The Royal Australian & New Zealand College of Psychiatrists

Victorian Branch

RANZCP Victorian Branch Submission

Victorian Government Ministerial Review: Victorian Public Sector Medical Staff

2023 Engage Victoria

Acknowledgement of Country

We acknowledge Aboriginal and Torres Strait Islander Peoples as the First Nations and the traditional custodians of the lands and waters now known as Australia, and Māori as tangata whenua in Aotearoa, also known as New Zealand. We recognise and value the traditional knowledge held by Aboriginal and Torres Strait Islander Peoples and Māori. We honour and respect the Elders past and present, who weave their wisdom into all realms of life – spiritual, cultural, social, emotional, and physical.

Recognition of Lived and Living Experience

We recognise those with lived and living experience of a mental health condition, including community members and RANZCP members. We affirm their ongoing contribution to the improvement of mental healthcare for all people.

About the Royal Australian and New Zealand College of Psychiatrists

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) is the peak organisation representing the medical speciality of psychiatry in Australia and New Zealand with over 7900 members; the RANZCP is responsible for training and educating psychiatrists in addition to advocating on their behalf for excellence and equity in the provision of mental healthcare.

The RANZCP Victorian Branch (the Branch) has more than 1900 members including around 1300 qualified psychiatrists and over 500 members who are training to qualify as psychiatrists. Psychiatrists have a critical role within the mental health and wellbeing system as medical specialists, including through the provision of best practice treatment, care and support, academia and research, service improvement, and clinical leadership roles.

Notes about this submission.

The recommendations contained within this submission are based on consultations with the RANZCP Victorian Branch membership and the RANZCP Victoria Branch Committee, an expert committee comprising of psychiatrists, trainees and community members with lived and living experiences of mental health challenges and recovery.

The Branch acknowledges that language and the way we use it can affect how people think about different issues. We acknowledge the need to consider the words we choose when communicating with and about people with a lived and living experiences of mental health challenges and recovery. We recognise there are a variety of terms people prefer to use, such as ‘client’, ‘consumer’, ‘patient’, ‘peer’, and ‘expert by experience’.

To discuss this document please contact: Jo Balmforth, RANZCP Victorian Branch Policy and Advocacy Advisor, ranzcp.vic@ranzcp.org

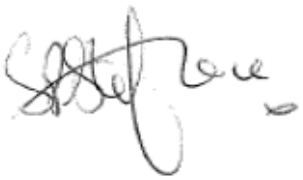
Foreword

The Royal Australian New Zealand College of Psychiatrists (RANZCP) Victorian Branch (the Branch) appreciates the opportunity to respond to the *Engage Victoria Survey* and assist in the Ministerial Review: Victorian Public Sector Medical Staff. During negotiations for the Medical Specialists and Doctors In Training Enterprise Agreements, the Australian Medical Association and the Victorian Hospitals' Industrial Association identified that numerous workplace system and employment-based matters would benefit from an in-depth Ministerial Review. The Review will be relevant to the work of psychiatrists, and psychiatrists in training.

In this submission, the Branch have responded to all the terms of reference listed in the Engage Victoria Survey. In approaching the matters and issues raised, Branch members have drawn on their knowledge and experience (best available evidence and research); and considered the role of psychiatrists in relation to each of the terms of reference. Our key recommendations will propose that workforce wellbeing, retention and service excellence can be achieved by ensuring that the system is appropriately resourced to permit sustainable workloads; and enable the development of clinical leadership that values relational, ethical and adaptive ways of working.

The Branch will also draw attention to the recommendations of the RANZCP's Rural Psychiatry Roadmap 2021-3 to highlight a number of measures, developed through consultation with regional Fellows, that will improve the recruitment and retention of psychiatrists in regional Victoria. Further to this, the Branch will outline the actions we believe will attract doctors-in-training to choose a career in psychiatry. Finally, we address opportunities to retain psychiatrists in the public sector after they complete specialist training, including the re-design of jobs that support them to work to their full scope of practice and spend more time treating patients, engage in clinical research and treatment innovation; and enable leadership development.

The Branch commends the Victorian Government's long-term vision and commitment to improving the health and wellbeing of the Victorian community, and its significant commitment to reform. The Branch further commends the leadership provided by the Victorian Department of Health (Vic DH) and the Division of Mental Health and Wellbeing. Psychiatrists are committed to advocating for improvements which will benefit the health of the Victorian community and we look forward to continuing to work collaboratively to this.



