Supporting regional, rural and remote psychiatry training

Discussion Paper

The Royal Australian and New Zealand College of Psychiatrists

October 2020

AHA Australian Healthcare Associates
Australia's largest health & human services consulting firm

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Abbreviations

Term	Definition
ACRRM	Australian College of Rural and Remote Medicine
AHA	Australian Healthcare Associates
ASGS	Australian Standard Geographic System
FEC	Formal Education Course
FTE	Full time equivalent
HWA	Health Workforce Australia
IMGs	International Medical Graduates
IRTP	Integrated Rural Training Pipeline
MVTP	Military Veterans Training Program
MHA	Mental Health Act
NRGP	National Rural Generalist Pathway
PWDG	Psychiatry Workforce Development Grants
RA	Remoteness Areas
RACGP	The Royal Australian College of General Practitioners
RANZCP	The Royal Australian and New Zealand College of Psychiatrists
RCS	Rural Clinical Schools
RTH	Regional Training Hub
SIMG	Specialist International Medical Graduate
STP	Specialist Training Program
TMSD	Training More Specialist Doctors in Tasmania

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Have your say

In this paper, we use the term **'rural'** to refer to all regional, rural, and remote locations in Australia and New Zealand.

In Australia, this covers areas classified by the Australian Statistical Geography Standard - Remoteness Areas (ASGS-RA) (2016) as RA 2 - 5 locations.

In New Zealand, this applies to areas outside of major centres.

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) has engaged Australian Healthcare Associates (AHA) to undertake a scoping project to support regional, rural and remote psychiatry training.

This discussion paper:

- summarises the current state of the rural psychiatry workforce and training in Australia and New Zealand
- seeks your views on the opportunities for expanding psychiatry training in regional, rural and remote settings and the resources and support needed.

Your feedback will contribute to the development of a **Regional, Rural and Remote Blueprint** and inform advice on **strategic recommendations** for governments and planning authorities to develop dedicated and sustainable regional, rural and remote psychiatry training pathways and networks.

We are seeking feedback from rural psychiatry stakeholders, including:

- rural RANZCP Fellowship Program stakeholders such as educators, supervisors, consultants
- Trainees
- rural Fellows
- rural Specialist International Medical Graduates (SIMG)
- rural health services and Aboriginal Community Controlled Health Organisations
- relevant government departments and agencies
- education and training stakeholders such as Regional Training Hubs and Rural Clinical Schools
- rural consumer networks and other advocacy organisations.

This project provides a unique opportunity to have a say in how to increase the rural psychiatry workforce and training opportunities for regional, rural and remote communities in the future.

This paper is intended to promote active, constructive contributions from all stakeholders. We encourage you to have your say on the future of regional, rural and remote psychiatry training.

Your feedback

You can provide feedback through the following methods:

Online via a feedback form

Email
RANZCPrural@ahaconsulting.com.au

Focus groups will be held with:

- Trainees, SIMGs and members of the Psychiatry Interest Forum
- Rural educators, supervisors and consultants involved in the RANZCP Fellowship Program.

You can register your interest to participate in a focus group by completing the online registration form.

Please submit your response by **6 November 2020**.

1 Rural psychiatry workforce

1.1 Mental health in rural areas

People living in rural areas face a range of interrelated health and social issues (National Rural Health Alliance, 2017), including:

- higher prevalence of some chronic conditions and disability
- generally poorer health
- higher rates of risky drinking, smoking and illicit drug use
- fewer employment opportunities, leading to lower incomes and less financial security
- greater exposure and vulnerability to natural disasters
- higher rates of housing stress and homelessness.

The prevalence of mental illness in rural and urban areas is similar throughout Australia. However, rates of suicide and self-harm are higher in rural areas, and further increase with degree of remoteness (Harrison & Henley, 2014).

