic status. The vast majority of private psychiatry practices are located around the inner city and the eastern suburbs of Melbourne.

Occupational aggression

The most severe presentations are in the ED and the inpatient units. Violence towards staff and other patients, which is usually drug related, is an issue in these units and requires a skilled workforce to effectively manage these unwell patients.

Community teams

The community team works 24-hour per day, seven days per week, but is not well supported because of an insufficient psychiatric and allied health workforce.

Key issues for North West AMHS

- Insufficient financial incentives to readily attract newly graduated psychiatrists to full-time public sector positions.
- Inadequate psychiatry workforce relative to clinical load.
- Violence in inpatient units and a recognised need for a skilled workforce to manage aggressive patients well.
- Insufficient affordable private practice resources to support public workforce demands.
- Inadequately staffed community team.

Northern AMHS

Workforce profile

Northern AMHS			
		Number	Details
Consultant psychiatrists (11.6 EFT)	Full time	6	1 academic appointment – incumbent is Chair of local research committee
	Part time/VMO	11	
Junior medical workforce (17.5 EFT)	RANZCP trainees	4	<ul style="list-style-type: none"> • 1 STP • 1 VMST program (Aboriginal MHS)
	SIMGs	8	
	HMOs	5.5	10–12 week rotations

Consultant psychiatry subspecialties at Northern include: adult, youth early psychosis, CLP, and addiction psychiatry. While psychotherapy is not formally funded, two consultant psychiatrists have an interest and psycho-dynamic issues and concerns are always being addressed by the psychiatry workforce.

Forensic patients

Many patients at Northern have shared care with forensic services. Northern has a very high proportion of patients with non-custodial supervision orders (NCSO). Management of the complex patients with an NCSO (e.g. those with a severe personality disorder) includes monthly review meetings. The involvement of a psychiatrist with a forensic background/interest would be beneficial for these reviews.

Workforce issues

Recruitment of trainees

A current trend for medical practitioners coming from the UK to Australia is to be initially employed as an HMO with the longer term aim of entering the RANZCP training pathway.

Community registrars

The community team is experiencing high levels of acuity, which is presenting safety issues (the community workforce carries a duress alarm). Community psychiatrists and registrars need to be able to work autonomously. Therefore, in these settings registrars must be senior. Balancing this need with that of the overall workforce creates great difficulties in the configuration of rosters.

Overseas Trained Doctors

OTDs seeking Australian medical registration need to undertake a certain number of months of experience in areas of medicine and surgery. To achieve all their necessary experience to gain Australian medical registration, at times they need to abandon their position in the psychiatry workforce mid-rotation to accept a new position in another medical specialty. This creates instability in the workforce and means that workforce levels are not guaranteed. The flow on effect is unexpected and lengthy vacancies. To illustrate, the lead time to fill a registrar position is approximately nine to twelve months; for an HMO it is a little less. Vacant positions place a burden on the remaining workforce who must carry an extra clinical workload.

SIMG–local trainee imbalance

A greater number of SIMGs work in outer metropolitan hospitals compared to local trainees, who generally live inner city and prefer to work closer to home. This creates a workforce imbalance in that SIMGs very often require more supervision than RANZCP trainees.

Weekend workforce shortages

Northern has two registrars for on call periods. The first on call registrar undertakes twelve hour shifts over the weekends and is called back overnight. The second on call registrar undertakes four hour shifts on Saturday and Sunday mornings to help to clear the backlog of overnight work. On call consultant psychiatrists are called in on average for approximately eight hours per day each Saturday and Sunday.

Supervision of trainees

Supervision of trainees is accommodated but it is difficult to do so. Very often consultants undertake supervision of trainees on their own time.

Leave requirements

The psychiatry workforce cross covers each other for leave. Long service leave is funded so, theoretically, it can be backfilled. This is not necessarily the reality, however, because sometimes it is difficult to find a psychiatrist for this purpose – short-term positions aren't desirable because most psychiatrists are looking for a permanent position.

If a floating registrar or consultant was considered as an option for leave cover they would need to be relatively senior so they could work across a variety of disciplines. In addition a floating registrar position could not be accredited because supervision would be difficult. Given this, registrars undertaking training – including both RANZCP trainees and SIMGs – could not undertake the role.

Types of patients

A growth corridor exists in Northern. The demographic is very multicultural and has a disparate socio-economic status. An emerging trend is the integration of Aboriginal clients from the inner city. Patients often have severe co-morbidities and/or personality disorders, and issues of privation, acculturation, addiction, and forensics.

As there is no general hospital/ED at Broadmeadows, Northern works closely with North West. The level of patient acuity at Northern is slightly higher than it is at Broadmeadows because Northern has better facilities to deal with the medically acute. As such more high risk patients and those with a greater number of co-morbidities tend to be admitted to the Northern inpatient unit.

Mental Health Act 2014

The requirements of the updated *Mental Health Act 2014* (the Act) reviews have impacted upon the workforce in several ways. First, the tribunals require the preparation of a detailed court report, which is usually done by registrars with input from consultants. Second, the Act requires that either a registrar or a consultant present at the tribunal (around 50% of presentations are by registrars and 50% by consultants). Northern has about two to three tribunal hearings every week, each of which is approximately 30 to 60 minutes in duration. Thus the requirements of the Act have created a significant time impost for registrars and consultants. Last, the requirements of the Act make it more difficult to maintain high quality work because time devoted to meeting the requirements is compromised elsewhere – e.g. depth of notes, meetings with families, length of handover – and quality across the board suffers.

Inpatient unit

The 50 bed inpatient unit at Northern is a taxing and challenging environment with high levels of physical and verbal aggression. This has a significant cumulative effect on the psychiatry workforce and has led to increased levels of fatigue, a concomitant of which has been an increase in sick leave. In addition to time pressures created by the requirements of the updated Act is a constant pressure to discharge patients to create bed access. Psychiatrists are needing to do quality work in a short space of time. The sum of these issues contributes to workforce fatigue and has led to the inpatient unit having a higher than average turnover. Consultants have left or requested a decrease in their number of sessions or a move to a community setting.

Key issues for Northern AMHS

- Need for a forensic psychiatrist.
- Imbalance in the proportion of SIMGs to local trainees.
- Workforce shortages caused by need for OTDs to resign to gain experience elsewhere.
- Growing Aboriginal population.
- Retention issues for consultant psychiatrists.

NWMH Aged Care MHS

The NWMH aged care mental health program covers all of the NWMH AMHS as well as the Austin AMHS catchment area. The aged care MHS have three inpatient units, each with an inpatient and a community team, including

- Bundoora extended care –15 beds
- Broadmeadows Health – 19 beds
- Sunshine Hospital – 20 beds.

The aged care mental health program also has an intensive community team (ICT), which is a seven days per week service. The program also manages the psycho-geriatric residential aged care facility (RACF) services in the catchment area of which there are greater than 165 beds.

Psychiatry workforce profile

Position	No.	Details
Consultant psychiatrist	8 FTE	<ul style="list-style-type: none">• Constituted by approximately 14 psychiatrists• 1 academic position
Registrars	10 FTE	<ul style="list-style-type: none">• 1 STP funded
RANZCP trainee	1 FTE	<ul style="list-style-type: none">• Geriatric registrar – 6 monthly rotations• VMST program funded

The NWMH aged care MHS has a professor of old age psychiatry who also undertakes clinical sessions. This provides a link between the academic and clinical programs.

Workforce issues

Weekend workforce

The combination of the small medical workforce and their uneven distribution across the large geographical area of NWMH creates difficulties. When registrars undertake on call weekends and evenings shifts, they may travel across all three regions (Bundoora, Broadmeadows, Sunshine), which creates time inefficiencies owing to the amount of time required for travel. Over the last few years the on call work periods have become much busier. To illustrate this, over the last five years, the cost of the psychiatry workforce for weekend and after hours on call work has doubled.

CLP workforce

The ageing population is growing and most people in hospitals are greater than 65 years of age. Demand for CLP services in respect of aged care assessments has, therefore, grown. Despite these factors, funding for CLP services has not kept up with the increased clinical needs of the population. There is no dedicated funding for CLP aged care MHS.

Aged care psychiatry workforce ratio to patients

Concurrent with the ageing population has been general changes to the condition of aged care patients requiring medical care. On one hand, patients are often much more unwell insofar as they will often have more comorbidities; on the other hand, many older patients are physically fitter than their contemporaries of previous generations. As such, when these patients become aggressive they are much more difficult to manage. The increasing complexity of patients is affecting the staff to patient ratio requirements.

Current funding for aged care MH beds is currently too low, which is stretching the medical workforce, as well as those for nursing and allied health mental health. Funding for psycho-geriatric beds in RACF is also inadequate. While these beds are financially viable, the total amount doesn't cover the cost of all the necessary resources.

Combined aged care psychiatry and geriatrics model of care

In Australia, geriatric medicine and aged care MHS have separate funding streams. This is inefficient in that it leads to duplication. Some European countries have overcome these inefficiencies by establishing combined mental health-geriatric units.

Outpatients' clinic

NWMH aged care services has been providing some Medicare funded bulk-billed outpatient clinics. All the income generated from these services is redirected back in to the outpatient clinic to fund resources (salaries) – i.e. 100% donation model – but the income generated doesn't cover all the clinic's costs.

NWMH aged care would like to expand the number of Medicare-billed outpatient services. This would require employing another person for its psychiatry workforce. Achieving this is a catch-22 situation, however – the funding for the extra staff member needs to be generated by the Medicare income stream but this can't be generated without the extra staff member.

Key issues for NWMH aged care MHS

- Significant increase in costs for weekend workforce over last few years.
- Increased complexity of patients not reflected in funding per bed.
- Inefficiencies caused by separate models of care for geriatric and psychiatry.
- Expansion of bulk-billed outpatient clinic requires start-up funding.

Recommendations for NWMH aged care MHS

- Explore the supports required to support expansion of outpatients' services.
- Explore options for a combined/joint/partnership model of care between geriatrics and aged care mental health.
- Undertake an analysis of the actual cost per psycho-geriatric bed in light of the healthier old age population.
- Undertake a needs analysis of the correct CLP requirements for aged care mental health.

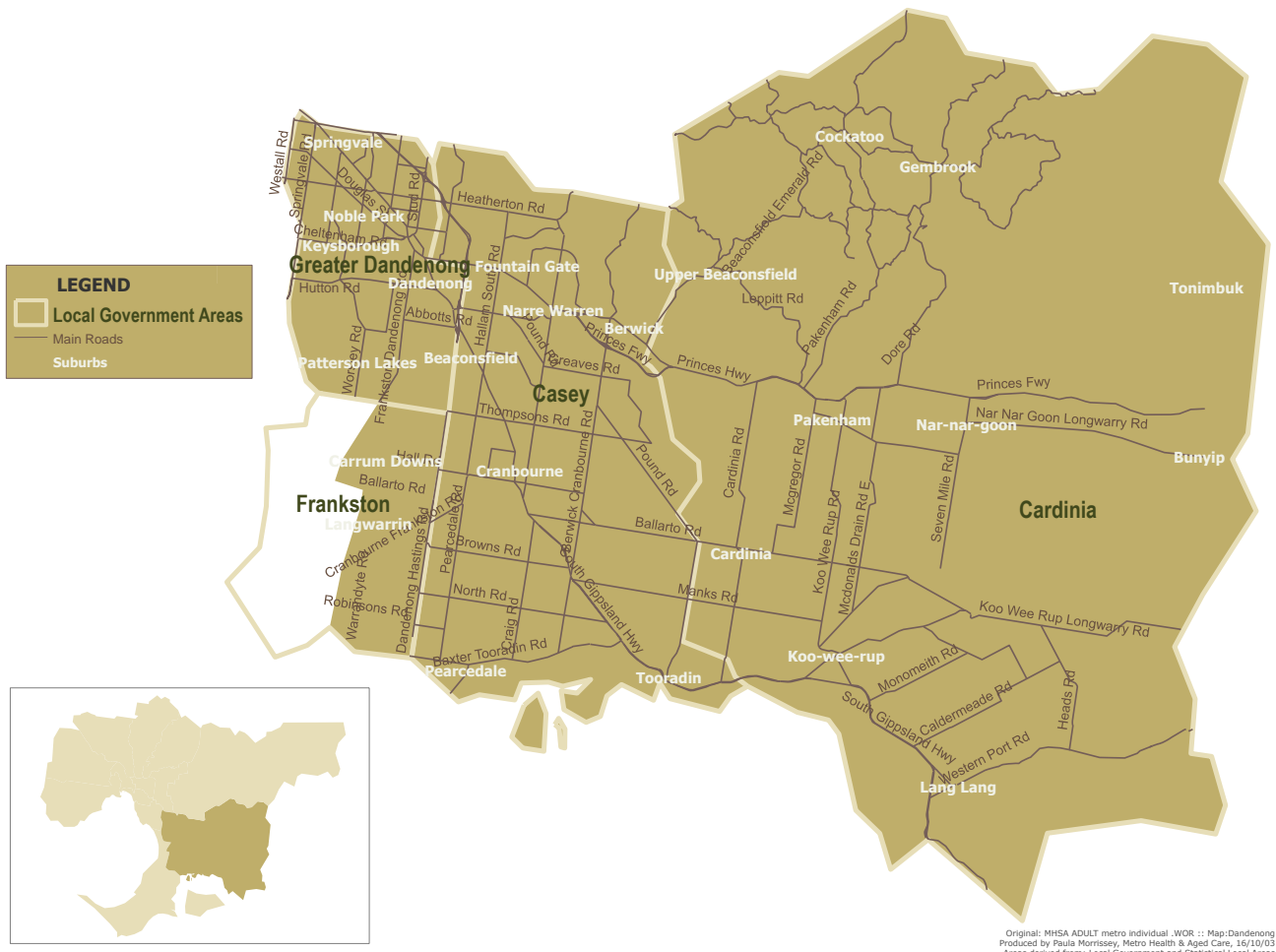
Monash Health

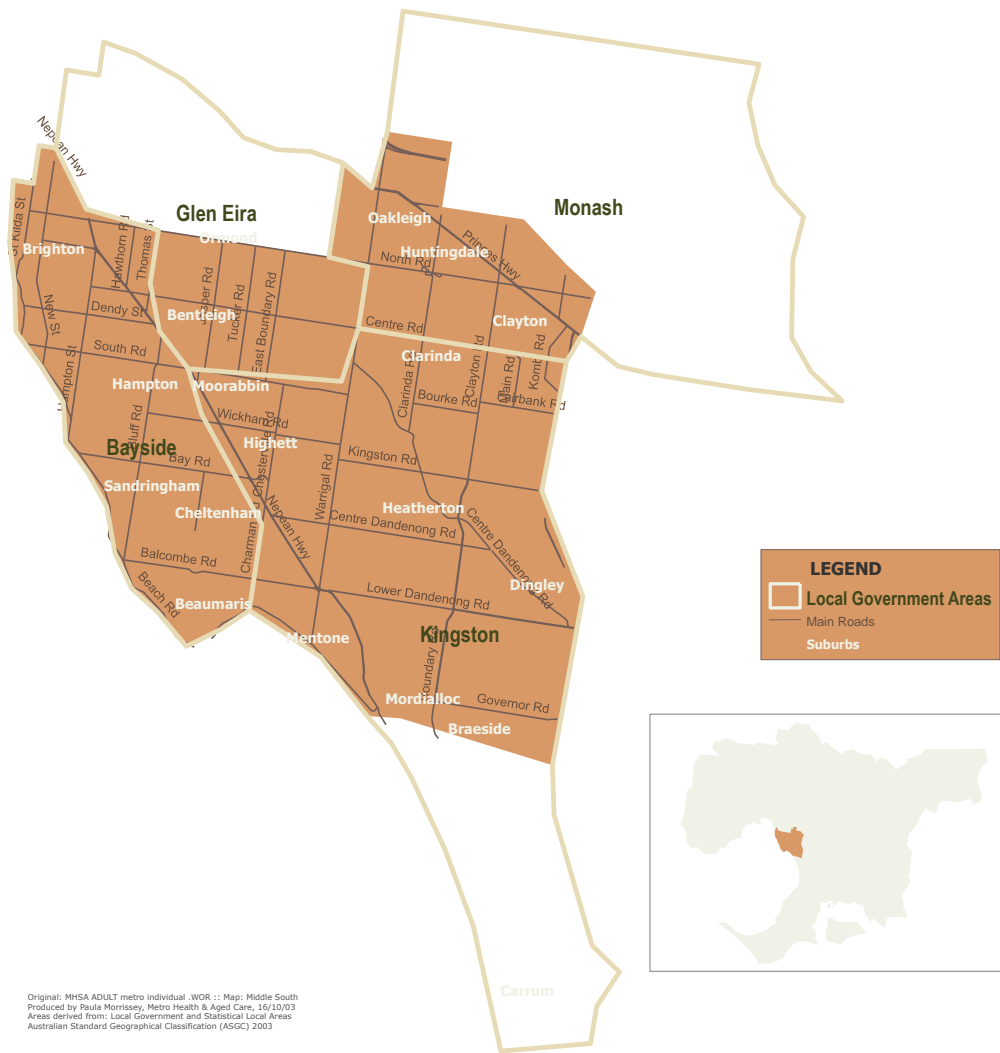
Monash Health is the largest mental health provider in Victoria. The health service covers the area of Greater Dandenong, Casey and Cardinia and includes one of Melbourne's growth corridors. The region has very few private practitioners. Monash Health provides comprehensive services in both hospital and community settings including:

- Acute MHS
- Alcohol and drug services - south east
- CA services
- Mental health community services
- Rehabilitation services
- Consumer and carer relations.