A/Prof Simon Stafrace
Chair, RANZCP Victorian Branch

ToR 1: Recruitment, retention, supply of doctors (including local graduates and International Medical Graduates), training, training pathways and coordination of doctors across the public health sector recognising that this is a particular issue in regional and rural settings and hard to fill specialities.

i. Equitable access to medical staff to meet the needs of the Victorian community.

The Branch supports equitable funding, distribution and resourcing of medical staff for public health services commensurate with epidemiological and demographic need of the Victorian community. The Branch would further emphasise that Victorians must have access to specialist services of the same quality, regardless of their location or circumstance. It is therefore considered essential for regional communities to be provided with clear pathways to access the health services they need, including specialist services. The growth and sustainability of the medical workforce, including psychiatrists, within the public health system is crucial to ensuring equitable access to best available treatment care and support and by extension, the health and wellbeing of the Victorian community.

Data from the Australian Institute of Health and Welfare indicate that in 2021 there were 3960 psychiatrists employed in Australia, including 17 psychiatrists per 100,000 population in Victoria in 2021. The critical shortage and maldistribution of psychiatrists employed per 1000,000 population is evident in metropolitan and regional areas of Victoria with major cities recorded at 19.9, inner regional at 0.1, outer regional at 2.0 (remote and very remote n/a).

ii. Workforce wellbeing, leadership and organisational culture.

The Branch agrees that workforce wellbeing is tied implicitly to issues of workforce retention and perceived workplace attractiveness. Services must be well resourced with the capacity to support the wellbeing needs of their workforce in real-time – as well as respond flexibly as workforce needs change over time. Important considerations for ensuring workforce wellbeing includes:

- resources to ensure that clinical and service excellence and safety for all can be achieved;
- leadership that is ethical, adaptive and relational and can enable the workforce to develop its capabilities and deal with challenges, threats and opportunities; and
- workplace attitudes and behaviours that allow for the participation of workforce and service users in setting the priorities and values of services and contributing to their design and evaluation.

The Branch agrees that a core part of addressing workforce staffing levels is to ensure that the health and wellbeing of workers is prioritised by monitoring staffing levels and screening for burnout in the workplace. Follow up of measurement and review with clear actions will help ensure that workforce wellbeing is not just noted, but also improved. Embedding workforce wellbeing measurement and accountability mechanisms at the service level is essential as the benefits of this will translate into positive outcomes for Service users. Activity must occur in alignment with state and federal mandates, especially where employers have a legislated duty of care to provide environments conducive to mental and physical wellbeing.

The Branch recommends priority for leadership development as a pathway to workforce wellbeing, workforce retention and service excellence. The Branch has been commissioned by the Vic DH to develop a Leadership Framework for Psychiatrists (the Framework). The Framework was developed in collaboration with people with lived experience of mental illness and psychological distress. It highlights ethical, systemic/adaptive and relational perspectives that emphasise the centrality of service users and collaborative practice to the task of delivering a contemporary mental health system. This is an example of an initiative that with further refinement could provide a template for the development and support of future clinical leaders across regional and metropolitan Victoria.

iii. Supply: Rural, Regional and Outer metropolitan

Rural and regional communities 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. The Branch agrees, workforce attraction, training and retention in rural, regional and outer metropolitan areas is a key issue affecting equity across Victorian health services, including in mental health.

In comparison with metropolitan areas there are fewer psychiatrists and other medical specialists in rural Australia relative to the population. Among psychiatrists, only one-third of the rural workforce live in rural Australia – the rest travel in from cities or use telepsychiatry. Rural areas are often reliant on Specialist International Medical Graduates (SIMGs) and other trainees to provide services, and these groups are subject to greater challenges with respect to access to professional training and support.

The Branch agrees there is a need to develop and support a model that attracts specialist medical doctors including psychiatrists into rural, regional and outer metropolitan practices. This would include improving workplace conditions and developing solutions to address issues such as professional isolation. The RANZCP produced a report titled Rural Psychiatry Roadmap 2021-31 (the Report) which highlights investment in rural training as a key to producing positive outcomes in the quality of the training and trainee results and ultimately - in positive mental health and wellbeing outcomes for rural and regional communities. The Report recommends developing a range of substantial and competitive incentives such as:

- improved remuneration
- resourcing of dedicated education and support facilities
- improved access to locum assistance allowing professional and personal leave.
- support intra- and inter-jurisdictional rural networks to expand training opportunities.
- transition to Practice programs to improve retention of Fellows in areas of training.
- facilitate community integration by creating information packages for prospective and new employees regards local services and amenities, including for those with caring responsibilities.
- support for short and long-term accommodation options.