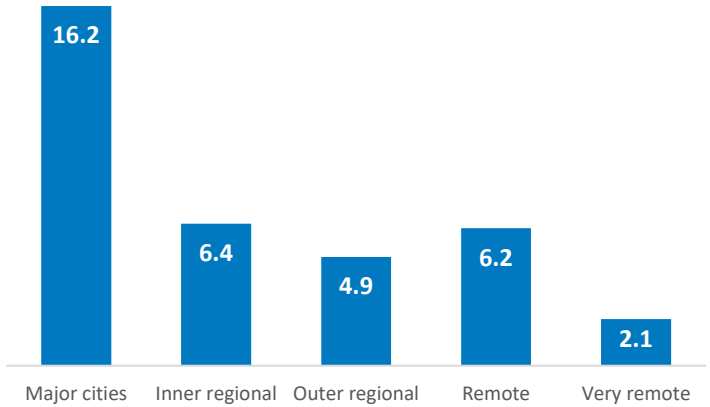
1.2 Psychiatry workforce shortages

Several factors may contribute to the comparatively poorer mental health outcomes of people in rural areas (Garvan Research Foundation, 2015; National Rural Health Alliance Inc, 2016; Rural Doctors Association of Australia, 2016). These include:

- less availability of, and access to, primary healthcare and hospital services
- limited supply of specialist professionals and mental health services, including fewer psychiatrists, psychologists and mental health nurses per head of population
- reluctance to seek help with mental health
- travelling distances
- cultural barriers
- cost of accessing services.

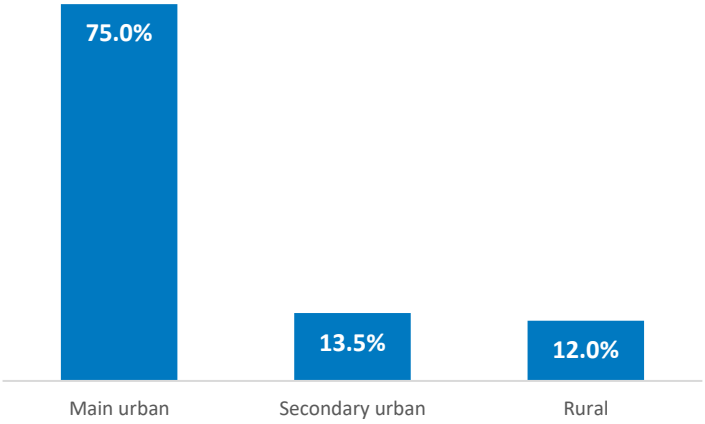
Despite the high need for mental health services in rural areas of Australia, (RANZCP n.d.), the proportion of psychiatrists is comparatively lower than in major cities. As shown in Figure 1-1, the number of full time equivalent (FTE) psychiatrists per 100,000 population is 16.1 in major cities, reducing to 6.4 in inner-regional areas and just 2.1 in very remote areas (AIHW, 2019).

Figure 1-1: Geographical distribution of the psychiatric workforce in Australia (FTE per 100,000 population)



New Zealand is also characterised by significant imbalances in the geographic distribution of health professionals, with the lowest ratios of medical practitioners to population found in rural regions in the North Island and in the West coast of the South Island (Zurn & Dumont, 2008). As shown in Figure 1-2, in New Zealand, 75% of doctors practise in main urban areas, 13.5% in 'secondary' urban areas and 12% in rural areas (Medical Council of New Zealand 2018).

Figure 1-2: Geographical distribution of medical workforce in New Zealand



Both countries rely heavily on international medical graduates to supply psychiatric services in rural and regional areas (Australian Department of Health, 2016, Medical Council of New Zealand, 2018). Specialist workforce growth rates are hampered by poor retention rates, especially among newly qualified specialists and SIMGs (Association of Salaried Medical Specialists, 2019).

1.3 Working in rural locations

1.3.1 Benefits

Research has identified that there can be considerable benefits to working and training in rural locations, including:

- development of valuable insight into cross-cultural service delivery
- a broad scope of practice and opportunities to gain skills and knowledge in other areas of health care
- development of clinical skills, patient care and communication skills
- opportunity to improve skills in leadership and management and health advocacy
- greater autonomy than in a metropolitan setting
- increased opportunity to collaborate with other health professionals and interact with diverse population groups (Humphreys et al., 2010; RANZCP 2019 – STP Trainee Survey).

Rural psychiatrists often fulfil multiple roles, such as training multidisciplinary staff, providing mental health leadership, helping with mental health promotion and prevention activities and community activities, among others. This range of responsibilities presents opportunities but sometimes can also place a burden upon the individual (Lau et al., 2002).

1.3.2 Barriers

Key identified barriers in growing the rural psychiatry workforce include:

- lack of psychiatry positions or workforce available in rural areas, particularly in smaller rural locations
- lack of recruitment and retention incentives
- the lack of career pathways for rural psychiatrists
- personal and professional challenges affecting clinicians' decisions to live and practice in rural communities
- a medical education and training system that is largely located in urban areas (Hogenbirk et al., 2015, Lau et al., 2002).