Monash Health has three main acute and subacute adult inpatient units and one aged care unit:

- Clayton (beds: 28 acute adult; 20 CA)
- Dandenong (beds:50 acute adult, 50 SECU, 20 aged care)
- Berwick (beds: 25 acute adult)
- Kingston (beds: 20 aged care).





Workforce profile

Position	number	details	
Consultants	70	<ul style="list-style-type: none"> Approximately 50% full-time 1 Chair research 2 SIMGs – Substantially comparable 	
Registrars	RANZCP trainees	45	<ul style="list-style-type: none"> 9 STP funded positions
	Non-RANZCP registrars	5	

Monash Health has two professorial units, Monash and Dandenong.

Workforce issues

Recruitment

Owing to new and larger facilities at Dandenong, a lot of recruitment for the psychiatry workforce has been undertaken over the last two years. Although the medical workforce is now fully staffed, to achieve this the recruitment of two SIMGs from overseas was necessary.

Retention

Monash Health has good retention of its psychiatry workforce, with minimal resignations.

Inpatient Units

Notwithstanding retention rates at Monash, owing to the high acuity of mentally unwell patients, it is very difficult to find psychiatrists who want to work in inpatient units. Occupational safety is of concern in these environments. To highlight, recent Monash Health statistics demonstrated that 25% of adverse events were due to physical assault of staff while 9% related to verbal abuse. Significantly, the need to call police to help manage situations (code black) is increasing in frequency.

Increase in ED presentations

Over the last five years, the number of ED presentations have doubled and yet the population has not. There are several possible reasons for this including, for example, increased drug use within the community and a greater number of people being delivered to the ED by police. Peripheral MHS are experiencing an increasing number of presentations of mentally unwell patients with a criminal history.

Despite the increase in presentations, for the last 10 years Monash Health has not experienced any growth in bed numbers. Bed numbers are inadequate to meet clinical demand, which means patients admitted to inpatient units are being discharged earlier than desirable to create bed access.

Weekend workforce shortages

Over the weekends on call consultant psychiatrists are now doing a full day's work.

Leave cover

Funding for sabbaticals is not available. Funding for long service leave is available, however, managing backfill for persons on long service leave is difficult.

Leave requirements are not factored into workforce funding. To illustrate, at any one time there will invariably be a staff member on leave (e.g. annual leave, sick leave, conference leave) and so a clinical load that requires an optimum number of, for example, three staff instead becomes distributed amongst two.

Key issues for Monash AMHS

- High level of occupational violence in inpatient units.
- Constant pressure on psychiatry workforce to discharge patients before they are clinically ready.
- Increasing number of presentations of mentally unwell patients with a history of violence and criminal offences.
- Continuous understaffing owing to lack of recognition of leave requirements in funding model.

Alfred Health

The Alfred Psychiatry Department provides services to people living in the Inner South East Area of Melbourne (cities of Stonnington, Port Philip, Bayside, Kingston and Glen Eira). The services provided include acute hospital care, community treatment and continuing care programs.

Alfred Health has two psychiatry units and a total 58 inpatient beds.

Workforce Profile

Position		No.	Detail
Consultants		20 EFT	<ul style="list-style-type: none"> • 50% full-time, 50% part-time • 1 SIMG (partial comparability) Subspecialties: <ul style="list-style-type: none"> • aged care • CLP • CA • psychotherapy • adult
Registrars	Non- RANZCP registrars	3–4 EFT	<ul style="list-style-type: none"> • Unaccredited positions
	RANZCP trainees	36–38 EFT	<ul style="list-style-type: none"> • No. fluctuates according to rotations • on external rotations • 2 STP positions
Academic positions		3 EFT	<ul style="list-style-type: none"> • All have appointments at Monash University • 1 EFT professorial position DHHS funded • 1 EFT Healthscope funded* • 1 Honorary funded by research grants (plus 1.5 clinical days)

Research Centre

*The Alfred has a research centre, the funding model of which is a public-private partnership (Alfred-Monash-Healthscope).

Addiction psychiatry

The Alfred Hospital treats many people with drug and alcohol problems but despite this cannot employ any addiction psychiatrists because it is not funded for these clinical services.

Psychotherapy experience

Not a lot of opportunity exists at The Alfred for registrars to get defined psychotherapy experience, which is embedded within internal rotations and also during external rotations at private hospitals and at Headspace.

Trainee welfare

The Alfred has a focus on trainee welfare. Registrars don't work longer than 12 hour shifts and have discrete on call overnight arrangements. Supervisors are high quality. The CLP team has a focus on occupational aggression and has introduced initiatives to optimise safety.

Recruitment and Retention

All mandatory RANZCP training requirements and some elective components can be undertaken at the Alfred. Each year 5–6 first year trainees commence their training at The Alfred. Another 5–7 positions are replaced each year, totalling an annual turnover of approximately 12 staff. Approximately 90% of RANZCP trainees remain working at The Alfred once they graduate.

Trial of seven days per week psychiatry workforce model

Over the last three years the ED has undergone a great transformation to meet the National Emergency Access Target (NEAT) 4-hour ED rule. Currently the ED is funded to provide comprehensive psychiatry services five days/week. The Saturday and Sunday ED workforce consists of a consultant psychiatrist for four hours and a registrar for eight hours. Support staff includes a Nurse Practitioner for eight hours, an Alcohol and Drug RN for eight hours and three mental health RNs.

The Alfred is about to commence a three month WIES-funded trial involving a seven days/week psychiatry workforce model, with the aim of demonstrating that the increased workforce will:

- decrease ED waiting times
- reduce the back log of clinical work
- improve the efficiency of clinical work within the inpatient units.

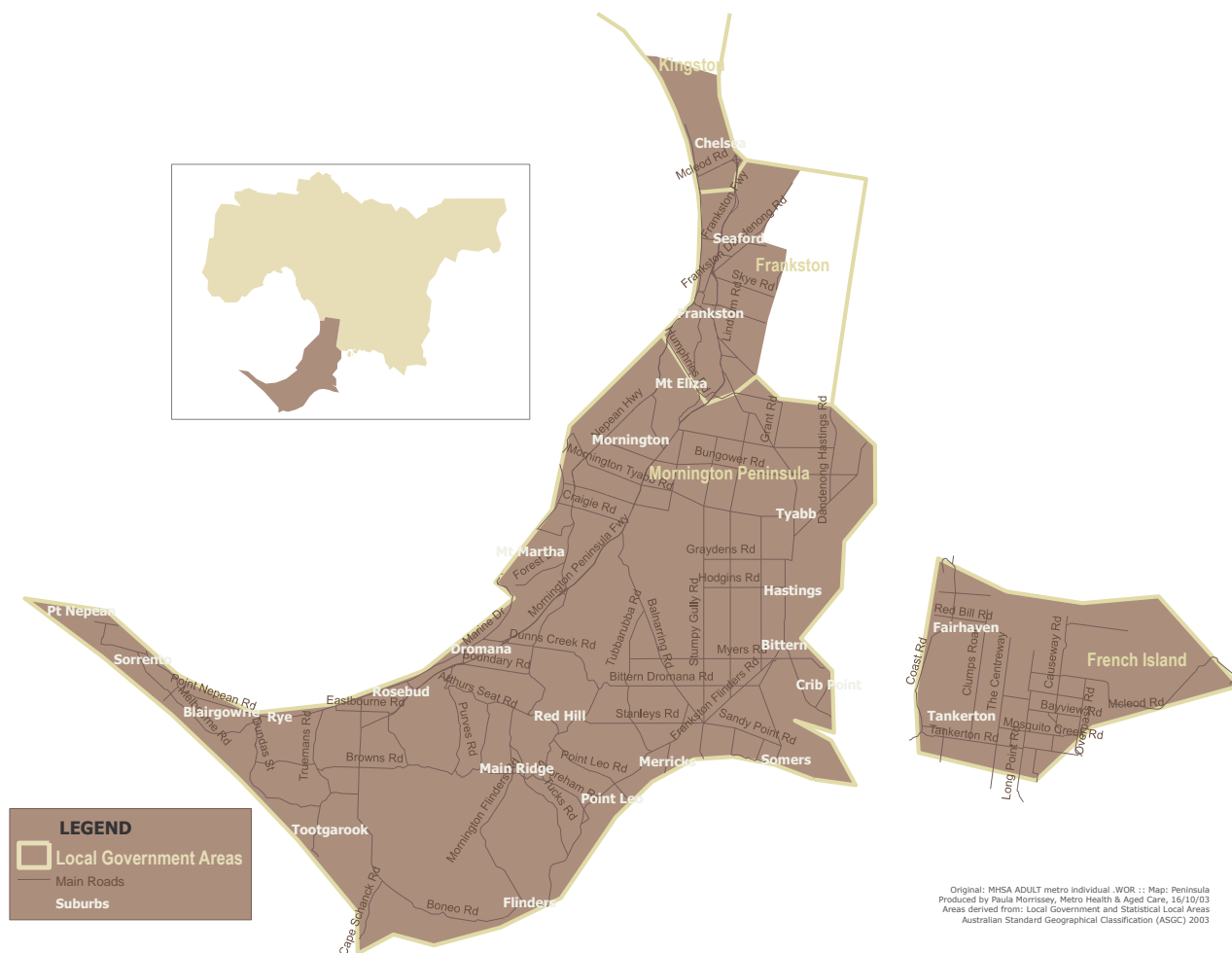
During the trial period the psychiatry workforce will consist of a registrar for six hours, a consultant psychiatrist for four hours and CLP support, as required. The inpatient unit will have 24 hour registrar cover, and 6–12 hours consultant cover.

Key issues for Alfred Health AMHS

- Need for addiction psychiatrists.
- Limited opportunities for trainees to get defined psychotherapy experience.

Peninsula Health Mental Health Service

Peninsula Health MHS is provided by a multidisciplinary team that focuses on a person-centred, recovery orientated framework which supports consumers to make decisions about their care and treatment. The scope of services offered includes acute and subacute services for youths (16–24), adults (16–64) and the aged (65 and over). Peninsula Health MHS has two inpatient units and CLP services for the general hospital. There is no CA psychiatry service within Peninsula Health MHS.



Workforce profile

Position	No.	Detail
Consultant Psychiatrists	20	<ul style="list-style-type: none"> All are FRANZCP 12 (60%) part-time; 8 (40%) full-time Subspecialties: <ul style="list-style-type: none"> old age adult youth CLP (1 consultant, 2 registrars)

RANZCP trainees	13	No STP positions
JMO (PGY1)	1	<ul style="list-style-type: none"> • 10 week rotations in acute psychogeriatric inpatient unit • Shortage – ideal number would be 2
HMOs	8	<ul style="list-style-type: none"> • 1 OTD • 4 wanting to enter RANZCP training program

Deficiencies in psychiatry workforce

- CAP – Frankston does not have any CA psychiatrists. Registrars rotate to Monash to gain CAP experience.
- Addiction psychiatry – Drug and Alcohol services fall under mental health governance. Frankston has an addiction physician but no addiction psychiatrist but needs one.
- Perinatal psychiatry – Frankston does not have a perinatal psychiatrist. Perinatal matters fall under the auspices of general psychiatry.
- Psychotherapy – one session per week for supervision but need for sessions. Getting appropriate supervision for registrars is an issue and more psychotherapy hours are required.
- Forensic psychiatry – No forensic psychiatrists – registrars rotate to Thomas Embling for six months to gain this experience.
- CLP – the workforce is inadequate. Currently, there is funding for one CL psychiatrist and two registrars, which is inadequate to meet the needs of ECAT services. A second CL psychiatrist is needed to meet demand.
- Aged care – more registrars, including a full-time registrar, are required in the inpatient unit. More registrars are also required in the community clinics. Although Frankston Hospital has a Dementia Behavioural Advisory Management Service (DBAMS) and a Sever Behavioural Response Team (SBRT), it is also in need of a separate team for visiting RACF to assess the management of behavioural problems.

Recruitment

Recruitment of consultant psychiatrists is difficult and the process can be lengthy. This is especially so for positions in acute inpatient units and some community positions in the outer areas of the Mornington Peninsula owing to the burden of travel included in these positions. Frankston Hospital does not have an academic appointment for psychiatry medicine, however, such a position would be helpful in attracting staff.

In respect of trainees, Frankston Hospital used to have a constant shortage of psychiatry trainees and/or other registrars. Over the last two years this has not been the case, which is most likely because of the increased number of medical graduates.

Weekend workforce

On call consultant psychiatrists are spending a greater amount of time in the hospital on weekends owing to the higher acuity of patients. The length of time varies between six to eight hours per day. The weekend workforce is inadequate to meet clinical demand.

On weekdays and after hours, the ED is staffed with mental health Nurse Practitioners to assist in the assessment of patients. Their contribution helps expedite discharge thereby facilitating patient flow and increasing bed access.

Leave cover

The hospital has been able to backfill for sabbatical leave but hospital management recently changed this policy and is introducing internal arrangements to cover leave.

Key issues for Peninsula Health MHS

- Inadequate psychiatry workforce to meet clinical demands including: CAP, perinatal psychiatry, addiction psychiatry, old age psychiatry and CLP.
- Inadequate psychiatry workforce on weekends to meet clinical demand.