The Branch notes the difficulty in attracting and recruiting psychiatrists to public inpatient units, which is a greater challenge the more rural and remote the service is situated. In all services, shortages in staffing within inpatient units are significantly felt during on-call periods, afterhours, and weekends. During this time the psychiatry workforce is minimally staffed, and allied health staff are not available to provide the same level of support. We suggest assessment of workload including benchmarking for psychiatrists, trainees, and junior medical officers.

As a matter of urgency, the Branch further recommends funding technological improvements and access to equipment which would assist in creating better linkages between metropolitan and rural services to enable patient access to specialist services, as well as teaching and training via video-link.

iv. Training and Training Pathways

Removing barriers to workforce growth through training requires coordinated, flexible and sustained funding for trainee positions plus funding for commensurate supervision and support and appropriate administrative support. The Branch would emphasise **an urgent need to support health services through the provision of assured funding models that enable adequate placements with appropriate support.**

Additional consideration is needed to link funding models and health service requirements to meet accreditation standards such as assurance that the availability of workforce meets clinical demand.

Within the psychiatry training model, the offices of the Director of Training (DoT) are the cornerstone of navigating and supporting specialist training which includes trainees' wellbeing, training standards and progression, and workplace support of training. Demands on these offices have increased, as Victoria continues to see a growth in psychiatrists undertaking training. This includes a growth in first-year intake by 65% in the past 5 years. The roles proved critical in providing support to trainees during the Covid-19 pandemic and in minimising the potential disruption to progression to Fellowship that may have occurred because of the public health emergency. **The Branch notes it imperative that these positions continue to be funded and that growth accompany any increase in trainee numbers**.

Any expansion of training opportunities is heavily reliant on the availability of supervisors available to meet the requirements of RANZCP-accredited training. This is exacerbated in rural locations where the supervisor workforce is already overtaxed by high service demands. Other factors that negatively impact on the availability and capacity of supervisors in rural settings include fly-in fly-out models of service delivery; lack of support for overstretched rural psychiatrists; and a reliance on SIMGs who are often unfamiliar with RANZCP Fellowship supervision requirements. Consideration must be given to ensuring that growing registrar positions are appropriately resourced to provide the clinical supervision required for Fellowship.

The Victorian Psychiatry Training Partnership (VPTP), positioned within the Vic DH; consults with key partners in the delivery of specialist psychiatry training. Key partners include the RANZCP, Victorian Psychiatry Training Committee (VPTC), the Commonwealth, public and private health services, psychiatry trainees, and the Vic DH. The impact of the VPTP has been improved data collection and reporting across services to support continuous improvement. In addition, streamlines planning, allocation and accreditation processes. The RANZCP submits that the VPTP must continue to be supported to drive the development and coordination of training across the state.

v. Rural and Regional Psychiatrists in Training

The Branch recommends support for the establishment of a RANZCP training program in towns with a rural medical school. For rural and regional 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 which includes providing funding to support a medical education psychiatrist/registrar position to facilitate support programs and increase psychiatry conversion rates. The Branch also recommends funding to increase the numbers of JMOs and HMOs allocated to psychiatry services to support rural Area Mental Health Services.

vi. Supply: Specialist International Medical Graduate (SIMG)

The Branch recommends addressing issues in SIMG training through dedicated attention in collaboration with specialist training organisations such as RANZCP. This includes providing targeted support to help SIMGs working in regional, rural and remote areas to better understand the rural health and community context and to support their professional practice, including mentoring and professional networking. Rural communities notably rely on SIMGs who are likely unfamiliar with the RANZCP Fellowship Program curriculum or regulations, experience cultural and/or language barriers and have not yet built professional networks. This is unfortunately likely to result in and compound increased professional and social isolation. The RANZCP provides mentoring programs for all trainees and early career psychiatrists; however, SIMGs reported that further orientation and support was needed.

vii. Supply: Specialist Training Program (STP)