1.3.3 Challenges

In addition, research has also highlighted that there can be challenges in working and training in some rural settings, particularly smaller settings. These include:

- access to supervision, professional development, mentoring and networking, which may lead to professional isolation and a lack of collegiate support
- managing clinical workloads and training, with higher workloads for some trainees as a result of high ratios of on-call and weekend rostering
- availability of some sub-speciality rotations, potentially those requiring a return to a metropolitan setting to facilitate progression through the course
- trainee exam preparation and support
- attending conferences, courses and other professional development events (Kumar et al., 2002) (RANZCP 2019 – STP Trainee Survey; (Australian Department of Health, 2016); AMA, 2020).

Medical practitioners also cite personal and family commitments, such as children's schooling needs or partner employment opportunities, as a common reason for leaving (or not going to) rural areas (Eagles, 1996). However, psychiatry is reported as being more compatible with normal family life than other medical disciplines and as such is arguably less of a barrier to practicing in rural areas (Perkins et al., 2007).

1.4 Addressing workforce shortages

Medical graduates who practise rurally in their early career (1 to 9 years post-graduation) are likely to have previous connections to rural areas, through either their basic medical training, their schooling, or both (McGrail, et al., 2018).

Rural origin and the early aspirations at the start of students' medical training are better predictors of expressed intention to take up rural practice than rural clinical placements (Jones et al., 2014). Furthermore, evidence shows that trainees who spend *lengthy* periods both training and *living* in a rural area are more likely to stay following achievement of Fellowship (Smith et al., 2006).

1.4.1 Rural training initiatives

The Australian National Medical Workforce strategy, currently in development, seeks (among other objectives) to 'reduce geographic maldistribution of medical professionals to improve access to high quality care for all' (Australian Department of Health, 2020).

For more the 20 years, the Australian Government has used education and training programs to influence health workforce distribution. This has led to substantial investment in rural medical education and training initiatives. A range of initiatives to grow the rural medical workforce and increase training opportunities are discussed below.

Current Australian initiatives

Rural Clinical Schools

The **Rural Clinical Schools** (RCS) Program was launched in 2000 to enable medical students to undertake extended blocks of their clinical training in regional areas. Under the program, rural clinical schools are tasked with delivering significant components of the medical curriculum, with students undertaking a year or more of their medical training in a rural location (Urbis, 2008).

> Evidence shows that trainees who spend lengthy periods both training and living in a rural area are more likely to stay following graduation.

The RCS Program has increased opportunities for medical students to have long-term clinical placements in rural health services. (Greenhill et al., 2015).

Specialist International Medical Graduates

Specialist International Medical Graduates (SIMGs) are recruited and incentivised to work in rural areas by the offer of permanent Australian residency or Australian citizenship. There are currently 210 active SIMGs (205 in Australia and 5 in New Zealand).

Increased funding for vocational training

In 2016, the Australian Government provided additional funding for vocational training places, resulting in 1,500 people undertaking a traineeship in Australia in 2016 – an increase of 21% since 2013 (Australian Department of Health, 2017).

Regional Training Hubs

The Australian Government has established 26 Regional Training Hubs, supported by 15 universities (Australian Department of Health, 2019). These Hubs are established at Rural Health Multidisciplinary Training Program locations and are dedicated to integrating medical training opportunities for medical students and junior doctors within their catchment area.

Specialist Training Program

The Australian Government funds 202 FTE psychiatry STP posts, with trainees working across more than 550 locations. These are provided in addition to posts funded by the state government and private organisations and form part of the RANZCP Fellowship Training Program (see Section 2.1).

National Rural Generalist Pathway

A Rural Generalist is a medical practitioner who trains to meet the diverse range of healthcare needs of people living in rural and remote areas. They provide general practice, emergency care and other components of medical specialist care, including mental health care (National Rural Health Commissioner, 2018).

The National Rural Generalist Pathway (NRGP) is being rolled out to address the inequity to health services faced by those living in rural and remote areas. In August 2020, the Australian Government announced an additional $27 million investment to establish Rural Coordination Units to support junior doctors navigating the training pipeline. Under the NRGP, training is to be delivered by the Australian College of Rural and Remote Medicine (ACRRM) and the Royal Australian College of General Practitioners (RACGP).