St Vincent's Mental Health

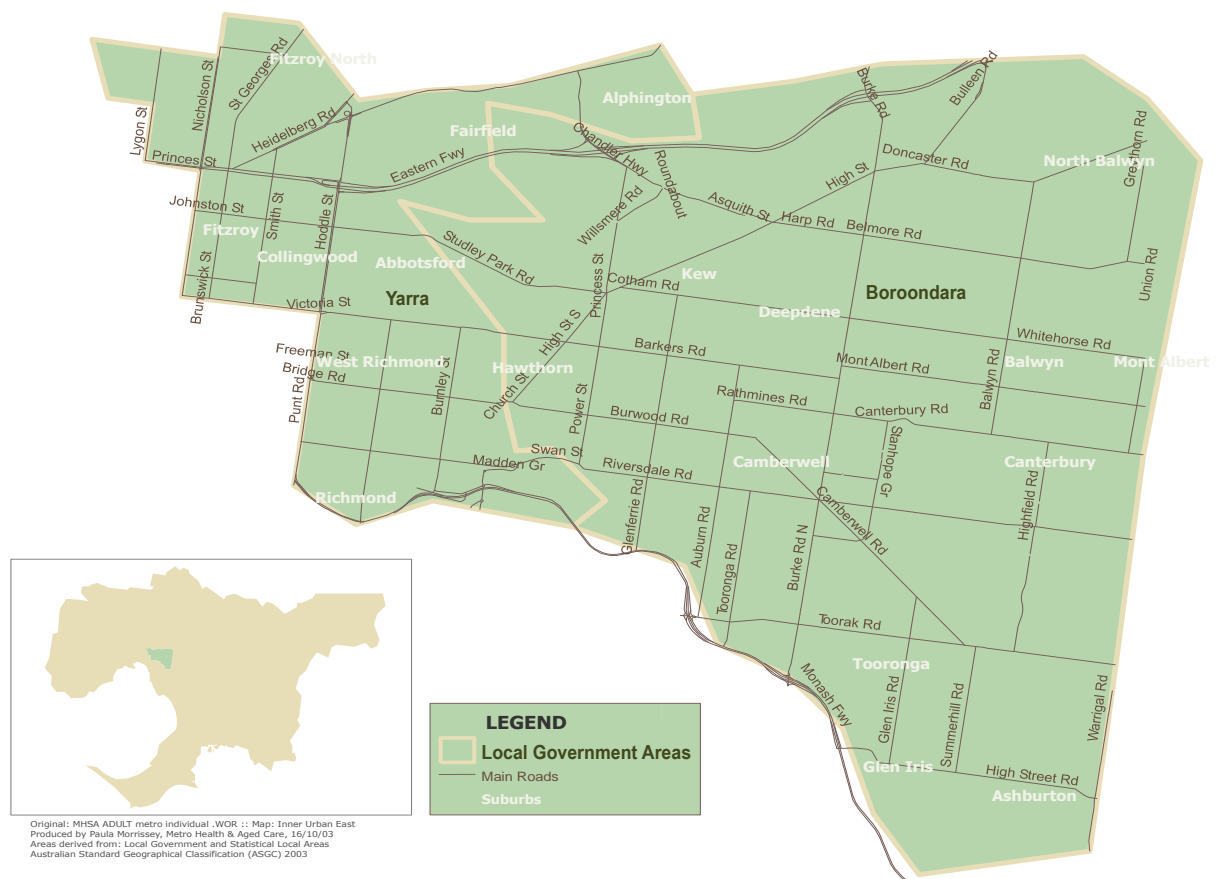
St Vincent's Mental Health (SVMH) includes an adult area mental health service for the inner city areas of Yarra and Boroondara. The adult mental health service components are primary MHS, the Footbridge Community Care Unit, the 44-bed acute inpatient service located on the St Vincent's Hospital site, and two community MHS at Hawthorn and East Melbourne.

Community MHS comprise the Triage CAT service, extended triage and MH-HARP, continuing care, mobile support and treatment, and homeless outreach services. A CLP service is provided to the health service. NEXUS dual diagnosis service, the body image and eating disorders assessment and treatment service, and NEVIL training cluster are regional services.

The aged service includes a 20-bed inpatient unit (St George's, Kew), aged psychiatry assessment and treatment team (working out of St George's Campus in Kew) and two-30 bed aged mental health residential services (Auburn House in Hawthorn East and Riverside House in Richmond). Statewide services are the Victorian dual disability service, the Victorian transcultural mental health and dual diagnosis education and training unit.

The acute inpatient service includes five beds designated as the Koori state-wide inpatient service and linked to the Victorian Aboriginal health service. St Vincent's Health incorporates a correctional health service which provides health services including mental health to Port Phillip prison (Laverton) and the youth health and rehabilitation service (Parkville).

St Vincent's is unique in Australia in that it is closely linked with St Vincent's in Sydney for research purposes.



Workforce

Positions	No.	Details
Consultant Psychiatrists	30	<ul style="list-style-type: none">• Majority are fractional• Subspecialties<ul style="list-style-type: none">○ old age (8)○ adult○ CAP○ CLP• 1 Full-time, which includes some academic work• 5 in leadership positions• 4 academic positions
RANZCP trainees	36	5 STP funded positions 3 Victorian Medical Specialist Program positions
HMOs	2	Unaccredited positions

STP positions

The STP funded positions at SVMH are vital in that they allow hospitals to provide training in Areas of Need (e.g. Aboriginal health, transcultural, youth justice mental health and psychotherapy).

CLP services

Currently, CLP services are inadequate as the available funding does not meet the clinical and population requirements. Adequate CLP funding is important because CLP services impact upon service demand, length of stay (average 11.4–12.6 days) and clinical outcomes.

The Victorian Medical Specialist Positions (VMSP) are helpful in that they subsidise the CLP and addiction psychiatry workforces, provide expanded access to CLP services and, for the registrars, enable them to expand their skills.

Recruitment

SVMH does not have recruitment problems. The organisation attracts a diverse, high calibre group of both consultants and trainees. Over the last four years the quality of RANZCP trainee applicants has been particularly high.

Retention

Retention of psychiatry workforce at SVMH is a problem – people leave to get employment in the private sector because it pays more. In addition, the acute environment of the inpatient unit is very demanding and very few psychiatrists will stay longer than 2–3 years. SVMH has four academic positions, however, two have resigned recently: Lecturer (0.4 EFT) and one academic appointment (0.5 EFT). A review of all clinical academic appointments is pending.

Leave cover

Backfill is not provided when a staff member is on leave, which can have a burdensome and profound impact on the workforce when a staff member is away for protracted periods.

Funding

St Vincent's receives block funding, which is not linked to health care costs or outcomes. A significant amount of the funding goes to the parent health service to cover infrastructure costs but an insufficient amount goes towards the running of MHS. Funding does not cover the cost of resources for running the inpatient units, which have to be cross-subsidised. There is no accountability or transparency for how the block funding is divided or spent.

Types of patients

SVMS is at the centre of a catchment area and the preferred hospital in the area because of its traditional pastoral values. This gives rise to a large number of mental illness presentations/admissions, the majority of whom present via the ED. Among those presenting is an over-representation of certain issues, including people with a lack of social supports (e.g. homelessness), and people with physical health issues including comorbidities and acuity of risk.

Occupational violence

The use of crystal methamphetamines has led to an increased acuity of patients because of the drug's effect of increasing aggression. This phenomenon has led to an increase in staff assaults. Management of aggressive patients requires a skilled and well-supported psychiatry workforce. The aggressive patient presentations increase during after-hours. Paradoxically, these are the periods when there is less support available for the psychiatry workforce, e.g. allied health, skeletal psychiatry workforce.

SVMS old age psychiatry – St Georges

The old age unit of SVMS is based at St Georges in Kew. The inpatient unit has 20 beds, which includes 2 psych-geriatric beds, and a community team. About 12 months ago the academic unit moved from St Georges to NWMH and there is current uncertainty about the appointment of another academic.

Position	No.	Details
Consultant psychiatrists	8 (persons)	<ul style="list-style-type: none">• full-time• 6 fractional – work combination of public and private
RANZCP trainees	2.5 EFT	Rotate from St Vincent's

The old age unit is popular among many psychiatrists because of its attractive location. Adding to its appeal is that St Georges is a small service, which provides a collegiate atmosphere. The work is also interesting. For these reasons psychiatrists are reluctant to leave. There are not enough sessions for all staff to be full-time, which is why the public-private division is appealing to the psychiatrists who work there.

Key issues for SVMH

- Insufficient funding for CLP workforce to meet clinical demands.
- Difficulty in retaining full-time consultants owing to insufficient financial incentives and high levels of occupational violence.
- Inadequate leave provisions.
- Inadequate after hours and weekend workforce to meet clinical load.

Austin Hospital/North East AMHS

The North East Area MHS (NEAMHS) provides general adult psychiatric services to people over 16 years of age and residing in the north eastern area of metropolitan Melbourne.

Workforce profile

Position	No.	Details
Consultant psychiatrists	40	1 Academic position – Chair, Department Psychiatry, University of Melbourne Subspecialties: <ul style="list-style-type: none">• psychotherapy• CLP• addiction• adult• aged care
RANZCP trainees	41	
JMOs	3	<ul style="list-style-type: none">• PGY1 x 2• PGY2 x1

Workforce issues

RANZCP training program

Registrars can undertake all of their mandatory training requirements at NEAMH. As NEAMHS does not have a strong aged care presence, trainees undertake rotations at Bundoora Extended Care to gain old age psychiatry experience. They also undertake rotations at private hospitals.

Recruitment of trainees

NEAMHS does not have any recruitment problems. In terms of trainees, the organisation has been oversubscribed in applicant numbers. The quality of applicants has improved exponentially over the last few years.

Retention of consultant psychiatrists

NEAMHS has a constant battle to maintain an adequate number of full-time consultants for several reasons. The primary reason is that they perceive their income to be inadequate and move to the private sector where they can earn more and experience less aggression.

Other disincentives to remaining in the public sector on a full-time basis include:

- increasing red tape, unnecessary duplication
- lack of support for basics such as clinical informatics
- lack of control over environment (i.e. occupational safety issues – physical and/or intense verbal aggression).

Leave cover

Leave cover is inadequate, particularly for sabbaticals. The covering of leave creates a burden in the workforce and is a stress point for registrars. The re-call workforce model (i.e. 9 am to 5 pm with recall, as required) is a grievance of the registrars.

Key issues for NEAMHS

- Difficulty in retaining full-time consultant psychiatrists owing to perceived insufficient financial incentives and occupational violence.
- Accommodating leave requirements places a strain on the workforce.

Eastern Health

Eastern Health (EH) is the second largest mental health service in Victoria after Monash, and has a catchment population of approximately 850,000. The organisation is affiliated with Monash and Deakin Universities.

Workforce profile

Position	No.	Details
Consultant psychiatrist	40	Subspecialties: <ul style="list-style-type: none"> • general adult • CA • CLP – 1.3 EFT (0.4 funded by DHHS) • aged care
RANZCP trainees	35	<ul style="list-style-type: none"> • EFT consultant-liaison (1 EFT funded by DHHS) • 6 STP funded positions
HMOs	25	The majority of senior HMOs wish to commence the RANZCP pathway
SIMGs	3	Undertaking RANZCP pathway to Fellowship
Interns (PGY2)	4	Undertake 3 month rotations

Workforce issues

Academic position

EH does not have an academic position due to lack of funding. One would be helpful, however, because it would contribute towards recruitment and retention rates. An academic position would also enable EH to establish a research culture. EH is regularly approached by industry to participate in clinical trial but is unable to do so because of not having an academic position. The approximate amount required to establish such a position would be \$300,000 (shared funding model would be possible – one third of funding each from EH, Monash University, and DHHS).

Recruitment of trainees

EH is self-sufficient in attracting RANZCP trainees which it does so from its pool of HMOs. The nationality of trainees is mixed – predominant ones include African, Indian, British and Eastern European. An emerging ethnic group is Iranians. The calibre of the applicants has increased significantly over the last few years. In 2016, EH had six first year RANZCP trainee positions.

Revised training program

The establishment of a high quality RANZCP training program has contributed to attracting and retaining high quality consultants and recruiting a sufficient number of quality trainees.

Several measures have been undertaken over the last few years to establish the high quality training program including:

- Establishing a pool of consultant psychiatrists committed to public mental health and to mentoring and supervising trainees.
- Developing an exciting in-house training program (including protected time for supervision and education and in-house tutorials).
- Commencing all SIMGs on the RANZCP pathway. These SIMGs become eligible to supervise trainees once they gain their Fellowship.
- Establishing a monthly consultants' meeting to discuss the strengths of the registrars and the areas in which they need to develop.
- Establishing a 5-year strategic plan for training program with the goal of making the program trainee centric.
- Guaranteeing supervisory requirements:
 - strict 1:1 formal supervision
 - all supervisors FRANZCP to ensure high quality supervision
 - registrars encouraged to speak up if unhappy with supervision
 - protected time for journal club presentations each week (2.5 hour sessions).
- Masters of Psychological Medicine – mandatory component of RANZCP training program.
- Establishing trainee coordinator position (0.5 EFT). The psychiatrist currently in the role is only 5–7 years older than the trainees. The small age difference is beneficial because it means the coordinator and trainees can relate well to each other.

Trainee welfare

Trainee welfare at EH has not been a problem for many years now because of training program. The standout features of a good training program include:

- an academic program and protected time for program
- high quality psychiatry supervisors
- a mentoring system (optional) – different to a supervisor
- a mentoring program for recently qualified psychiatrists (limited positions)
- an in-house written exam preparation on a weekly basis
- no after-hours training.

STP funding

STP funding is helpful in that it boosts the number of training places. From a funding perspective, however, STP does not cover the entire cost of a registrar and Eastern Health must subsidise the positions. Greater flexibility with the STP program in terms of eligible training rotations would be helpful.

Occupational violence

The types of patients seen in public mental health are all severe in their conditions, which include drug and alcohol problems, schizophrenia, bi-polar and severe personality disorders. The inpatient unit is unpopular to work in because of the large number of high acuity patients and the associated violence including physical assaults, spitting and extreme verbal abuse.

Leave cover

There is no funding to backfill for sabbatical leave. When a trainee within the hospital goes on leave, another from a community setting is brought in to pick up and share the workload. This increases the clinical load burden on the workforce in the community. Increasing the number of JMOs within the inpatient unit would help to reduce the clinical load burden on the psychiatry workforce.

Consultant–liaison psychiatry workforce

Funding for CLP services is within WIES funding, which is impractical and doesn't meet service requirements. Over the last 18 months the demand for MHS has skyrocketed because of the increasing use of crystal methamphetamines. Despite this, resources have decreased. CLP requirements would be better met if funding was based on the number of patient contacts.

Key Performance Indicators (KPI)

The NEAT KPIs are unrealistic. At EH the average length of stay is 8.7 days, which is shorter than the comparative average. The pressure of meeting the KPIs is causing the early discharge of patients to create bed access for more recent patient presentations. This is counterproductive because it is leading to higher patient dissatisfaction and readmission rates, which is increasing the cost burden on resources.

Key issues for Eastern Health AMHS

- No academic position.
- High level of occupational violence.
- Inadequate leave cover arrangements.
- Inadequate CLP workforce to meet clinical demand.
- NEAT KPIs creating pressure to discharge patients before they are clinically ready.