The Branch recommends advocating to the Commonwealth for ongoing support and expansion of STP training posts and potential associated projects including STP training places to be formally incorporated into strategic workforce planning and a review of the impact of STP supervision in the public sector. Also required is priority for funding of Directors of Advanced Training and associated administrative support to support the development of specialist doctors. This would require an investigation into the potential for expanding specialist training opportunities in primary care and rural and regional locations.

viii. Supply: Future sustainability

Addressing the current workforce challenges is a multi-generational commitment and will need considerable investment from the federal and state/territory governments. There is a need for further consideration around the current inconsistencies in working conditions between states and territories, and how this is contributing to medical workforce gaps particularly in rural and regional and specialist services in Victoria. Additionally, state-based planning processes need to be linked to local planning where workforce issues are more likely to be felt and understood.

The Branch is keen to understand the intersection of Victorian Government's strategies with the targets and benchmarks contained within national frameworks The RANZCP continues to engage with the Federal Government regards the national psychiatric and general Medical workforce. The RANZCP responded to the draft National Medical Workforce Strategy 2021-2031 which aims to guide long-term collaborative medical workforce planning across Australia, as well as the National-Mental-Health-Workforce-Strategy-2022-2032 which supports the opportunity to grow and strengthen an appropriately skilled, diverse, flexible and innovative mental health workforce. In addition, the RANZCP provided a submission to the National Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021-2031, co-designed with Aboriginal and Torres Strait Islander people, this plan's target is for First Nations people to be fully represented in the health workforce by 2031.

ToR 2: Adequacy of existing classification structures and exploration of future clinical management roles, including the potential of expanding the utilisation of classifications such as Medical Officers.

The Victorian healthcare system is diverse and evolving with advancements in technology, patient demographics and healthcare delivery models. Therefore, the Branch supports a review of the existing classification structure to ensure an effective and responsive public healthcare system. The Branch supports establishing classifications for clinical management roles to encourage the development of expert clinical managers and leaders.

The Branch does not have a consolidated view about the utility of Medical Officers and would recommend further consultation, including with regional centres; to determine the need and the possible role descriptions for training and supervision to support professional development.

The RCVMHS Interim Report recommended mandatory psychiatry rotations for all Junior Medical Officers (JMOs) by 2023. Mental Health Reform Victoria (MHRV) funded RANZCP to design training to support Victorian JMOs and registrars in 2021-2022 the Junior medical officer psychiatry rotation framework. More recently, the Vic DH advised that it considered a target of 70% of all junior doctors in postgraduate positions a more realistic target.

The Branch continues to support the JMO psychiatry rotation framework as an important measure toward building the capacity of the medical workforce to support early intervention of psychological distress and

mental illness and promote specialist psychiatry training. The Branch would recommend its further development and the funding of roles to support delivery. Notably, the requirement for Directors of Training (Mental Health) to coordinate a robust orientation program for JMOs, reflective practice as well as psychiatry education sessions. As well as this is the support needed from supervisors, mentors, and the multidisciplinary team.

The Branch are concerned however, that recent announcements of co-contributions by health services for this program have led to a reduction in positions being provided in 2024. We submit that the need identified by the Royal Commission remains active and recommend that the Vic DH report annually on the proportion of junior doctors in PGY1 and PGY2 are accessing psychiatry rotations, and on the numbers of junior doctors entering the postgraduate psychiatry training program each year, as a way of reporting on the targets set by the Royal Commission.

ToR 3: Exploration of the barriers to recruitment and retention of ongoing medical staff arising from different modes of employment, such as fractional specialists and fulltime specialists, and the impact of wage relativities between modes on attracting a stable medical workforce.

The Branch agrees the systematic exploration of barriers to recruitment and retention of medical staff is fundamental for ensuring a stable and sustainable healthcare workforce and this requires a nuanced understanding of the diverse preferences of medical staff. Variety of modes of employment, such as fractional specialists and full-time specialists, do however introduce complexities requiring thoughtful consideration (refer also to ToR 5 & 6). Indeed, a collaborative approach is critical. Open dialogue with the medical workforce including around flexible hours, job satisfaction and career progression can inform effective strategies to improve recruitment and retention outcomes. The Branch further recommends embedding regular reviews, benchmarking against industry standards, and implementing adjustments to maintain competitiveness.