Ongoing need

Despite these initiatives, there continues to be an identified need to deliver more training in rural areas (Australian Department of Health, 2016).

Consultation questions

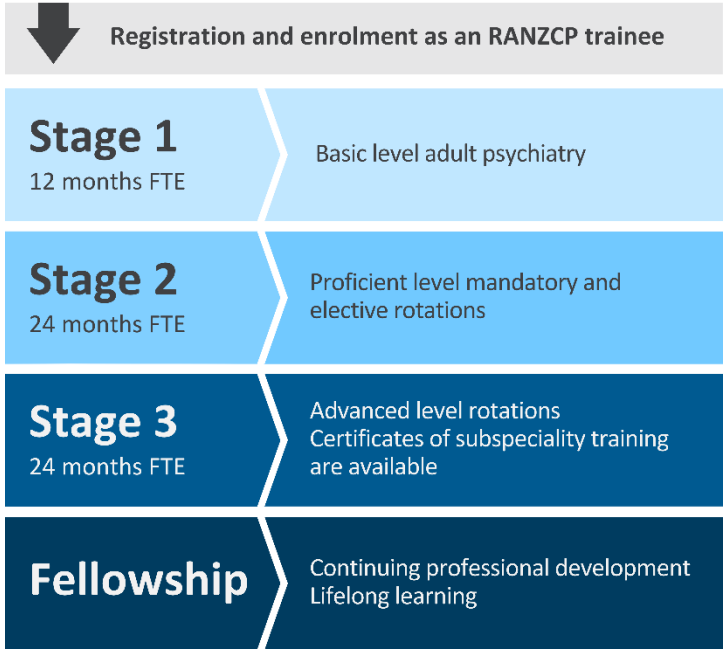
1. What do you think are the key factors driving *workforce shortages* in rural psychiatry?
2. What are the key attractors to *recruiting* trainee psychiatrists in rural locations?
3. What are the key attractors to *retaining* trainee psychiatrists in rural locations?
4. What do you believe are the major *benefits* of psychiatry training and working in rural and remote locations?
5. What do you believe are the major *challenges* of psychiatry training and working in rural and remote locations?

2 Operation and delivery of rural psychiatry training

2.1 RANZCP Fellowship Program

The RANZCP Fellowship Program involves a minimum of 60 months (FTE) of training to enable a trainee to practice as a psychiatrist in Australia or New Zealand. As shown in Figure 2-1, training is undertaken in three stages (RANZCP n.d.), culminating in Fellowship and continual professional development.

Figure 2-1: Overview of the RANZCP Fellowship Program



In Australia, training is delivered through RANZCP-administered state and territory schemes, based at health service locations in each state and territory.

In New Zealand, RANZCP-administered training schemes are run in major centres across the country (Auckland, Hamilton, Wellington, Christchurch, and Dunedin), with occasional training in other areas overseen by a major centre (Every-Palmer et al., 2020).

Each RANZCP Branch Training Committee is responsible for overseeing the delivery of the RANZCP Fellowship Program. The key training components include:

- 6-monthly mandatory and elective rotations which take place in either public or private health services
- completion of a RANZCP-accredited Formal Education Course (FEC) component.

FECs are delivered differently in each jurisdiction and may include a master's degree in psychiatry from an accredited university or a tailored education program delivered at health service sites and consistent with the RANZCP curriculum.

FECs are delivered in multiple formats, including classroom training, online courses, webinars and workshops.

2.1.1 Accreditation

All sites providing training must meet the RANZCP Fellowship Program accreditation standards. The RANZCP accredits training programs across five standards.

RANZCP training accreditation standards

STANDARD 1 – Training Program Co-ordination

1.1 Each training program has a Branch Training Committee or, in New Zealand, the New Zealand Training Committee

1.2 Each program has a Director of Training formally recognised by the Committee for Training

1.3 There are adequate administrative support and resourcing appropriate to the needs of the training program.

STANDARD 2 – Provision of Required Training Experiences

2.1 A RANZCP-accredited Formal Educational Course is available to trainees

2.2 The training program has an adequate capacity to train and provide a range of experiences

2.3 There are adequate processes to ensure that training requirements are met within rotations.

STANDARD 3 – Selection, Monitoring and Support of Trainees

3.1 There are adequate processes for the selection of trainees into the training program

3.2 There are adequate processes to monitor and manage the number of trainees within the program and an allocation process to ensure that placements are organised so that this Standard is met

