The Royal Australian & New Zealand College of Psychiatrists
Tū Te Akaaka Roa
New Zealand National Office

Your Health in Mind
Hauora hinengaro Manatuhia

16/02/2026

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Via email: consultation@MCNZ.org.nz

Tēnā koe Joan,

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) welcomes the opportunity to provide feedback on the Medical Council of New Zealand's proposals for the regulation of physician assistants/physician associates (PAs). We acknowledge the Council's work in developing this consultation.

RANZCP supports the Council of Medical Colleges' (CMC) position that existing regulated health professions can perform all tasks that PAs would perform, and we advocate for investing in locally trained workforces, including expanded psychiatric training. We oppose the regulation of PAs in Aotearoa New Zealand.

However, if regulation proceeds, we have critical concerns regarding patient safety, cultural safety, adequacy of supervision, and impact on the mental health workforce. Tū Te Akaaka Roa, RANZCP's New Zealand committee, is committed to supporting this kaupapa long-term to ensure that any PA role introduced into our health system benefits our communities and is grounded in evidence-based best practice that honours Te Tiriti o Waitangi.

This letter draws on the CMC's February 2026 submission to MCNZ, available research evidence, and our specialist expertise in mental health service delivery to outline specific risks and necessary safeguards for mental health contexts. The CMC submission reinforces our concerns, noting that the evidence base for PA efficacy remains limited, that PAs are untested in New Zealand, and that acute mental health and after-hours care present heightened risks.

ALIGNMENT WITH CMC POSITION

RANZCP endorses the Council of Medical Colleges' position statement and emphasises the following in mental health contexts:

The CMC's submission highlights that the evidence base for Physician Associate effectiveness remains thin, particularly in Aotearoa New Zealand, where PAs have not yet practised. The UK experience, which provides the closest comparator, raises significant concerns. A 2024 quantitative study (King & Helps, BMJ Open) comparing PAs with foundation year 1 doctors in an English emergency department found that, after adjustment, wait times to consultation were similar, but patients seen by PAs had a significantly longer length of stay (52 minutes longer). Notably, PAs had a significantly higher proportion of mental health presentations than junior doctors (4.3% vs 2.6%), despite lacking the

legislative authority, prescribing rights, or specialist training to manage these presentations safely.

The CMC submission notes that acute mental health and after-hours care present risks, as workers in these environments are often the only practitioners a patient will see, and these are areas of high patient demand and acute need. We note too that the CMC's member colleges raised concerns that the introduction of PAs may lead to further fragmentation of patient care and information being missed at the point of diagnosis – a risk that is particularly acute in mental health, where comprehensive assessment and continuity of care are essential.

Key position points:

- We advocate for a clear, definitive scope of practice that reflects competency. Mental health requires specialised training in mental health and psychiatry. PAs must be explicitly excluded from Mental Health Act assessments, independent psychiatric diagnosis, crisis assessments, and treatment decisions.
- Cultural competency isn't achieved through a single training session. It demands ongoing learning, regular competency assessments, and self-reflection. A deep understanding of Te Tiriti and ongoing accountability are essential for working in culturally appropriate ways. This also includes systemic measures to reduce the 'cultural loading' burden on junior doctors and Māori health workers.
- Clear roles are essential to prevent confusion. We endorse using the term "Clinical Assistant" (an RNZCGP/RACP position) to help minimise patient misunderstanding, which is particularly important in mental health, where trust is fundamental.
- PAs must work in fully functional, multidisciplinary teams. Team-based practice is required to ensure whai ora safety. PAs must never be the sole clinician for mental health assessment. Require in-person, continuous supervision by vocationally registered psychiatrists. No remote supervision.
- PAs should not be in urgent care: Support CMC position. Mental health presentations in these settings require skilled clinical judgment. PAs should not assess undifferentiated mental health presentations. The CMC submission explicitly states that PAs should not practise in urgent care or general practice settings, and that regulation should not permit PAs to work in situations where they are the only practitioner a patient may see. This aligns with our view that PAs should initially be deployed only in well-resourced, multi-disciplinary secondary care teams with strong supervision capacity.
- Prescribing within a tight scope: Psychopharmacology requires extensive specialised training; we vehemently warn against all forms of independent psychiatric prescribing.
- Regular cultural competency training: Support CMC requirement but emphasise the need for competency-based (not knowledge-based) assessment aligned with WAI 2575 findings.
- Multidisciplinary supervision and peer reflection sessions are mandated. Continuous support from supervisors and time for reflection and peer review are essential to fostering best practices and continuous learning.

MENTAL HEALTH-SPECIFIC CONCERNS

- **Mental Health Act Incompatibility:** The Act specifies roles for "medical practitioners" and "psychiatrists." With an impending change to this law, we need to make clear that

PAs must be explicitly excluded from compulsory assessment/treatment decisions, from providing certificates required under the Act, and from serving as a responsible clinician.