The impact of wage relativities influences the ability to attract and retain a stable medical workforce and the identification of barriers to recruitment and retention associated with each employment mode is also required. This may involve analysing factors such the impact of flexible work hours on job satisfaction and career progression opportunities. Assessing the impact of wage relativities between fractional and full-time specialists is key to understanding how compensation structures influence workforce stability.

The Branch would also highlight the importance of recognising the unique challenges in recruiting and retaining specialists, including psychiatry within the public health system. Disparity in renumeration and employment conditions, for example, provides challenges in attracting and retaining medical staff in certain roles. Acknowledging the role of fair and competitive compensation relative to their counterparts in other specialties which currently psychiatrists do not. The Branch would therefore emphasise the need for tailored strategies.

Specialists prefer part time roles for a variety of reasons including work-life balance or pursuing multiple professional commitments. Others may opt for full-time positions for career stability and focused commitment. The Branch submits however, it is time to phase-out the pay gap between fractional and full-time specialists. When first established, this pay-gap reflected the cost to practitioners of running a private practice while spending short periods of time in the public sector. Fractional contracts are now being used to employ specialists up to 28 hours per week (0.8 FTE) and beyond. Non-salary benefits of fractional and full-time specialists are identical, so that there is now a positive disincentive for specialists to accept full-time contracts.

ToR 4: Rostering practices that that result in high levels of ad hoc overtime and on call that may impact the health, safety, and welfare of doctors and any alternative practices.

Prolonged working hours are the primary contributor to burnout and may result in greater risk of errors in the delivery of treatment, care and support. This issue is particularly relevant to trainees, including psychiatrists in training, who are often on the front-line of specialist services and are therefore more frequently exposed to complex and emotionally charged situations.

The Branch agrees examining the impact of current rostering practices and exploring alternative practices is necessary to ensure a supportive and sustainable work environment that prioritises the well-being of medical professionals. The impact of rostering practices, particularly those leading to elevated levels of ad hoc overtime and on-call responsibilities, can have detrimental effects on the physical and mental health of doctors.

Exploring alternative rostering models may include implementing flexible, autonomous scheduling. Funding to cover annual and other forms of leave is also required, which may include locums or arrangements flexibility worked into the original work-load allocation. Currently, the arrangement is for other clinicians to cover within their existing hours creating conflict with existing workload and requiring prolonged working hours risking reduced productivity. Establishing robust monitoring and feedback mechanisms is essential to regularly assess the impact of rostering practices on the well-being of doctors and those in training. This allows for timely adjustments to be made to address any emerging issues and improve overall work conditions.

The Branch further recommends ensuring where an algorithm is used for staff-patient ratios this duly considers the existing workload and an adequate FTE consultant specialist workforce, with the correct level and mix of subspecialties, that can meet clinical needs and where applicable, requirements for trainee supervision. Other measures of support include advocacy and support services for doctors and doctors in training can also prove be beneficial. This includes access to mental health resources, counselling services, and mentorship programs to assist navigating the challenges of their profession and maintaining their overall well-being.

ToR 5: Review the current Out of Hours arrangements for Specialists, particularly for Fractional Doctors and Doctors in Training with emphasis on how technological advances may be changing the delivery of out of hours care.

The Branch considers a review of current Out of Hours arrangements for medical specialists, including Fractional doctors and those in Training critical to ensure that specialists can effectively contribute to patient care beyond traditional working hours. The Branch recommends that a review recognises the evolving landscape of healthcare, including the pivotal role of technological advances in reshaping how care, including out-of-hours care, is provided. It further addresses the unique requirements of doctors and doctors in training - and supports the healthcare system to adapt to the changing needs of the community. Reviewing Out of Hours arrangements should involve exploring models that cater to the varying schedules.

Technological advances, especially in telehealth, have transformed the delivery of healthcare services. Whilst incorporating telehealth solutions into out-of-hours care has progressed, allowing specialists to provide remote consultations, support, and advice is particularly relevant for psychiatrists who may need to address urgent mental health concerns.

As technology becomes integral to out-of-hours care, increased funding, support and resourcing are required as the equipment and connections available to consumers in regional areas remain problematic. Providing adequate training and support for medical specialists, including psychiatrists, is crucial as is raising public awareness of these options. Ensuring proficiency in using telehealth platforms and other digital tools will enhance the effectiveness of virtual consultations and contribute to positive patient outcomes and experiences.