3.3 There are adequate processes within the training program to support trainees

3.4 There are adequate processes to monitor the progress of trainees within the training program

3.5 There are robust processes within the training program to assess, monitor, promote and deliver trainee welfare and well-being in the workplace

3.6 RANZCP policies regarding trainee safety are followed within the employing service and the post.

STANDARD 4 – Standard of Training

4.1 There are adequate processes for quality assurance and evaluation of the training program, so that a good standard of training is provided

4.2 A good standard of training is provided at all training posts within the program

4.3 There are adequate processes to monitor the standard of the training experience in all posts within the training program

4.4 There are adequate processes to accredit/dis-accredit training posts within the program.

STANDARD 5 – Supervisors

5.1 There is adequate provision of supervision within the training program

5.2 There are good standards of training for supervisors within the training program

5.3 There are adequate processes to monitor the performance of supervisors within the training program

5.4 There are adequate processes to support supervisors within the training program.

2.1.2 Number of trainees

In 2019, the RANZCP had 1,802 trainees (1,558 in Australia, 210 in New Zealand and 34 on leave and not currently affiliated with a program). A total of 295 trainees commenced the RANZCP Fellowship Program (RANZCP, 2019).

Table 2-1: Trainees by location (as of 19 March 2020)

Location	Total	Stage 1	Stage 2	Stage 3	Intake 2019
ACT	**42**	9	20	13	9
NSW	**478**	119	165	194	77
NT	**21**	11	6	4	5
Qld	**351**	95	128	128	60
SA	**100**	26	35	39	19
Tas	**20**	5	10	5	3
Vic	**423**	99	149	175	72
WA	**123**	26	44	53	19
Australia	**1,558**	390	557	611	264
New Zealand	**210**	52	83	75	31
Not part of a local program	**34**	6	18	10	-
Overall	**1,802**	**448**	**658**	**696**	**295**

2.1.3 Rural trainee psychiatrists

Remoteness area data is available for Australian trainees placed in locations during rotation 1, 2020. This indicates that of the 1,366 Australian trainees, 86% were located in major cities (RA1) with the remaining 14% situated in regional, rural and remote locations (RA2-4). No trainees were placed in very remote locations (RA5).

Table 2-2: Trainees by remoteness area

Location	Total	Major cities RA1	Inner Regional RA2	Outer Regional RA3	Remote RA4
ACT	**36**	36	0	0	0
NSW	**415**	371	42	2	0
NT	**22**	0	0	18	4
Qld	**304**	233	33	38	0
SA	**95**	91	3	1	0
Tas	**22**	0	22	0	0
Vic	**366**	342	23	1	0
WA	**106**	99	1	2	4
Australia	**1,366**	**1,172**	**124**	**62**	**8**
Percent	**100%**	**86%**	**9%**	**5%**	**1%**

Source: RANZCP 'InTrain' administration system. Data for rotation 1, 2020 was extracted on 30 September 2020. Note: Percent totals may vary due to rounding.

2.1.4 Specialist International Medical Graduates (SIMGs)

International medical graduates (IMGs) are medical graduates who have achieved their basic medical qualifications in overseas locations. IMGs, make up around 25% of the total medical workforce in Australia (AIHW, 2011), and an even higher proportion of the rural workforce. These clinicians enter Australia under a range of employment arrangements and visa categories (Mason, 2013).

In 2019, a total of 71 IMGs with specialist qualifications (SIMGs) were accepted to join a RANZCP pathway to Fellowship (see Table 2-3). These SIMGs are employed predominantly in Victoria, Queensland and New South Wales.

SIMGs seeking registration to practice as a psychiatrist in Australia or New Zealand must apply directly to the RANZCP to have their existing training and experience assessed for specialist recognition of equivalence to Australian/New Zealand training standards. Depending on the outcome of the assessment process, SIMGs will be provided with one of three possible outcomes: Substantially Comparable, Partially Comparable or Not Comparable (RANZCP, 2019).

Health Workforce Australia (HWA) projections suggest that current workforce shortages in psychiatry (along with general practice, ophthalmology, radiology, obstetrics, and gynaecology) will continue into the future. Australia will, therefore, remain highly reliant on IMGs and SIMGs for rural medical service capacity.