Forensicare

Forensicare is the state wide specialist provider of forensic MHS in Victoria. The agency is the only one in the state that provides clinical services that span the mental health and justice sectors. Forensicare’s clinical services include:

- *Thomas Embling Hospital* - a 116 bed secure hospital for patients from the criminal justice system who are in need of psychiatric assessment and/or care, together with treatment of patients from the public mental health system who require specialised management.
- *Community forensic mental health service* - a state wide service providing assessment and multidisciplinary treatment to high risk clients referred from area MHS, correctional providers, courts, the adult parole board, Thomas Embling Hospital, prison services, government agencies and private practitioners.

Workforce profile

Position	No.	Details
Consultant Psychiatrists	12.8 EFT	<ul style="list-style-type: none"> • Comprised of 26 persons • 7 (27%) are full-time • Some work as little as 1 session per week
Registrars	15 EFT	<ul style="list-style-type: none"> • 12 RANZCP trainees <ul style="list-style-type: none"> ○ 1 SIMG ○ All stages 2 and 3 trainees • 2 HMOs • 1 overseas doctor (from Ireland) – gaining forensic experience* • 0 STP positions

Consultant forensic psychiatry workforce

Staffing levels at Forensicare are adequate because the Victorian Government has contractual obligations with the prison management company to provide a certain level of cover. The forensic psychiatry workforce provides outpatient services at correctional facilities state wide including Ararat, Castlemaine, Lara, Shepparton and Barwon. Typically, these visits will involve both a consultant psychiatrist and a registrar.

Approximately 60% of Forensicare’s consultant psychiatry workforce have qualifications in forensic psychiatry. Some have not undertaken a Certificate of Advanced Training in Forensic Psychiatry although they may have forensic experience. The organisation is happy to employ good generalist psychiatrists. Forensicare avoids recruiting locum psychiatrists, finding them variable in quality.

Employing consultant psychiatrists on a full-time basis (or at least 6 sessions per week, which may be spread over 3–4 days) is desirable because this provides a greater amount of flexibility in the scope of work they can undertake, e.g. manage an inpatient unit. Of the 26 consultant psychiatrists at Forensicare, only around one quarter (7; 27%) work full-time as most prefer to work part-time.

Most of the part-time consultants started on a full-time basis and eventually changed to part-time – not because they find the work stressful, but because of other interests, e.g. family commitments, private practice work, Mental Health Tribunal appointments.

A large part-time workforce at Forensicare creates several workforce challenges including:

- rostering to meet workforce requirements is difficult
- hot-desking because of an insufficient number of desks
- clustering meetings at the beginning of the week to optimise attendance
- engendering a culture in which part-time staff feel part of the organisation
- reducing the pool of those that can provide supervision for trainees (those who work less than three sessions per week cannot be a supervisor)
- reducing the pool of those available for inpatient work (those that undertake only a small number of sessions are only suitable for prison visits and they work in a solo and unsupervised capacity).

Academic position

Previously, Forensicare had a Chair/Clinical Director position, which was funded equally by the University of Melbourne and the Victorian Government. The funding is no longer available although there is an in-principle commitment for the academic position and Forensicare hopes to reinstate it. The academic position contributed to Forensicare gaining an international reputation. The absence of an academic appointment has had flow on effects in its attractiveness to SIMGs, particularly those with an academic portfolio. The absence also means that Forensicare can no longer attract PhD students.

RANZCP trainees

All the RANZCP trainees are at Stage 2 or 3 of their training program. Some Stage 3 trainees are undertaking the RANZCP Certificate of Advanced Training in Forensic Psychiatry and need to complete a greater variety of experiences to fulfil their training requirements. Forensicare has several Stage 3 trainees, four of whom are undertaking the Certificate of Advanced Training in Forensic Psychiatry. Forensicare has the potential to establish more of these positions.

Pressure is placed on the workforce when a trainee drops out or is struggling with the training program. By the end of every six-month rotation, the workplace invariably becomes stretched. For these reasons Forensicare tries to recruit 1–2 EFT registrars above recruitment.

Recruitment and retention

Another two substantially comparable SIMGs will arrive soon to commence work at Thomas Embling. The organisation is currently recruiting for another 9 EFT consultant psychiatrists that are required by 2017 in preparation for a wave of prisoners who will require the services of the facility. In addition, another 13 EFT registrar positions, which have to be accredited, are required in preparation for the new prison.

Forensicare has close links with a Professor and Clinical Director in Ireland, which helps to facilitate the recruitment of SIMGs who are usually from England or Ireland. Consultant psychiatrists who undertake their training in the UK are registered with the UK General Medical Council and have gained a Certificate of Completion of Specialist Training (CCST). The qualification guarantees their preparedness for the requirements of Australian forensic psychiatry workforce.

Barriers exist to recruiting SIMGs to Forensicare, however. This is because, relative to other jurisdictions, Victoria lacks a competitive edge in the financial incentives it offers. Queensland and NSW, for example, offer substantially better remuneration compared to Victoria, the differential being as much as \$100–150K annually.

Trainee welfare and supervision

Supervision is adequate, however, since the introduction of the Competency-based Fellowship Program (CBFP) there has been less time to look after the welfare of the trainees, including pastoral feedback and formative training. Greater familiarity with CBFP requirements is expected to address concerns about the amount of time needed for supervisors to undertake assessments versus the amount of time for pastoral care. The RANZCP is also piloting a mentor program for trainees. For SIMGs an external assessor may be helpful.

Leave funding

Funding for sabbaticals is not available and the consultants do not take them.

Forensic patients

Although funding for the psychiatry workforce has kept pace with the clinical load, funding for forensic mental health beds has not kept pace with population requirements. The current forensic facilities in Victoria were built to cater for a catchment population of 3000, which has increased to 6000 but without an increase in bed numbers. Currently, at least 10 people at any one time are waiting for a bed at Forensicare, the length of time varying between 30–50 days.

Key issues for Forensicare

- Difficulty in attracting SIMGs because of lack of academic appointment and lack of competitive financial incentives relative to other jurisdictions.
- Reliance on SIMGs to meet workforce requirements.
- Little supervisor time for pastoral feedback and formative training.
- Forensic patients are becoming an increasing burden on peripheral hospitals.

Recommendations for Forensicare

- Undertake an evaluation of incentives that would attract SIMGs to Forensicare and give it a competitive edge over other jurisdictions.

Barwon Health Services

Barwon Health Services covers the Local Government Areas of Greater Geelong, Queenscliff, Surf Coast, Colac-Otway and surrounding districts. A variety of specialist MHS specialised services are available across the age range, from children to those over 65 years of age. The service places an emphasis on providing early intervention to young people and developing partnerships with other organisations to utilise a full range of services. Drug and alcohol services are targeted to people with serious problems resulting from their use of alcohol or other drugs. Services are also available for those who have a concurrent drug and alcohol problem and a mental disorder. Barwon uses an integrated care model in which the community team also looks after their own inpatients.

Mental Health Service Area - Barwon



Workforce profile

Position	No.	Details
Consultant psychiatrists	21	<ul style="list-style-type: none">• 19 Full-time; 2 sessional• 1 academic chair
RANZCP trainees	26	<ul style="list-style-type: none">• 4 Stage 1• 6 Stage 2 :<ul style="list-style-type: none">○ 2 CA○ 2 aged care psychiatry○ 2 CLP• 9 STP funded positions

Workforce issues

Recruitment of consultant psychiatrists

Barwon has a good workforce profile because of the presence of an academic Chair, which is a drawcard for psychiatrists wanting to work in the area. All consultant psychiatrists within Barwon Health's psychiatry workforce have RANZCP Fellowship and are accredited supervisors. All psychiatry subspecialties are represented. Most of the psychiatry workforce have undertaken their training in the area and the turnover is infrequent. Barwon does not have any SIMGs because there is no shortage of applicants from local consultants when positions are advertised.

Retention of graduate trainees

No junior consultant psychiatrist positions are available once trainees gain their Fellowship but opportunity is available for them to set up locally in private psychiatry practice. Junior consultant psychiatrists can also get admitting rights at the local private hospital. Another option for them is to join the private psychotherapy clinic, which opened in February 2016, on a sessional basis but they can only bulk-bill patients. The clinic is beneficial in that it provides opportunities for both junior consultants and trainees. The income stream generated by the Medicare services (\$1m annually) provided in the region has enabled outpatient psychiatry services to keep going.

RANZCP has a requirement that each Fellow undertakes 10 hours of support per year received either in a peer group or in 1:1 supervision. At Barwon Health the junior consultant psychiatrists do both – they join a peer support group and every 6-8 weeks they have 1:1 supervisory meetings with the Clinical Director in which a coaching model is used.

Recruitment of trainees

Deakin Medical School, which is locally situated, has helped with identifying trainees. Barwon is a very popular place to undertake training because of the focus on trainee welfare. Related initiatives include no on call work and part-time work is acceptable. In 2015, Barwon received 70 applications to commence the training program in 2016. The organisation has four first year RANZCP trainees commence each year. To take on any more would be challenging.

STP positions

A large proportion (35%) of Barwon Health's trainee positions is funded by the STP. Each position is funded \$100,000 but needs to be subsidised by an extra \$50,000, with wages being the main cost. The STP has helped with the provision of rotations in outpatient settings. The uncertainty about whether STP funding will be ongoing is problematic. This is because, owing to lead times, offers of employment have to be made before confirmation has been received that the STP funding for the position will be provided.

Supervision of trainees

A benefit of WBAs is that they hold both the trainee and the supervisor to account because they allow for the identification of underperformance of both parties.

Leave cover

Funding for sabbaticals is available but they are not taken up very often. Backfill is not provided when annual leave is taken. This is not burdensome, however, because the psychiatry workforce is reasonably large so the extra workload becomes reasonably well-distributed among the remaining workforce.

Weekend workforce

The service is a five days per week model with an on call weekend roster, which is light (1:22). Consultant psychiatrists are on call via telephone and almost never have to come into the hospital.

Occupational safety

Patients seen at Barwon have moderate to severe mental illness or are at moderate to severe risk of deteriorating if not treated. Barwon has very good protocols around violence and prevention. Owing to these protocols, over the last 12 months the seclusion rates have been markedly reduced by 75%.

Key issues for Barwon Health AMHS

- Uncertainty of STP funding which supports a large proportion of trainee workforce.

Warrnambool & District Base Hospital Psychiatric Services

Warrnambool & District Base Hospital Psychiatric Services provide specialist treatment and recovery-oriented services to people with serious mental illness living in South West Victoria. The region covers Glenelg, Southern Grampians, Moyne, Warrnambool and Corangamite-North. An Acute and an Extended Care Inpatient Unit are located in Warrnambool.

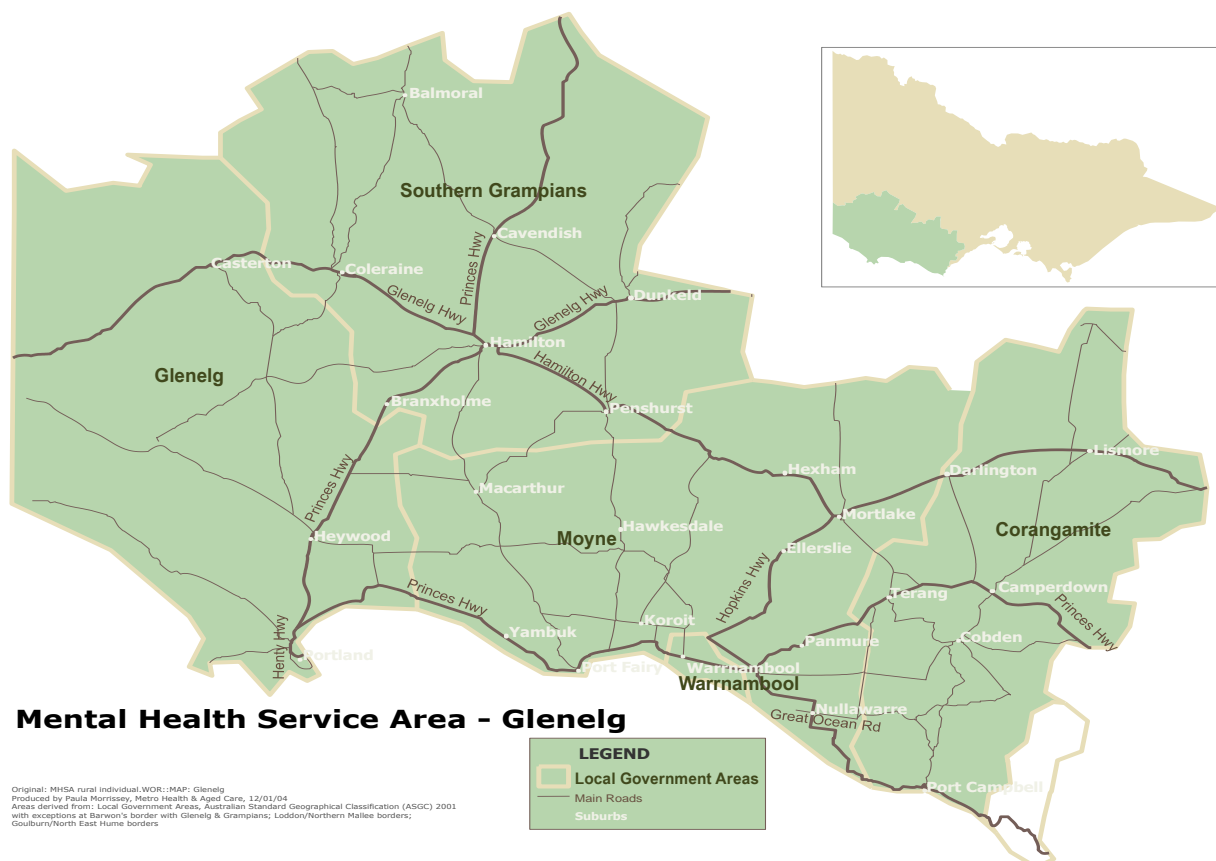
Workforce profile

Position	No.	Details
Consultant psychiatrists	1	<ul style="list-style-type: none">• 3 general adult• 1 CA• 1 old age (vacant)
RANZCP trainees	0	No RANZCP training program

Workforce issues

Recruitment of consultant psychiatrists

Owing to Warrnambool being 3.5 hours drive from Melbourne, distance is an issue in attracting local consultants to work there. The old age psychiatrist recently resigned. Long-term incentives need to be explored to attract locally trained consultants to the area.



Absence of a Clinical Director of MHS

Currently, Warrnambool & District Base Hospital Psychiatric Services does not have a MHS Clinical Director. The absence of an incumbent Clinical Director has led to a disconnection between the consultant psychiatry workforce and hospital management. This has led to poor annual leave cover and a highly stressed workforce. As an interim measure, SWHAMHS has commissioned the Clinical Director of Barwon Health Mental Health to provide clinical leadership one day per month.

RANZCP training program

The potential exists to establish a RANZCP training program and the AMHS administrator has a long-term plan to establish one. The initial step to achieve this is to build up the psychiatry workforce by recruiting SIMGs who, once they obtain FRANZCP, will become eligible for accreditation as supervisors. Once critical mass for a permanent consultant psychiatrist workforce is reached, a training program can be established whereupon trainees will be recruited.

Key issues for Warrnambool & District Base Hospital Psychiatric Services

- Difficulty in attracting locally trained psychiatrists owing to distance.
- Inadequate consultant psychiatry workforce.
- Absence of a permanent Clinical Director of MHS.
- Unhealthy workplace culture.
- Absence of a RANZCP training program.