While embracing technological advances, it is paramount to maintain the quality of care provided during out-of-hours periods. Comprehensive guidelines and protocols should be established to ensure that remote consultations are conducted with the same level of professionalism, thoroughness, and person-centred focus as in-person interactions. This would include establishing formal communication and collaboration pathways among specialists, healthcare institutions, and support staff - crucial for seamless out-of-hours care.

Embedding formal review and feedback mechanisms is essential. Regular assessments and evaluations can help identify areas for improvement in out-of-hours arrangements, ensuring continuous refinement of practices based on the evolving needs of the healthcare system.

ToR 6: Exploration of working arrangements, including part time and casual employment.

The nature of medical practice is evolving, and specialists, including psychiatrists, often engage in diverse roles. The Branch agrees that for careers to meet community needs, be attractive and retain employees, medical specialists require adequate resourcing and distribution. Additionally required is an available career path, suitable renumeration, support for professional and personal wellbeing, and access to flexible working conditions including autonomous, hybrid and part-time hours.

Medical registrars in specialty training engage with a significant volume of commitments including outside of work hours with on-call commitments, training requirements and necessary self-study. Psychiatrists in training report that flexibility with work hours and ways of working (that were supported during COVID) contributed significantly to their ability to access meetings, educational activities, and other work-related tasks remotely and flexibly, as well as positively support caring and personal relationships, and overall wellbeing.

The Branch acknowledges these type of arrangements have long demonstrated their contribution to mentally healthy workplaces and improved accessibility of diverse populations to the workforce. Notable however is the required level of organisational maturity to support such arrangements which includes enabling staff to demonstrate their ability to prioritise workflow and take a more sophisticated and creative approaches to their work. Workplace culture and leadership are significant features in this. Improved trust, organisational maturity and more meaningful leadership engagement and cohesion with the team are possible benefits of this workplace change.

ToR 7: Work design which may include task allocation and support.

Ultimately, medical staff, including psychiatrists and psychiatrists in training, want to deliver services that are holistic, integrated, and responsive to diversity. They want to be part of a public health system that centres on developing positive therapeutic relationships, continuity of care and collaboration across services. They want to work in environments that enable them to take the time to understand the needs and unique circumstances of consumers, families, carers, and supporters – and facilitate informed decisions about what support is right for them. That is, work to their full scope of practice and have opportunities to

extend this to support the Victorian community. The current public health system has a reduced opportunity for psychiatrists to be involved in the provision of treatments such as psychotherapy and systemic/family therapies, and there are limited opportunities for treatment innovation and translation, clinical research and leadership development.

The Branch therefore recommends:
- improve transparency of state-wide distribution of service funding.
- develop and implement a funding model that meets acute clinical demand 7 days per week.
- undertake an analysis of correct workforce requirements and introduce staff–patient ratios and benchmarking service delivery, considering local demographics and socio-economic indicators, supervision and leave requirements, along with other factors.
- Re-design full-time specialist positions to allow for greater breadth of practice through access to outpatient clinical work including academic and treatment innovation clinics, academic research and/or teaching, or service leadership.
- develop and implement safety measures for both patients and staff to address the unacceptable risks of aggression and violence.
- provide administrative support to optimise time for undertaking clinical patient care.
- ensure support administrative areas the medical practitioner must undertake which could include MH tribunals or VCAT.

i. Workforce Capabilities

The RCVMHS highlighted the critical need for system reforms that harness the collective strengths of the workforce. The system must provide better support for the workforce by enabling the use of their existing capabilities (knowledge, skills, and attributes) effectively and to continually improve the quality of treatment, care and support they provide.

The Branch would highlight the importance of providing clarity to clinicians in understanding responsibilities. Psychiatrists value the opportunity to contribute within a multidisciplinary team to share expertise and ultimately to achieve integrated care within the mental health and wellbeing workforce as well as the wider Victorian health system. The importance of integration of care and multidisciplinary approaches is considered essential, as is the continued collaboration between consumers, carers, mental health professionals, general practitioners, non-government and government agencies.

ii. Diversity

The Victorian community is diverse, and the Branch supports fostering a workforce that supports diversity to meet the community needs, and values individuals' identity within the workforce. The Branch recommends the implementation of targeted programs aimed at attracting and supporting a diverse range of medical students and doctors.