Because SIMGs have not trained in Australia and do not have the professional networks that training in Australia can provide, SIMGs may be more likely to experience professional and social isolation than their Australian-trained peers. Cultural and language barriers may further increase professional and community isolation (RANZCP, 2019)

Without specific support, SIMGs may also face additional challenges due to limited knowledge of the context of the Australian health and community care systems. These issues are likely to be amplified for those living and practicing in rural areas.

Given the critical and ongoing importance of IMGs and SIMGs to Australia's rural medical workforce, it is vital that appropriate professional and social support and training pathways are in place (O'Sullivan et al., 2019).

Table 2-3: Specialist Pathway SIMG Assessments by employer state (January to December 2019)

Employer state	Total	Partially	Substantially
ACT	**-**	-	-
NSW	**14**	8	6
NT	**1**	-	1
Qld	**25**	12	13
SA	**-**	-	-
Tas	**-**	-	-
Vic	**29**	19	10
WA	**2**	-	2
Australia	**71**	39	32
New Zealand	**-**	-	-
Overall	**71**	**39**	**32**

2.2 Working and training in rural locations

In 2018, the RANZCP conducted a survey of trainees participating in the RANZCP Fellowship Program at 34 Integrated Rural Training Pipeline (IRTP) posts across Australia. Nineteen trainees responded to the survey (RANZCP 2018 STP/IRTP trainee survey). Given the small number of survey respondents, the results should be interpreted with caution.

The survey found that:

- 28 posts offered 'whole of pathway' training (stages 1 to 3), and 6 posts offered stage 3 training only
- 62% of respondents rated the overall experience of their last 6 months in an IRTP post as positive or very positive
- The majority of respondents (57%) had not lived in a regional, rural or remote setting at any time during their childhood, while 43% had spent one or more years growing up in a regional, rural or remote area
- 14% of respondents had not experienced working in a regional, rural or remote area prior to taking the IRTP position
- The key attractors to an IRTP post were 'working in a rural location' (77%) and 'working in a particular facility' (69%)
- 29% of respondents completed their primary medical degree outside of Australia
- 33% of respondents had been located at the primary site for 1 or 2 rotations; 13% had been at the primary site for 4 rotations; and 7% for 3, 5 and 8 rotations
- 23% of respondents reported issues including inadequate supervision and missed opportunities.

2.2.1 Technology

New communication technologies continue to emerge and provide new and useful ways to approach patient consultation, as well as training and supervision for rural psychiatrists.

Service delivery

Studies have demonstrated that telepsychiatry can be as effective as face-to-face consultations in improving health outcomes (Garcia, 2010).

The RANZCP supports the use of telepsychiatry to augment the delivery of local mental health services and notes its practical application in reaching people in rural and remote areas. This has been particularly evident through the COVID-19 pandemic. However, the RANZCP cautions that telepsychiatry should not be considered a stand-alone service. Rather, it requires a planned and coordinated approach built on a foundation of local services and providers.

Training

Psychiatrists in rural and remote areas are increasingly using the internet to access supervision, training and professional development in other areas.

COVID-19 travel restrictions may also influence the take-up of online support for rural psychiatrists, including remote supervision models, expansion of webinars, online networking and peer support groups, and other online learning opportunities.

Consultation questions

6. Are there any training standards or Fellowship regulations, policies or procedures that are difficult to meet because of training/working in rural locations? If so, what are these? Why is this the case?
7. Are there opportunities missed by training in psychiatry in rural locations? If so, what are these?
8. How could technology improve or enhance psychiatry training in rural locations?
9. Are there different modes of learning (such as webinars, remote supervision, etc.) that could be used to meet training requirements?
10. Is additional exam support needed for rural trainees? If so, what type of support is needed?
11. Are there other challenges in delivering or participating in a rural program? If so, what are these challenges? How could these challenges be addressed?