Recommendation for Warrnambool & District Base Hospital Psychiatric Services

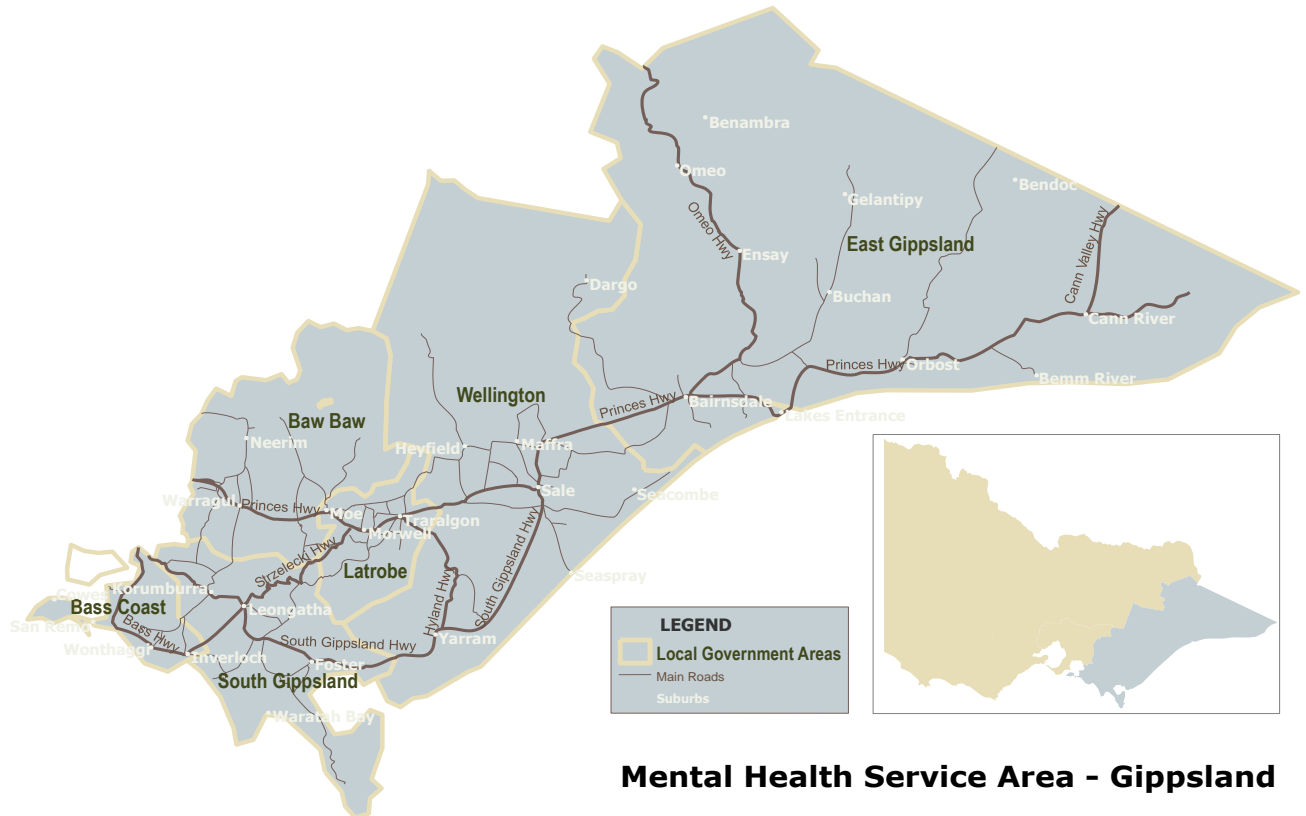
- Explore opportunities for linking the old age consultant psychiatrist position with an academic appointment. Funding could be shared between Deakin University and the AMHS.

Latrobe Regional Hospital Mental Health Service

Latrobe Regional Hospital MHS (LRHMHS) provides MHS to all of Gippsland, Wellington, Baw Baw, Bass Coast and Latrobe. The catchment population is approximately 250,000.

Workforce profile

Position	No.	Details
Consultant psychiatrist	10	<ul style="list-style-type: none"> • 1 Forensic • 1 psychotherapist • 4–5 CA • 3 aged care
RANZCP trainees	6	
HMOs	14.5 EFT	
JMOs		3 month rotation, which is optional



Mental Health Service Area - Gippsland

Original: MHSA rural individual WOR: MAP: Gippsland
Produced by Paula Morrissey, Metro Health & Aged Care: 12/01/04
Areas derived from: Local Government Areas, Australian Standard Geographical Classification (ASGC) 2001
with exceptions at Barwon's border with Glenelg & Grampians; Loddon/Northern Mallee borders;
Goulburn/North East Hume borders

Workforce issues

Inadequate consultant psychiatry workforce

LRHMHS now has a structured psychiatry workforce, with highly experienced consultant psychiatrists who are also teachers/supervisors. Most of them are fractional (between 1–2 days per week), however, which precludes them being able to participate in clinical leadership.

The organisation has the correct number of junior doctors but the overall workforce numbers to meet clinical demand is inadequate. Correct workforce levels has been extrapolated as:

Subspecialty	Current EFT	Ideal EFT	Difference
CLP	0.8	0.8	0
CA	1.4	2.5	1.1
adult	9.3	11.3	2.0
addiction	0	2.0	2.0
psychotherapy	0.3	1.0	0.7
forensic	1.0	2.0	1.0
old age	1.8	2.0	0.2
Total			7.0

Academic position

LRHMHS is linked to Monash University and a local medical school has recently been established in the region. Monash University places an emphasis on research, which is a contemporary core component of medical training. No formal research is undertaken at LRHMHS, however, given the university's requirements for research, the organisation is currently exploring the possibility of establishing an academic position.

GP mental health workforce

LRHMHS does not have any private practice psychiatrists in the region and is heavily dependent upon the skills of the local GP workforce. GPs cannot be a substitute for psychiatrists, however, as they do not have the same scope of referral.

Recruitment of consultant psychiatrists

Recruitment of locally trained consultant psychiatrists is a problem at LRHMHS. This trend is changing somewhat as more recently LRHMHS has begun receiving unsolicited expressions of interest for sessional work from some consultant psychiatrists based in Melbourne.

When a vacancy for a JMO position is advertised, LRHMHS receives approximately 70 applicants, mostly from OTDs who may or may not have psychiatry experience, and, from that pool, will interview around 8–10 people.

SIMG workforce

Owing to the distance between the Latrobe Valley and Melbourne, LRHMHS has historically had difficulty attracting Australian trained psychiatrists and relied on SIMGs to create an adequate psychiatry workforce. Several disadvantages exist in relying on SIMGs, however, including:

- Skill level varies widely and entry to the RANZCP training pathway is necessary to gain Fellowship.
- Lengthy recruitment process (greater than six months) when the SIMG is coming from another country.
- Many hidden costs in the recruitment process.
- Uncertainty about the comparability status that the RANZCP will accredit to them. The timing of the RANZCP accreditation creates a catch-22 situation in that SIMGs need to have their offer of employment confirmed before the RANZCP will accredit them.

Locums

LVRH used to need to frequently rely on locums (usually 3–4 week placements) to fill workforce gaps but this is less of an issue now. The reliance on locums introduced many problems including:

- lack of continuity of care leading to reduced quality of care
- staff, nursing and allied health needing to keep learning about the style of the consultant
- long lead times for recruitment.

A huge amount of time and energy goes into the recruitment process, which offsets time that could otherwise be put into clinical work, leadership and administrative duties. The burden of inefficiencies created by the recruitment process is a specific rural problem.

RANZCP training program

LVRH has a newly accredited training program in which trainees can complete entire program in the region. Training is undertaken across 6–7 sites scattered across Gippsland including Traralgon, Sale, Wonthaggi, Bairnsdale, Warragul and Orbost.

Trainee workforce

The quality of trainee applicants had been variable but is now good quality. Previously, trainees had a sense of isolation but this has dissipated as numbers have increased and critical mass achieved. All trainees travel to Melbourne one day each week to undertake a Masters of Psychological Medicine (MPM), which also contributes to reducing the sense of isolation. The need for trainees to take a day off each week creates a workforce shortage, however. As the MPM classes are held on Thursdays, the study day also creates a problem of perceived unfairness because the trainees then get rostered on to work on Friday evenings.

Supervision of trainees and junior consultants

Supervision time is well-accommodated because LVRH doesn't have a huge number of trainees. SIMGs eventually become accredited as supervisors once they gain Fellowship. Senior consultants provide ongoing supervision to junior consultants.

Occupational aggression

Approximately half of all admissions are drug and alcohol related. Other patients have general mental illnesses including chronic schizophrenia, bipolar and personality disorders. Borderline Personality Disorder patients usually have a short stay but their self-harm behaviour places a lot of pressure on community resources. Drug and alcohol affected and personality disordered patients impact on the care and wellbeing of other patients. The cohort of patients using crystal methamphetamines are likely to have used a combination of drugs. Although they may also have an underlying mental health problem, alcohol-related behavioural disturbances are the main concern. Aggression is a problem in the High Dependency Unit and creates a pressure cooker environment.

Leave requirements

Funding for sabbatical leave exists, therefore, these positions in theory can be backfilled but recruiting a consultant psychiatrist for only 6–12 months can be difficult because short-term positions are unattractive.

Effect of geographical expanse upon workforce

The geographical expanse of Gippsland and the limited train services available for patients to travel from one town to another can affect the availability of people picking up patients when they are ready for discharge. Even between the regions within Gippsland there is great variance in public transport availability. The wide area that Gippsland covers also impacts upon ambulance availability. Unlike metropolitan hospitals, logistical reasons, including the time taken to travel long distances and infrequent public transport services, create delays and inefficiencies for discharging patients. The geographical spread of the population needs to be taken into account in funding allocation because it alters the logistics of time-related matters.

Another issue peculiar to rural MHS is the greater demand placed on support services, e.g. paramedics and police. This leads to a lot of work being done behind the scenes by the psychiatry workforce to maintain goodwill.

Key workforce issues for LVRH AMHS

- Difficulty in recruiting locally trained consultant psychiatrists.
- Difficulty in attracting full-time consultants which undermines capacity for clinical leadership.
- Over-reliance on SIMGs which creates workforce shortages because of long recruitment lead times.
- Weekly workforce shortage on trainee's day of study leave.
- Occupational violence.
- Difficulty recruiting consultants for short-term positions to cover leave.
- Lack of recognition of the unique ways in which the rural geographical expanse impacts upon the psychiatry workforce.

Recommendations for LVRH AMHS

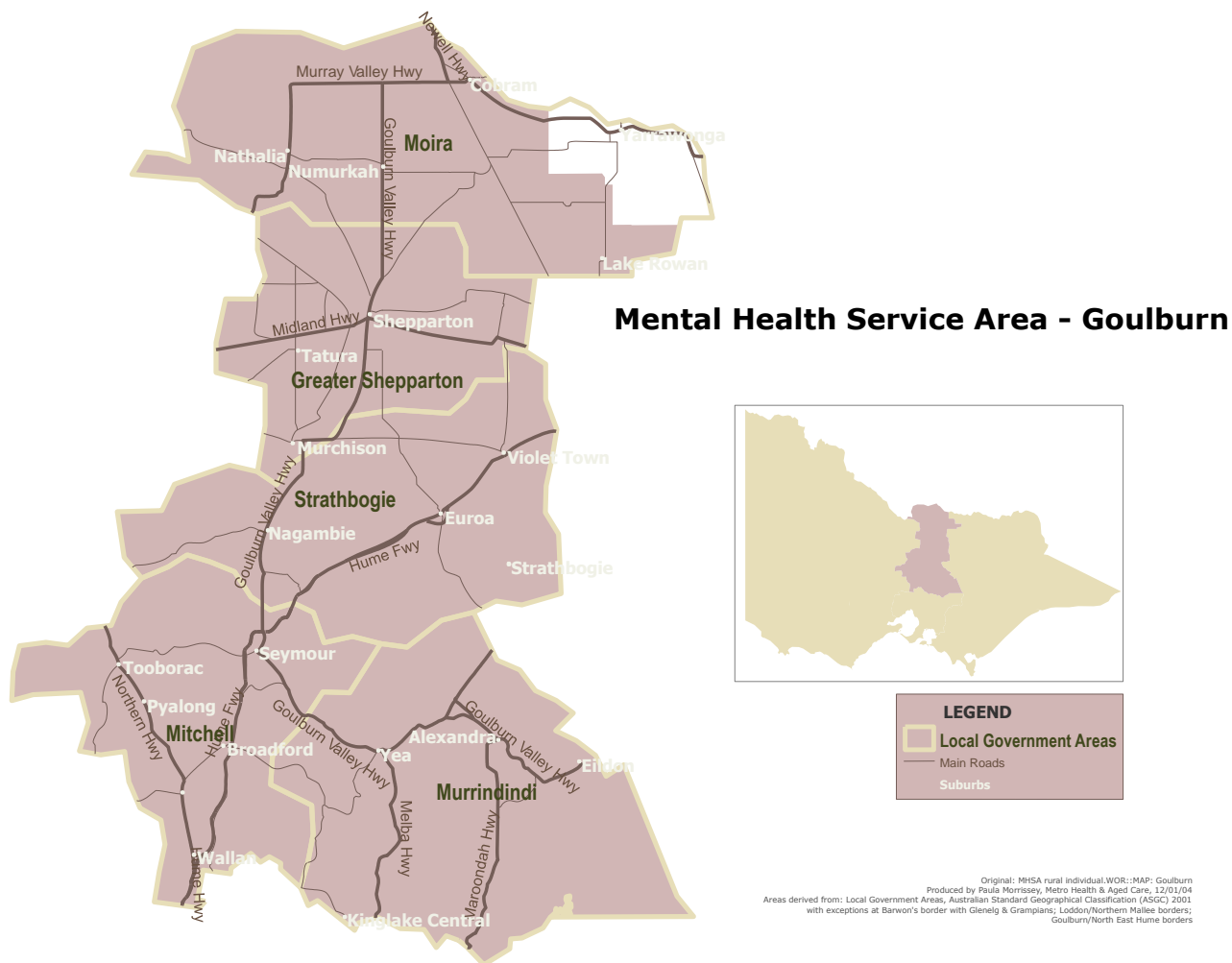
- Explore the potential to establish an academic appointment.

Goulburn Valley Area Mental Health Service

Goulburn Valley Health Area MHS (GVAMHS) covers the areas of Greater Shepparton, Strathbogie, Mitchell, Murrindindi and the surrounding district. A rural medical school of the University of Melbourne is based in Shepparton.

Private MHS

In early 2016, Shepparton Private, owned by Ramsay Health, opened. The facility has a 14-bed psychiatry inpatient unit and is the only private facility in the region.