- **Supervision Inadequacy:** Mental health workforce critically stretched. Psychiatry recently secured an increase from 44 to 64 training positions. PA introduction risks: diverting supervision from trainees, reducing registrar training placements or opportunities, and creating medico-legal risks if supervision drifts to junior doctors. Time-based requirements without competency benchmarks are insufficient.
- **Training Gaps:** No NZ PA training programme exists. Overseas-trained PAs will have minimal psychiatric content, no Mental Health Act knowledge, and no understanding of the cultural context in Aotearoa.
- **Proposed credentialling is time-based not competency-based.** The CMC submission notes that the scope of PA work is insufficiently defined and that tighter language is needed to clarify PAs' roles in diagnosis, delegated prescribing, and their vocational practice. A 2014 UK census of PAs in emergency medicine (Ritsema, Clinical Medicine) found that while 47.1% of PAs reported regularly performing psychiatric assessments, this was based on short generalist training with no specialist psychiatric content – underscoring the gap between what PAs do in practice and their actual competence in mental health. The CMC's position that progression from provisional to full registration should be competency-based rather than time-based is particularly important for mental health, where the consequences of inadequate assessment can be severe. International evidence also shows that, even in the United States, where PAs have been established for over 50 years, fewer than 1% of PA graduates pursue postgraduate specialty training programmes (Kidd et al., BMC Medical Education, 2021), highlighting the limited depth of specialist preparation available.
- **Cultural Safety Accountability:** WAI 2575 identified systemic cultural safety failures in New Zealand health care provision. Introducing overseas-trained PAs without robust competency assessment, ongoing accountability, and clear remediation mechanisms risks compounding these failures. Burden may inappropriately fall on Māori health workers or junior doctors, and most certainly impact tāngata whai ora Māori who already experience discrimination and unequal care in the health system today.
- **Workforce Diversion:** Queensland evidence shows that PA promotion with high salaries/short training reduced medical trainee applications, which is of particular concern for RANZCP, which is already experiencing a workforce shortage.
- **Investment in locally trained workforces:** We believe resources are better invested in expanded psychiatry training, mental health nurse practitioners, clinical psychologists, peer workforce, and kaupapa Māori services. Aotearoa New Zealand should be investing in growing a health workforce grounded in NZ tikanga and responsive to the needs of our communities, rather than outsourcing clinical roles to overseas-trained PAs from the UK and USA who lack understanding of Te Tiriti o Waitangi, te ao Māori, and the unique cultural contexts of mental health care in this country. The CMC submission reinforces this concern, noting the serious implications of a workforce that is solely overseas-trained and unlikely to have had experience caring for Māori and Pacific patients. We need investment in locally trained workforces – including expanded psychiatry training places, Māori and Pacific health workforce development, mental health nurse practitioners, clinical psychologists, and the peer support workforce – that would deliver more sustainable, culturally safe, and effective mental health services.
- **Clinical Governance Ambiguity:** Unclear who bears legal/clinical responsibility when PAs make psychiatric assessment errors, or patients come to harm through their care. Mental health decisions have profound consequences - accountability must be explicit.
- **Patient Confusion and Safety:** A previous NZ pilot found that clinicians misidentified PAs as doctors, leading to diagnostic errors. In mental health, where the therapeutic

relationship is foundational, role clarity is essential. We, along with other CMC member colleges, share a grave concern that the term "physician" in the title will create confusion for patients and dilute the public expectations of us and the care they receive. As an alternative, we prefer "clinical assistant". CMC members also raised concerns that differences in training and clinical experience may influence thresholds for investigation and referral, presenting risks of over-treatment and over-referral. In mental health, where nuanced clinical judgment is critical for distinguishing between presentations that require immediate intervention and those that do not, these risks are amplified.

KEY RECOMMENDATIONS

- **Scope:** Ensure a narrow, prescriptive scope with explicit mental health exclusions; no Mental Health Act involvement; no undifferentiated presentations; no urgent care/general practice, mandating multi-disciplinary team roles.
- **Supervision:** In-person, continuous supervision by vocationally registered psychiatrists; no remote supervision for mental health; define workload thresholds; prohibit delegation to junior doctors; prioritise trainee supervision.
- **Cultural Safety:** Competency-based assessment; Te Tiriti obligations demonstrated; mandatory NZ-specific orientation; ongoing accountability mechanisms; align with psychiatry trainee standards.
- **Training/Credentialling:** Competency-based (not time-based); NZ-specific orientation including Mental Health Act; demonstrated psychiatric triage/risk assessment competence; clear definition of "contribute to diagnosis."
- **Governance:** Clear legal/clinical accountability; mandatory (not advisory) scope compliance with enforcement; team-based practice only, never sole clinician.
- **Terminology:** Adopt "Clinical Assistant" to reduce patient confusion.
- **Prescribing:** Within a tightly defined scope (CMC position); no independent psychiatric prescribing.
- **Evaluation:** Independent evaluation before expansion; secondary care only as the initial environment, not community/primary care mental health.

CONCLUSION

Mental health assessment requires specialised psychiatric training, deep cultural competence, and understanding of New Zealand's unique and evolving legislative frameworks. Risks to patient safety, training quality, cultural safety, and health equity are too significant to proceed without robust safeguards. RANZCP urges MCNZ to implement CMC requirements with particular attention to mental health-specific concerns: explicit scope exclusions, adequate supervision, competency-based cultural safety, and protection of psychiatry training pathways. Investment should prioritise locally trained workforces that reflect communities served and honour Te Tiriti obligations.

The available evidence from the UK – the closest comparator jurisdiction – does not demonstrate that PAs deliver equivalent outcomes to doctors, and there is no evidence at all for PA efficacy in mental health settings in New Zealand. The CMC's February 2026 submission supports a slow and cautious approach that incorporates careful evaluation and assessment. We strongly endorse this position. Any expansion of Physician Associate roles into mental health must be preceded by independent evaluation in well-supported secondary care environments, with clear evidence of safety and effectiveness before broader deployment is considered.

Fundamentally, Aotearoa New Zealand's mental health workforce should be built on investment in locally trained professionals grounded in tikanga, te ao Māori, and the lived realities of our communities – not on outsourcing clinical roles to overseas-trained practitioners who lack this foundation.

We welcome the opportunity to discuss these concerns further with the Medical Council.

Nāku noa, nā

Dr Hiran Thabrew
Chair of Tū Te Akaaka Roa
Royal Australian and New Zealand College of Psychiatrists

REFERENCES

For your reference, key evidence sources are listed below:

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