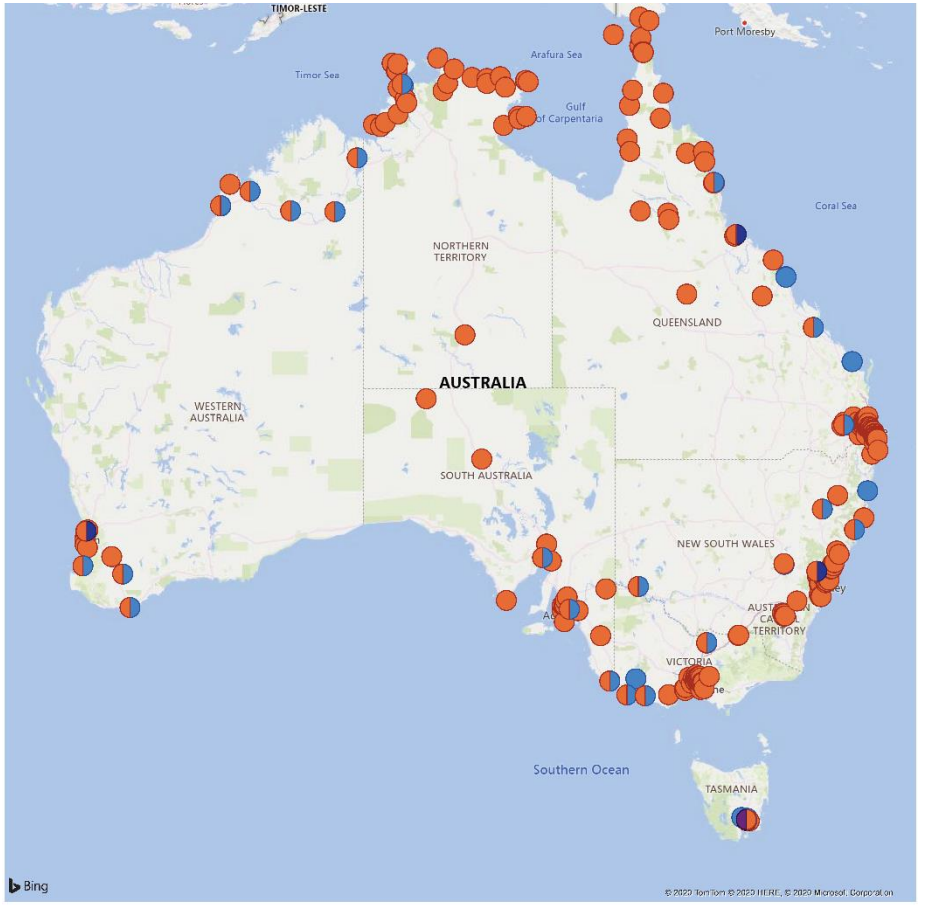
3 Expansion and creation of new rural training opportunities

3.1 Current training posts

Figure 3-1 maps the location of current RANZCP training posts in Australia for the following programs:

- Specialist Training Program (STP)
- Integrated Rural Training Pipeline (IRTP)
- Military and Veterans Psychiatry Training Pilot (MVP)
- Training More Specialist Doctors in Tasmania (TMDS).

Figure 3-1:Specialist Training Program trainees in Australia 2020



3.2 Conditions needed for expanding training opportunities

The RANZCP is interested in understanding where rural psychiatry training opportunities could be expanded. This includes:

- expanding training posts in existing training locations
- developing posts in new training locations
- developing new training posts in specific sub-specialties.

To create a new post, the RANZCP requires that posts must:

- meet RANZCP standards for training posts
- be provided as part of a RANZCP-accredited training program that meets Training Program Accreditation
- involve an agreement by a public health service to employ a trainee.

A private health service may also have a post accredited and employ a trainee.

The flow-on effects for the psychiatry workforce of creating additional training posts require careful consideration of the supervision and administration requirements.

Trainees currently face delays in moving through rotations, particularly mandatory Child and Adolescent Psychiatry and Consultation-Liaison rotations. Given the RANZCP Fellowship Program is competency-based, other settings or modes of learning could be explored to fulfil these rotations and minimise the bottlenecks (Australian Department of Health, 2016).

Consultation questions

12. What *barriers* exist to establishing new rural psychiatry training opportunities in your state, territory or region?
13. In your state, territory or region, what do you see as the *bottlenecks* to expanding training in rural locations (e.g. lack of particular rotations; insufficient supervision capacity to support training; funding, etc.)?
14. Are you aware of locations in your state, territory or region where additional posts *could* be created or expanded in the next 3 years? If so, where?
15. Are you aware of locations in your state, territory or region where additional posts *should* be created or expanded in the next 3 years? If so, where?
16. Are you aware of locations in your state, territory or region where *sub-specialty* training rotations could be created or expanded in the next 3 years? If so, where?
17. Are there different *settings* that could be used to fulfil Child and Adolescent Psychiatry, Consultation-Liaison Psychiatry and Certificate of Advanced Training rotations? If so, where could these be?