Workforce profile

Position	No.	Details
Consultant psychiatrist	8.7 EFT	<ul style="list-style-type: none"> All but 1 are FRANZCP 1 SIMG Full complement of subspecialties Most are in public but have diversified into private
RANZCP trainees	5 EFT	<ul style="list-style-type: none"> 2 STP funded positions

Workforce issues

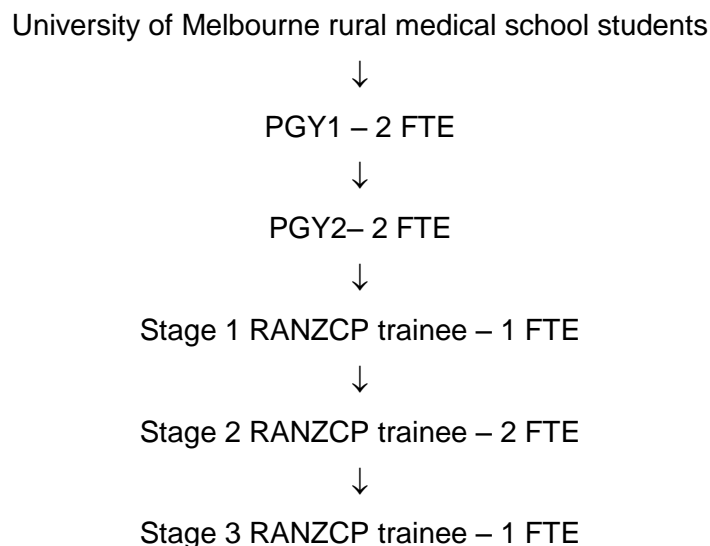
Academic positions

GVAMHS has two academic positions. One is 0.4 EFT, involves teaching and supervision of medical students and is affiliated with the University of Melbourne Medical School, Department of Rural Health, in Shepparton. The other position is 0.2 EFT and involves mostly teaching.

Academic positions are highly beneficial from a recruitment and retention perspective – they attract people to the area because of the variety of work they enable – e.g. teaching and research – which makes roles vastly more interesting and thus contribute to retention. Academic positions also enhance the meaningfulness of jobs – consultants are able to give back by teaching students.

Training Program

RANZCP trainees can complete all of their training program in the region. From a vertical integration/hierarchy/flow perspective, the region currently nurtures a good RANZCP training pathway, as follows:



The quality of the applicants for the RANZCP training program has been very high. Presently GVAMHS can only accept only one first year RANZCP trainee per year. The problem with this is that if a trainee needs extended training time (i.e. needs six years to complete their training program instead of five) the service does not have the available funding to take on a new first year trainee until the current trainee has completed their training.

Fragile critical mass

As the GVAMHS psychiatry workforce is very small, if just one workforce member were to leave critical mass would be lost and the training program will collapse. This is because the clinical load would then have to be distributed amongst those that remain. The individual load would become too burdensome, lead to burnout and eventual resignations. Supervisory requirements for trainees would, therefore, not be able to be met and so the training program could not be sustained.

To help the workforce be self-sustaining, a greater number of senior registrars (trainees), as opposed to a greater number of consultants, is required. Senior registrars have responsibility for low risk day-to-day work, enhance peer support, and provide support to consultant psychiatrists. This allows consultants to handle more high risk cases and support trainees at all levels.

GP psychiatry workforce

GVAMHS had funding for a first year GP psychiatry registrar position, the training for which was adapted from the Australian College of Rural and Remote Medicine program 2-year curriculum, but did not receive any applicants in 2016. This is because GPs are generally more interested in psychotherapy training, as required, rather than gaining more comprehensive mental health skills. GPs with mental health skills do not provide a substitute for consultant psychiatrists because rural areas require more the services of the latter.

Supervision of RANZCP trainees

Supervisory time is accommodated but the consultant psychiatrists are often doing overtime to fit it in. The time required of supervisors has increased dramatically because of the RANZCP requirements for EPA, WBA and 1 OCA every six months per trainee. There is no funding to pay staff for overtime.

Obtaining a consultant psychiatrist for the purposes of psychotherapy supervision has been difficult. Currently, Shepparton brings in sessional psychotherapists but is exploring how it can improve local capacity. RANZCP training requirements for psychotherapy set out that patients should come from the public sector. The psychotherapy supervisor can be sessional, however, because public hospitals don't have psychotherapy departments.

Leave cover

No funding is available for consultant psychiatrists to undertake sabbatical leave but allowances are made because such leave is deemed important.

Study leave for rural trainees

Undertaking the MPM one day per week at the University of Melbourne is mandatory for RANZCP trainees. They have to attend classes each week in person because, although theoretically they can attend classes via videoconference, in reality this is not ideal because of the poor videoconferencing network. Not enough attention has been paid to making the MPM online user friendly. Interactivity is missing because most of the time the lecturers forget the online students are present.

The need for rural trainees to attend the MPM classes creates a catch-22 situation – if they don't attend classes in person they miss out on professional networking and making friends but this mode of attendance creates a workforce shortage one day per week. The MPM fees are also very expensive. Universities in other Australian jurisdictions offer the qualification but there is wide variation in costs and accessibility.

Occupational aggression

Over the last 18 months the number of admissions has increased dramatically owing to the introduction of a new triage system. The patients who present have severe mental illnesses and issues of violence are common.

On call after hours and weekend workforce

As the psychiatry workforce in Shepparton is small, consultant psychiatrists need to be on call about once per week. The RANZCP trainees also do some on call work because they need to gain experience in managing emergencies.

STP funding

The STP funding for two trainee positions has enabled GVAMHS to achieve critical mass for its workforce. Some cross-subsidisation of funding is still required despite the rural loading that applies to these positions. Critically, the uncertainty of the ongoing nature of STP funding renders the psychiatry workforce in Shepparton vulnerable because if STP was withdrawn, as explained above, the training program would collapse. To offset such workforce vulnerability the funding of trainee positions in rural areas needs to be guaranteed and not reliant on uncertain funding. STP funding perceived as better suited to providing different opportunities in metropolitan areas.

Not only does achieving critical mass create less reliance on locums, it also helps to create a supportive workplace in which people feel valued and supported both on the job and in their professional aspirations.

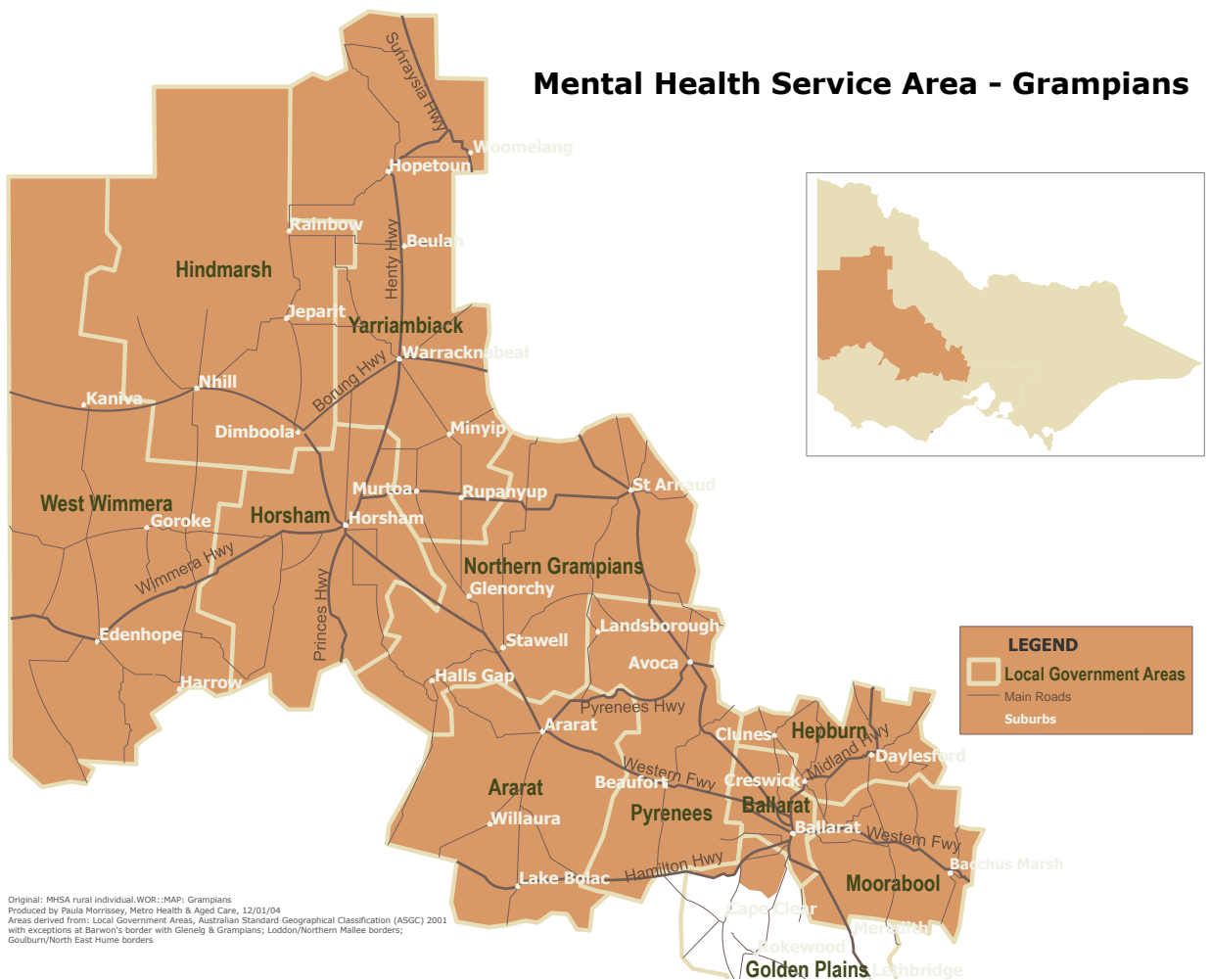
Key issues for GVAMHS

- Fragile critical mass such that the departure of one staff member would bring about the eventual collapse of the workforce including the RANZCP training program.
- Reliance on STP funding, which is not guaranteed, to achieve critical mass.
- Shortage of senior registrars to help create a self-sustaining workforce.
- Workforce shortage one day per week owing to trainee's day of study leave.
- Poor videoconferencing network for online attendance of MPM classes.

Ballarat Health Service Mental Health Service

Ballarat Health Service MHS (BHSMHS) covers Ararat, Ballarat, Hepburn, Hindmarsh, Horsham, Moorabool, Northern Grampians, Pyrenees, West Wimmera, Yarriambiack and surrounding districts. The geographical area covers 48,000 sq. kms, ranging from Bacchus March to the South Australian Border Town. The total catchment population is about 240,000. The area is identified as one of socio-economic disadvantage.

BHSAMHS has 23 bed acute adult inpatient unit, 2 CAP beds, 10 acute aged care beds and 5 beds in the mother and family unit.



Workforce profile

Positions	No.	Details
consultant psychiatrists	10	<ul style="list-style-type: none">• 8 full-time• 2 part-time• 7 SIMGs<ul style="list-style-type: none">○ 1 substantial comparability○ 6 partial comparability• All generalists in psychiatry• CA psychiatrist 0.4 EFT• 1 academic position
RANZCP trainees	0	No training program

BHSMHS has a generalist psychiatry workforce because the region does not provide the opportunity for a highly specialised one. An integrated model of care is used in which psychiatrists are allocated a geographical area and follow their patient's journey in the system, irrespective of whether the patient is in the community or is an inpatient. The public psychiatry workforce works closely with local GPs.

BHSMHS has one academic position, which has links with the University of Melbourne.

The township of Ballarat has 10 private practice psychiatrists.

Recruitment

Since a review of recruitment processes in 2004, several initiatives have been introduced to help build a skilled and sustainable local specialist mental health workforce including:

- Developing strong collaborative links with internationally renowned universities, the medical training programs of which are comparable to Australian standards.
- Visiting selected universities, meeting with Vice-Chancellors and senior academic staff.
- Senior professors from the above universities visiting BHSMHS.
- Selecting psychiatrists only after face-to-face interviews and substantiated reference checks.

Seven out of the 10 (70%) of the BHSMHS psychiatry workforce are SIMGs. BHSMHS has introduced a range of initiatives to help support SIMGs including:

- an intensive orientation and acculturation program
- a structured framework across professional, clinical and social domains to support a sustainable workforce
- a cultural competency and cross-cultural training to ensure both psychiatrist and consumer needs are being met.

Retention of consultant psychiatrists

The current workforce trend is that once SIMGs gain their Fellowship they usually leave the region for better remuneration opportunities, or stay in Ballarat but move into private practice. In the public sector, fractional staff earn a greater amount per hour than full-time staff, which is a disincentive to work full-time. There is a perceived need to increase full-time salaries substantially to improve retention of consultant psychiatrists.

On call after hours and weekend workforce

The small workforce means that psychiatrists are rostered on frequently for on call and weekend work, which is burdensome.

RANZCP training program

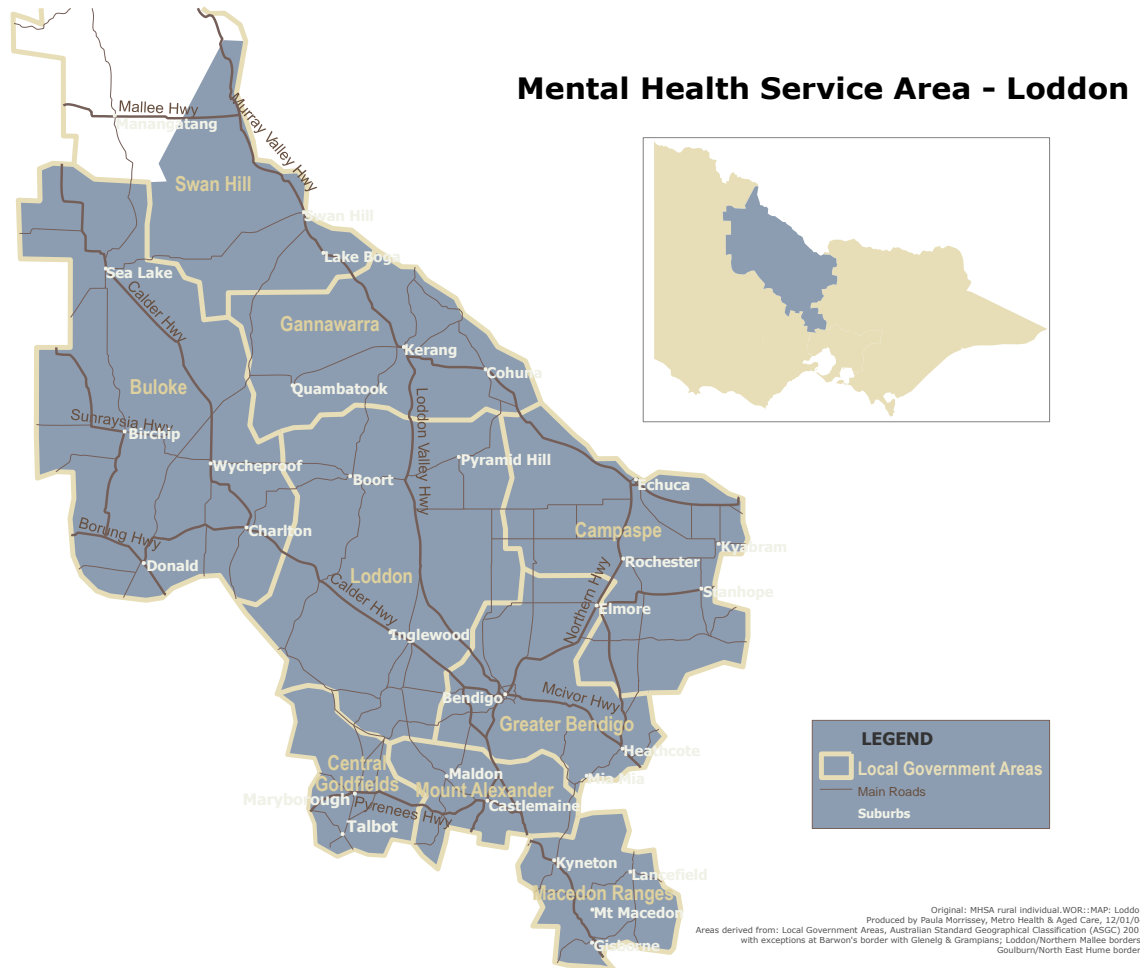
BHSMHS does not have a RANZCP training program. The plan is to establish one when the region reaches critical mass for a self-sufficient psychiatry workforce, with all subspecialties represented in the region. Trainees will then be able to undertake their entire training in the region. In the absence of a training program, rotations of metropolitan RANZCP trainees coming to Ballarat to undertake a three monthly rural rotation is deemed unhelpful for patient continuity of care.

Key issues for BHSMHS

- Difficulty in retaining SIMGs in the region once they obtain Fellowship.
- Perceived financial disincentives to working full-time in the rural public sector.
- Frequent on call weekend work owing to small psychiatry workforce.
- No RANZCP training program because difficulties in retaining SIMGs is undermining ability to achieve critical mass of consultant workforce.

Bendigo Health Psychiatric Services

Bendigo Health psychiatric services covers Bendigo, Macedon Ranges, Echuca and Swan Hill. Bendigo has a 24-bed adult inpatient unit, a 10-bed aged care inpatient unit, an 8-bed secure unit and 6 clinics.



Workforce profile

Position	No.	Details
Consultant psychiatrist	11.22 EFT	<ul style="list-style-type: none"> Comprised of approximately 20 psychiatrists Mix of part-time and full-time Some do private sessions Subspecialties: <ul style="list-style-type: none"> aged care CAMHS (sessional – from Melbourne) youth adult

RANZCP trainees	13 EFT	<ul style="list-style-type: none"> • Stage1 – 1 • Stage 2 – 5 • Stage 3 – 1
HMOs	6 EFT	<ul style="list-style-type: none"> • Some doing 3 month rotations; remainder 12 month profile

Workforce issues

Workforce shortage

Bendigo Health psychiatry services includes the following subspecialties: youth, adult, CLP, old age and CAMHS (sessional – from Melbourne). Two consultant psychiatrists are undertaking academic work with Monash University one day per week and working towards attaining a professorial position.

The workforce has gaps and inconsistencies, however. For example:

- Aged care has consultant psychiatrists but no junior medical staff.
- CLP services are underfunded (current funding is \$40,000 per annum) and there is no dedicated staff member. The hours are covered by a pastiche of psychiatrists who provide a varying number of hours. On days when there is insufficient staff, the psychiatrist providing the CLP services is available only via the telephone. This limitation affects both patient flow and the workforce – ED doesn't get the CLP services and the psychiatrist becomes stressed.
- More funding needs to be allocated to the ED, youth and CLP.

Recruitment of consultant psychiatrists

Bendigo has had difficulty attracting local consultant psychiatrists to the region. The last three were SIMGs, recruited from the United Kingdom.

A couple of years ago Monash University established the Centre for Rural Mental Health for the purposes of medical research. Funding was provided for a professorial position to complement the Centre but recruitment efforts were unsuccessful. The Centre for Rural Mental Health is currently dormant but is in the process of being reinvigorated.

A professorial position in Bendigo would enhance recruitment and retention because it would add gravitas and credibility to the service. Trainees may view the presence of a professorial position as significant in terms of how it can enhance the interest and development of their own careers.

MPM classes for RANZCP trainees

RANZCP trainees feel a sense of isolation because of distance between Bendigo and Melbourne, which is a key reason why they choose to travel to Melbourne to attend MPM classes in person. The travel places a burden on the trainees, however. Although the trainees are not rostered on night duty the night before the study day, they may have been working a night shift during the week from which they are still recovering. The need to attend the classes in person, therefore, creates a catch-22 – on one hand the trainees want to travel to Melbourne to connect with colleagues but on the other hand the travel is burdensome because it is tiring and superimposed on already existing fatigue.

An alternative to RANZCP trainees travelling to Melbourne each week is for them to attend classes, on occasion, via videoconference. The highly inadequate videoconferencing services – both the equipment and technical resources at either end – almost nullifies this as an option, however.

Another issue is that the one-day absence from the workplace each week introduces feelings of discomfort for the trainees because they know their absence burdens their peers with an extra heavy workload. The trainees also know they will be burdened by an extra heavy workload the day after the study day. Funding for the rural psychiatry workforce does not take into account that trainees are absent from the workplace one day per week.

Weekend workforce

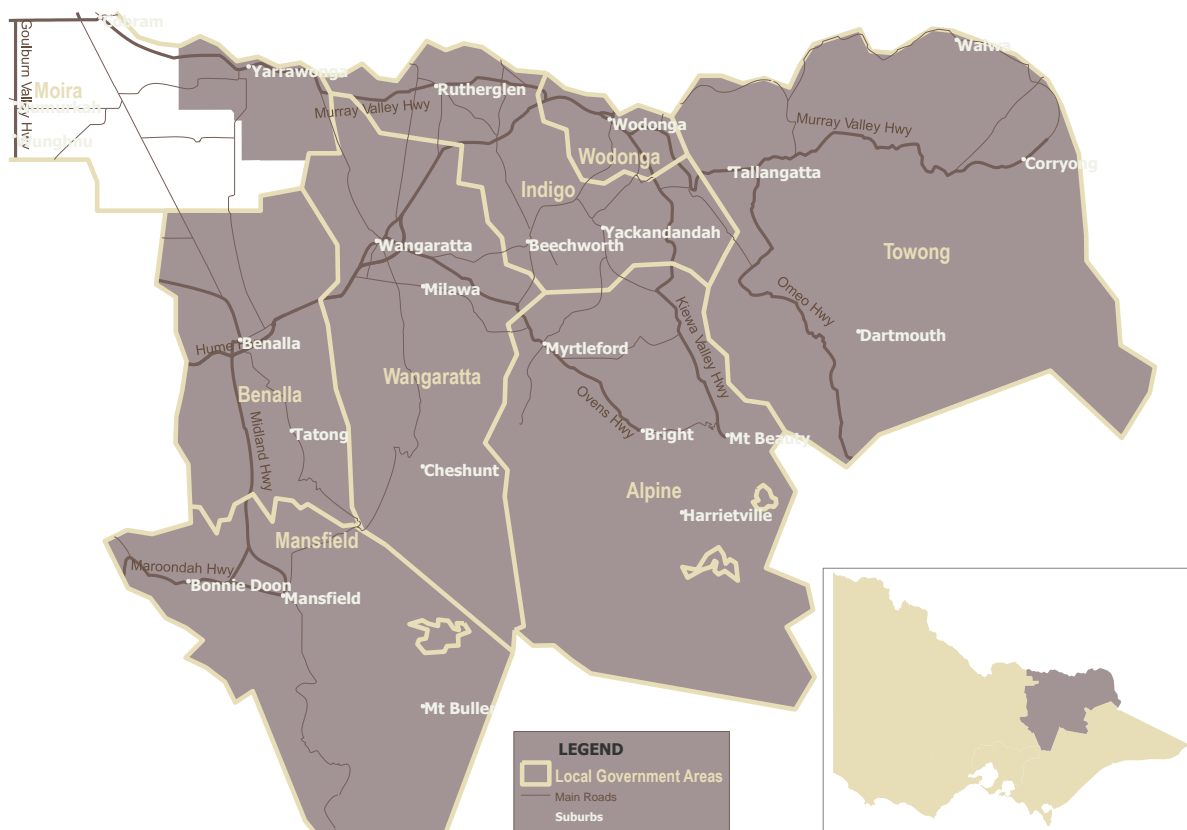
Weekend on call demand for consultant psychiatrists is variable – sometimes they will work only mornings but on other occasions they will be in for approximately nine hours.

Key issues for Bendigo Health Psychiatric Services

- Workforce shortages, particularly old age, CLP and youth psychiatry.
- Weekly workforce shortage because of trainees needing to take study leave to attend MPM classes
- Trainee welfare compromised because of their need to travel to Melbourne to attend MPM classes one day per week while tired.
- Poor videoconferencing services making the option for rural students to attend MPM classes online unviable.
- Cessation of rural–metropolitan links has led to negative flow on effects on workforce including much more inexperienced junior psychiatry workforce with concomitant greater burden on consultant workforce.

Northeast and Border Mental Health Service

Northeast and Border MHS (NBMHS) covers the Albury, Wodonga, Alpine, Indigo, Wangaratta, Benalla, Mansfield and surrounding districts and spans 55,000 square kilometres. The service has a catchment population of around 200,000 people. The northern part of the catchment area has a growth rate of 24% while the southern part has one of 32.5%. As the service spans the Victoria–NSW border, an intergovernmental agreement exists to jointly fund the health services. The health service model in each state is different, however – the Victorian model is fee-for-service and the NSW model is block funding. A 4-bed inpatient unit is at Albury Base Hospital and a 20 bed inpatient unit at Wangaratta Base Hospital.



Original: MNSA rural individual WOR:MAP: North East Hume
Produced by Paula Morrissey, Metro Health & Aged Care, 12/01/04
Areas derived from: Local Government Areas, Australian Standard Geographical Classification (ASGC) 2001
with exceptions at Benalla's border with Glenelg & Grampians, Loddon/Northern Mallee borders,
Goulburn/North East Hume borders

Mental Health Service Area - North East Hume

Workforce profile

Hospital	Position	No.	Details
Albury	Consultant psychiatrist	5 persons	<ul style="list-style-type: none"> 4 part-time – most are 1/day per week 1 full-time (Clinical Director) Work in both inpatient units and outpatient clinic

Wangaratta	Consultant psychiatrist	1	<ul style="list-style-type: none"> • 1 three days per week (local psychiatrists) • 2 SIMGs – substantial comparability
Wodonga	Consultant psychiatrist	2	SIMGs full-time; are also at Wangaratta one day/wk
	RANZCP trainee	1	On rotation from SWSAMHS*
	HMO	1	Occasional rotation

***South West Sydney Area Health Service**

The NBMHS psychiatry workforce composition is quite unstable, comprised of psychiatrists who are part-time, FIFO/DIDO or SIMGs. The area has a CAP service, more than 50% of demand for which is for children aged 12 years or less. One CA Psychiatrist lives locally and works part-time and the remainder are FIFO/DIDO.

The NBMHS has one RANZCP trainee who rotates from the NSW South Western Sydney Area Health Service (SWSAMHS).

There is no psychiatry registrar but on occasion a HMO will undertake a rotation there.

Retention of consultant workforce

A large proportion of the psychiatry workforce is mature age and will retire in the next five to seven years. A concomitant of this will be a great loss of skills and experience in the psychiatry workforce.

Recruitment of consultant psychiatrists

The inadequate current workforce means NBMHS has enormous difficulties attracting psychiatrists. To highlight, for more than a year NBMHS has been advertising for a psychiatrist at Wangaratta Base Hospital. Meeting workforce requirements is not simply about attracting psychiatrists but attracting those with the correct subspecialties to meet the needs of the demographics. It is also about being able to attract psychiatrists because the location can meet their needs as well as those of their family.

The small workforce owing to the inability to attract a sufficient number of psychiatrists is reflected in the AMHS's budget, which is now small and inequitable. This has created a catch-22 situation in that modern solutions to the workforce shortage exist – e.g. FIFO/DIDO workforce – but the small budget renders the NBMHS unable to afford these solutions. Although a FIFO/DIDO workforce is not ideal – e.g. these individuals cannot participate in an on call roster – they are better than nothing.

SIMGs

NEBAMHS has three SIMGs – two have been working in the region for a number of years. All are on the RANZCP substantial comparability pathway. Currently another SIMG is being sought with an interest in commencing as a HMO. Difficulties exist in attracting SIMGs to the region, however, irrespective of the availability of funding.

Retention of consultant workforce

A large proportion of the psychiatry workforce is mature age and will retire in the next five to seven years. This will result in a concomitant loss of skills and experience in the psychiatry workforce.

Contemporaneous pressures on psychiatry workforce

New issues have emerged that are placing increasing time pressures on the psychiatry workforce, including:

- Emerging health policies, including consumer engagement – talking to consumers and carers because they are more educated
- Increasing administrative procedures
- Increasing complexity of patients. Patients may receive, for example, a dual diagnosis of personality disorder and substance use, or have complex comorbidities. Such patient presentations requires psychiatrists to undertake longer assessments and consultations.

Workforce shortage

The NBMHS psychiatry workforce is critically understaffed – the current EFT is around 50% less than the state average. Three psychiatrists work at Wangaratta on a part-time basis: two work one day per week while one works three days per week. The NBMHS needs a dedicated CL psychiatrist but has no funding to establish the position.

Currently, there is no psychiatrist at Wodonga or Wangaratta that can respond to CLP requirements. Albury has only one registrar who can provide CLP services. No psychiatry services can be offered to local EDs because the workforce is so skeletal. The on call roster for Albury Base often has gaps, which the Clinical Director fills despite also being on call for parts of the services located in NSW.

Community MHS are located in Albury, Wodonga and Wangaratta. Owing to staff shortages, however, there is no opportunity for psychiatrists to participate in outreach services to the outermost areas of the catchment area. The workforce shortage has removed the opportunity to deliver mental health education to GPs so they are better skilled in management of such issues. Yet a GP workforce well skilled in mental health is necessary to support psychiatrists to participate in outreach services.

The insufficient psychiatry workforce is having significant undesirable flow on effects including:

- undermining quality and timeliness of care
- creating a stressed workforce
- eliminating time for input into service development, clinical leadership or education
- removing capacity to undertake research.

Financial assistance and practical travel arrangements should be available for psychiatrists visiting rural areas via outreach programs in communities where there are unmet needs and an inability to employ a resident psychiatrist.

Clinical Director

Beyond taking on extra clinical responsibilities to cover gaps in the on call roster at Albury Base, the workforce shortage is also impacting upon the Clinical Director to complete administrative work. These responsibilities include, for example, writing medico-legal reports and responding to expressions of interest for work. The Clinical Director has no administrative staff, however. This renders them without time to attend to other work, such as the preparation of position descriptions, contracts and correspondence.

Reliance on locums

NBMHS has been relying on locum psychiatrists to support its workforce, which is less than ideal for several reasons including:

- short tenure (ranging from one week to three months), which undermines continuity of care and, therefore, quality of care
- unpredictable quality of locums' skills and experience
- expensive and time consuming recruitment process, which may involve workforce gaps between the departure of one and the arrival of the next.

Travel to the region

Brindabella Airlines used to offer a flight between Canberra and Albury. One of the sessional CA psychiatrists living in Canberra used to fly with Brindabella Airlines until the airline cancelled the service. The psychiatrist continues to work in the area because they love the work and have a loyalty to the area but instead of flying they now they drive, which is a four-hour trip each way.

Wangaratta does not have an airport, therefore, if an individual is travelling to the town from Melbourne they need to get there by car or by train. These travel impositions cause many inefficiencies. In particular, funding is spent on travel and overnight accommodation costs instead of on direct service delivery.

Teleconferencing services

Given workforce shortages and geographical distance, telehealth services will be indispensable to the delivery of rural health care in the future. The use of telehealth services requires both the patient and the psychiatrist to travel to access suitable videoconferencing or skype services. Financial assistance and practical travel arrangements should be available for psychiatrists visiting rural areas via outreach programs in communities where there are unmet needs and an inability to employ a resident psychiatrist.