4 Resources and funding requirements

4.1.1 Current resourcing

Psychiatry training post funding comes from a variety of sources including:

- Australian and New Zealand Governments, Australian states and territories and private sector organisations to fund trainees to undergo the **RANZCP Fellowship Program**
- Australian Government Department of Health funding for the **Specialist Training Program (STP)** and the **Integrated Rural Training Pipeline (IRTP)**
- Australian Government Department of Health funding for a **pilot Military Veterans Training Program (MVP)** in five locations (including one rural location)
- Australian Government Department funding for the **Training More Specialist Doctors in Tasmania (TMSD)**.

Currently, most trainees are employed by public health services with some trainees directly employed through private hospitals or private practice.

Trainee salaries, however, vary across jurisdictions and are determined by client base. For example, Tasmania has a smaller client base and therefore lower salaries than mainland Australia, which has been identified as a factor that hinders the recruitment of psychiatrists to Tasmania. As a result, the Australian Department of Health has funded the provision of supervision as part of the TMSD.

4.1.2 Specialist and trainee incentives and support

In response to the shortage of mental health specialists in rural areas, the Australian Senate Community Affairs Reference Committee recommended that the Commonwealth Minister for Health work with Medical Colleges to develop strategies for the immediate improvement of professional supports and clinical supervision for registered health practitioners working in rural and remote locations. This includes the consideration of a form of incentive payment for supervisors to encourage a commitment to supervision and recognise the additional workload clinical supervision entails, over and above their own clinical work (Community Affairs References Committee, 2018).

The New Zealand Government has also highlighted a commitment to undertake measures to improve mental health services in rural areas (NZ Government, 2018).

Different jurisdictions take different approaches to supporting rural training and development. For example, in Victoria, the **Psychiatry Workforce Development Grants (PWDG)** were developed to support psychiatrists by facilitating participation in leadership development projects (leadership stream) and the use of digital technologies to support psychiatry training and workforce development (digital stream).

In 2019-20, digital stream grants were awarded to 3 recipients to support the:

- development of an online interactive educational resource to educate psychiatrists as to the role, purpose, functions and underpinning philosophies of the *2014 Victorian Mental Health Act* (MHA)
- development of online resources to build the knowledge and confidence of psychiatrists and psychiatry registrars to assess clients with coexisting mental health issues and gambling harms in rural and remote Victoria and provide effective treatment via telehealth
- provision of a RANZCP-accredited Leadership and Management module and leadership related mentoring to Victorian regional and rural psychiatrists and Stage 3 RANZCP trainees.

4.1.3 Coordination of rural training pathway stakeholders

There are many stakeholders with a part to play in developing the rural training pathway, including for an SIMG (May et al., 2017).

As part of this project, the RANZCP is keen to explore ways to strengthen relationships with Regional Training Hubs, rural education institutions and governments to develop rural pathways for medical students and to enable students to complete their training in rural locations.

Consultation questions

18. What are the financial, human and other resources needed to expand rural training opportunities?
19. Are there incentives or supports needed to attract and retain *psychiatrists*? If so, what is needed?
20. Are there incentives or supports needed to attract and retain *trainee psychiatrists*? If so, what is needed?
21. Are there specific incentives or supports needed for *supervisors*? If so, what is needed?
22. Are there specific incentives or supports needed for *Specialist International Medical Graduates*? If so, what is needed?
23. Are there improvements that could be made to the information on, or communication about available posts for rural trainee psychiatrists? If so, what is needed?
24. What role could Regional Training Hubs play in coordinating and supporting the development of psychiatry training opportunities and pathways in their regions?
25. Are you aware of any innovative rural medical workforce development, training programs or support models that could be examined as part of this Project? If so, what are these?

4.1.4 Conclusion

This paper outlines a range of key issues for comment and discussion. Your feedback will help improve rural psychiatry workforce and training opportunities.

Thank you for your contribution.

Other comments

26. If you wish, please provide additional comments related to this discussion paper.

5 Next steps

5.1 Have your say

We encourage you to provide feedback through one of the following methods:

Online via the online feedback form

Email RANZCPrural@ahaconsulting.com.au

Your response needs to be submitted by **6 November 2020.**

5.2 Register your interest for a Focus Group

Focus groups will be held with:

- Trainees, SIMGs and members of the Psychiatry Interest Forum
- Rural educators, supervisors and consultants involved in the RANZCP Fellowship Program.

You can register your interest to participate in a Focus Group by completing the online registration form.

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