Notwithstanding the strengths of telehealth, face-to-face clinical treatment is still relevant and necessary in some cases. For example, teleconferencing services within rural mental health facilities are suitable only for compliant patients – the ones that often need an assessment are the unstable, non-compliant patients who will not sit in front of a camera. As such, when managing non-compliant patients in rural health facilities, teleconferencing services are rendered no better than the patient's condition being discussed via the telephone (current arrangements are for highly skilled RNs to assess patients and then consult with the on call psychiatrist via telephone).

Rural trainees

Rural rotations should be integral to the RANZCP training program. Rural rotations are popular because the trainees enjoy the experience – they undertake an expanded range of responsibilities and learn more. Because the rural workforce structure is more egalitarian than those in metropolitan settings, trainees have far greater access to consultants – for example, opportunities arise to discuss educational issues in social settings.

Training program

The NBMHS wants to establish a RANZCP training program in the region. Key measures that must be in place to achieve this are dedicated funding for a 0.5 EFT:

- CL psychiatrist
- old age psychiatrist.

Shepparton has advised it can support NBMHS with any subspecialty requirements that cannot be met locally.

Key workforce issues for NBMHS

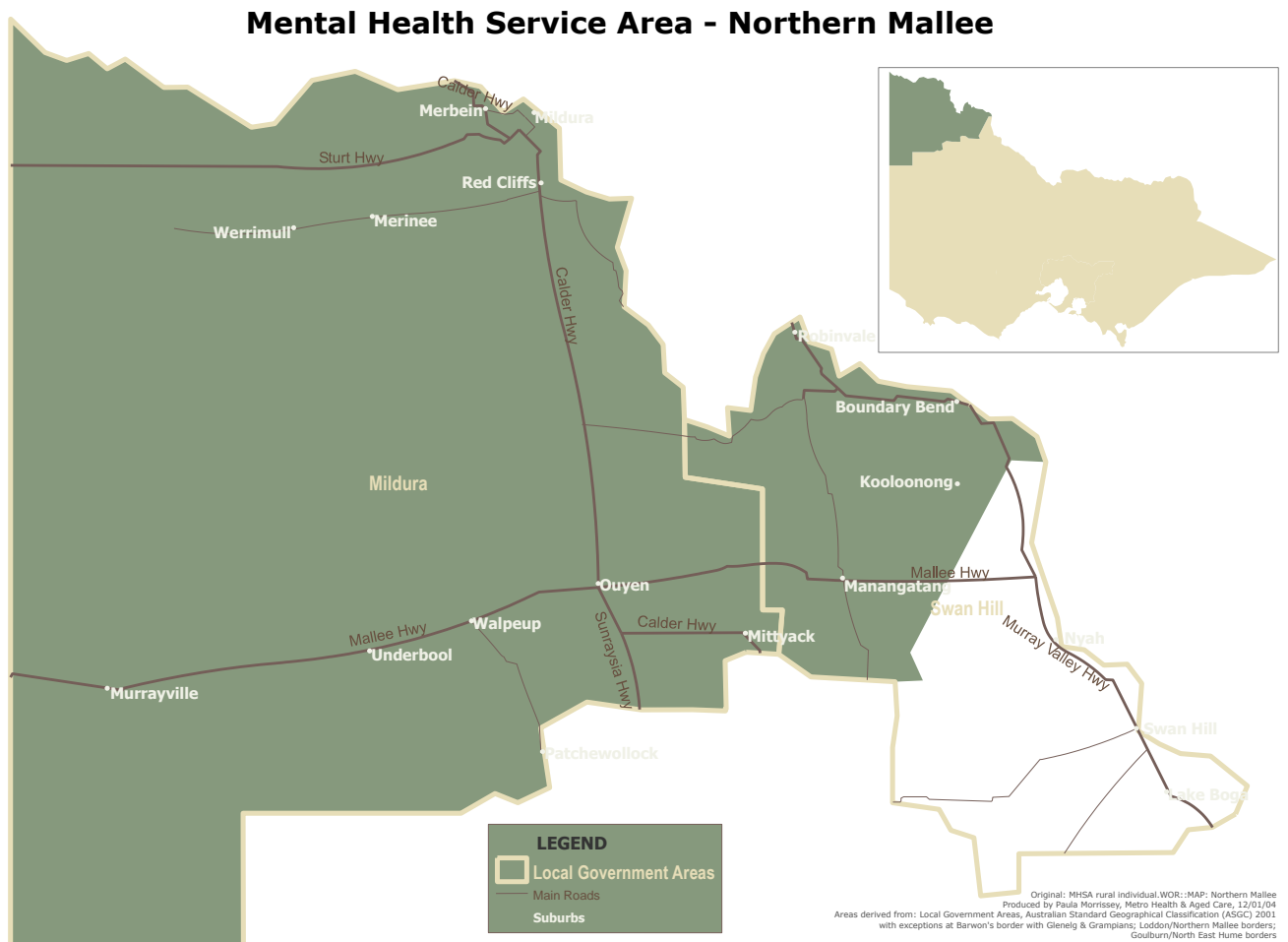
- Critical workforce shortage.
- Difficulty in attracting consultant psychiatrists.
- Insufficient funding to expand FIFO/DIDO workforce.
- Insufficient workforce impacting upon service provision.
- No RANZCP training program in area because of workforce shortage.

Recommendations for NBMHS

- In conjunction with NSW Health, develop a range of incentives to attract consultant psychiatrists to the area.
- Until a self-sustaining local workforce is established, undertake an evaluation of the supports required for a FIFO/DIDO psychiatry workforce to support the community in the interim.

New Northern Mallee Area Mental Health Service

New Northern Mallee Area Mental Health Service (NNMAMHS) covers Mildura, Ouyen, Robinvale and the surrounding district. NNMAMHS covers an area of 25,000 km and has a catchment population of up to 70,000 people, with a high indigenous population (approx. 5%), and a high level of drug and alcohol problems. Mildura Base Hospital has a 12-bed adult in patient unit.



Workforce profile

Position	No.	Details
Consultant Psychiatrists	4 (1.8 EFT)	Clinical Director – 0.3 EFT 1 EFT adult psychiatrist
RANZCP trainee	1	Stage 1 trainee
non-RANZCP registrar	1	
JMO	1	On rotation

Workforce issues

Workforce shortage

NNMAMHS has not had a permanent psychiatrist in the region for a very long time and all psychiatry services rely on locums. One consultant psychiatrist from the Melbourne Clinic visits three days per week. A locum CA psychiatrist also provides sessions once a fortnight, however, this person recently resigned and there are no private CA psychiatrists in the region.

The correct requirements of the NNMAMHS psychiatry workforce are:

- 2 full-time adult psychiatrists
- 1 CA psychiatrist, ideally 2 days/week public sector and three days/week private
- 1 full-time aged care psychiatrist.

Recruitment

NNMAMHS is currently attempting to establish a permanent workforce and been advertising for consultant psychiatrists for two years. No success has been achieved in recruiting local psychiatrists, however. The expected reasons for this are that:

- Psychiatrists do not want to be the last person standing – if another leaves they will be left to carry the burden of a large clinical load.
- Low workforce numbers means that people would be aware they need to work seven days per week – they can't take weekends off or take leave of any kind.
- Full-time in the public sector is undesirable because of the salary, red tape, types of patients and limited variety of work.

Notwithstanding this, psychiatrists do want some public sector work because of the camaraderie, support, and belongingness to a group that it provides.

Recruitment of SIMGs

Currently, SIMGs are recruited to fill psychiatry workforce vacancies because it is necessary to recruit those already trained in psychiatry. The SIMGs must be accredited by the RANZCP as 'Substantially Comparable' and not 'Partially Comparable'. This is in accordance with RANZCP's new 2015 rule which states that only SIMGs with substantial comparability can be appointed to an AoN.

Recently, NNMAMHS appointed a professor of psychiatry from an overseas country. Despite this success, the recruitment process provided a downside – the process was very lengthy given that it began at Easter 2015, and the costs were great particularly for the SIMG.

Locums

The quality of locum work is of a very high quality but they are employed for only two to four weeks at a time. This has disadvantages compared to a continuous workforce including:

- lack of continuity of care or planning leading to decreased quality of care and patient satisfaction
- patients and doctors don't get to know each other to establish a professional relationship
- lack of clinical leadership – no consistency of medical policies and procedures.

RANZCP training program

NNMAMHS does not have a RANZCP training program but would like to establish one.

Strategy to establish a self-sufficient workforce

The workforce level requirements in rural areas are quite different to those in metropolitan areas. The public sector and the private sector support one another and, as such, it is necessary to create a balance between the two.

The strategy for building a self-sufficient psychiatry workforce in Mildura is to establish:

- a part-time workforce (because it can't attract full-time staff)
- a private clinic by entering into a public-private partnership business with Healthscope
- a RANZCP training program
- an academic clinic.

Key workforce issues for NNMAMHS

- Difficulty in attracting locally trained consultant psychiatrists.
- Reliance on SIMGs to meet workforce requirements.
- Workforce shortages owing to lengthy recruitment process for SIMGs.
- Absence of RANZCP training program.

Victorian Private Psychiatry Sector

The larger private psychiatry facilities Victorian include:

- i. Albert Road Clinic
- ii. Delmont Private Hospital
- iii. Epworth
- iv. St John of God Pinelodge clinic
- v. The Geelong Clinic
- vi. The Melbourne Clinic
- vii. Victoria Clinic
- viii. North Park Private Hospital
- ix. South Eastern Consulting
- x. Harvester Clinic
- xi. Wyndham Clinic Private Hospital

i. Albert Road Clinic

Albert Road Clinic is owned by Ramsay Health and situated on the southern outskirts of the Melbourne CBD.

Workforce profile

Position	Number	Detail
Accredited psychiatrists	60	majority are part-time
Registrars	2	6 month rotations CAP registrar position is STP funded
Professorial team		Affiliated with University of Melbourne

Services

Albert Road Clinic has an 80 bed inpatient unit comprised of:

- 15 old age psychiatry beds
- 12 adolescent beds
- 50 adult beds
- 3–4 ICU beds.

The clinic also has an Electro-convulsive Training (ECT) suite and is the ECT training centre in Melbourne.

ii. Delmont

Delmont Private Hospital is an independently owned psychiatric facility in Glen Iris. The facility has an 88 bed inpatient unit for persons aged 18 and over, consulting suites, an ECT program, day programs and community outreach services. Delmont employs 53 accredited psychiatrists and psychiatric that offered focus on adult, addiction and old age psychiatry.

iii. Epworth

Epworth Clinic is located in Camberwell. Established 2.5 years ago, the facility has a 63-bed acute psychiatry unit.

Workforce profile

Position	No.	Details
Consultant Psychiatrists	80	<ul style="list-style-type: none">• Not all are accredited to admit patients• Subspecialties:<ul style="list-style-type: none">○ adult○ old age
RANZCP trainees	1	On 6-month rotation from Austin

iv. St John of God Pinelodge Clinic

Owned by St John of God, Pinelodge Clinic is located in Dandenong and treats persons in the regions of South Eastern Melbourne, Gippsland and the Mornington Peninsula. South Eastern Melbourne has a large immigrant population.

Workforce profile

Position	Number	Detail
Accredited psychiatrists	17	<ul style="list-style-type: none">• Many full-time
General Practitioners	2	<ul style="list-style-type: none">• Have admitting rights
Registrars	2	<ul style="list-style-type: none">• 1 from The Alfred; 1 from Monash• Both positions are STP funded• 6- monthly rotations• 3–5th year registrars

Services

Pinelodge Clinic has a 36-bed inpatient unit, a drug and alcohol unit, ECT services and funds a program for asylum seekers. All patients are voluntary. The inpatient unit is an open unit and has no HDU and, therefore, no capacity for constant observation of patients at risk of self-harm. Rarely do patients need to be made involuntary but when they do, they are transferred to a public sector hospital – Pinelodge liaises with the Monash Crisis Assessment Team (CAT) (Dandenong).

v. The Geelong Clinic

Owned by Healthscope, the Geelong Clinic has a 45 bed inpatient unit. Inpatient programs include those for addictive behaviours, eating disorders, depression, and post-traumatic stress disorder for veterans.

vi. The Melbourne Clinic

Owned by Healthscope, The Melbourne Clinic is situated in Richmond and is the largest private psychiatry facility in Australia.

Workforce profile

Position	Number	Details
Accredited consultant psychiatrists	200	<ul style="list-style-type: none">• 40–50 can admit patients• 50 onsite outpatient psychiatrists• A large number work across both public and private
Registrars	6	<ul style="list-style-type: none">• On rotations• Some STP funded

Services

The Melbourne Clinic has a 150–160 bed inpatient unit, offering services in adult/general, addiction, and old age psychiatry. The Clinic has an eating disorders clinic, an obsessive compulsive disorder program, and outreach services in rural areas including Nagambie, Ballarat and Geelong.

The Melbourne Clinic has a Professorial Unit, which is affiliated with the University of Melbourne. The Unit undertakes research and conducts clinical and academic teaching for university students and RANZCP affiliated psychiatry trainees. The research unit operates under the auspices of both The University of Melbourne and Healthscope.

vii. Victoria Clinic

Opened in 2001, the Victoria Clinic is situated in Prahran and owned by Healthscope. The hospital has a 52-bed inpatient unit and specialises in the provision of inpatient and outpatient MHS, including addiction recovery services.

Workforce profile

Position	No.	Details
Consultant Psychiatrists	8+	<ul style="list-style-type: none"> • 7-8 with admitting rights, most of these are full-time • Most are sessional, refer to day programs • Subspecialties: • General adult <ul style="list-style-type: none"> • Runs Victorian Program for Transcranial Magnetic Stimulation (TMS)
Registrars	2	<p>On rotation from The Alfred:</p> <ul style="list-style-type: none"> • 1 in inpatient unit (0.5 EFT); The Alfred (0.5 EFT) • 1 TMS Unit (1EFT)

Services

Victoria Clinic has two addiction physicians but the length of time for which they can admit patients is limited relative to the length of time for which a psychiatrist can admit. The hospital treats a lot of people with personality disorders and offers ongoing day programs that can address, for example, poor self-esteem, coping mechanisms and underlying anxiety. Some programs offered include Dialectical Behavioural Therapy, mindfulness, and cognitive behavioural therapy, which can help to provide greater stability to those with mental illness.

viii. Northpark Private Hospital

Owned by Healthscope and situated in Bundoora, Northpark private hospital offers MHS, including a 44-bed inpatient facility, day programs and outreach services.

ix. South Eastern Consulting

Privately owned and situated in Berwick, South Eastern Consulting comprises a team of psychiatrists and psychologists. The aim of the clinic is to support patients and GPS in the south eastern region of Melbourne. South Eastern Consulting does not have inpatient services.

x. Harvester Private Consulting Suites

Harvester Private Consulting Suites is a private practice for specialist practitioners including Consultant Psychiatrist, Psychologists and a Mental Health Nurse. The practice operates alongside Midwest Mental Health and neighbouring medical practices in and around Sunshine. Harvester Private is managed by Melbourne Health in conjunction with Glencairn Consulting Suites in Coburg.

The Consulting Suite has a team of 11 Consultant Psychiatrists, 2 Clinical Psychologists, 1 GP Specialising in Mental health, and 1 Mental Health Nurse.

xi. Wyndham Clinic Private Hospital

Situated in Werribee, the Wyndham Clinic Private Hospital has a 50-bed inpatient unit, drug and alcohol services, youth services, day programs, transcranial magnetic stimulation, and outpatient services.