The RANZCP supports efforts to achieve gender equity in psychiatry and in the wider health system. Enhancing gender equity, diversity and inclusivity is fundamental to the maintenance of a healthy and sustainable health system. Improving gender equity in health care settings can improve safety and the quality of care. Gender-based issues permeate many aspects of the health system including the provision of high-quality and effective mental health care, from trauma-informed care to high quality research translating into better health treatment. The RANZCP's Gender Equity Action Plan outlines the RANZCP's strategy to achieving gender equity in psychiatry. More details about gender equity in psychiatry and the health system can be found on the RANZCP website's Gender Equity page.

For many years, part-time training has been a feature of the RANZCP training pathway and has contributed to an increase in diversity of trainees. Part-time training must amount to a minimum of 0.5 full-time equivalent (FTE) training to be accredited with fees adjusted as needed.

Not to be missed is the opportunity to emphasise the importance of a medical workforce, including psychiatrists, that has the capability to treat groups with specific needs that cross multiple services and specialties. These are often the more vulnerable populations, including Aboriginal and Torres Strait Islander peoples, military veterans, asylum seekers and refugees, individuals experiencing substance use and gambling disorders, people who are LGBTIQ+, individuals facilities, those with serious and complex mental illness and culturally and linguistically diverse communities. These groups not only require tailored and appropriately resourced mental health and wellbeing services but a continuity of care requiring extended capabilities, across these services.

The Branch agrees it essential the government acknowledge the importance of cultural supervision in developing a mental health workforce which represents the Indigenous community. There should be appropriate mentoring, debriefing and supervision made available to Aboriginal and Torres Strait Islander mental health workers on an ongoing basis. This should include opportunities for clinical and cultural supervision. This must be further extended to other diverse groups including culturally and linguistically diverse and LGBTQIA+ populations.

iii. Lived and Living Experience

The RANZCP recognises the value of and making a commitment to partnering with people with a lived and living experience of a mental health condition (those with a lived experience). Partnering with people with a lived experience involves strong engagement, clinical governance, and quality improvement processes. The RANZCP further affirms the importance and value of respectful and cooperative partnerships between psychiatrists and carers.

iv. Leadership training

Workforce studies suggest an association between the best performing institutions and clinical practitioners in leadership positions. As clinical experts in mental health, psychiatrists are well-placed to provide clinical leadership in both clinical and academic settings. We recommend highlighting the importance of utilising psychiatrists as an integral part of service delivery and planning, and research and training in creating a more attractive workforce.

To support leadership development and pathways in the health system, there need to be opportunities to develop leadership skills. This requires investment in training and development and providing clinicians time so that they can take up these opportunities. Other professional opportunities may include secondments to experience and learning from the other parts of the employing service, government departments and key stakeholder organisations.

v. Specialisation

The Branch recommends design, delivery and evaluation of specialist roles that is evidence-based and developed in collaboration with medical professionals including specialists and those in training (undergraduate and postgraduate) and their representative associations including the RANZCP Victorian Branch, the AMA, consumer and carer health forums, and service administrators. Their collective insights and experiences can provide valuable perspectives on the adequacy of existing structures and the viability

of proposed changes, and work to ensure a comprehensive understanding of the evolving healthcare environment.

Accreditation frameworks across professional disciplines support the right balance between specialist capabilities and approaches to collaborative and integrated care across the system. Professional bodies such as the RANZCP are responsible for training, educating and representing medical specialists. There are core Fellowship competencies expected of all trainees on completion of the Fellowship Program, defined across the major roles expected of a contemporary psychiatrist.

The Branch also recommends consideration for the large numbers of specialists, including psychiatrists, that move from public to private practice once they are admitted to specialist practice by attaining their Fellowships. Training students to become doctors and then medical specialists, takes between 10 and 12 years that includes significant investment by the Victorian Government. For psychiatry, movement toward the public service occurs for a variety of reasons including a public system that does not support psychiatrists to work across their entire scope of practice, with limited opportunity to deliver treatment, to work directly with consumers, carers, and families, and limited support for their high administration burden and other non-clinical work. In addition, there is the idea that there may be more opportunity for autonomy over work patterns (see ToR 6).

vi. Subspecialisation

The Branch recommends further consideration of the challenges and opportunities associated with sub-specialisation, including decreased opportunities to provide appropriate and therapeutic specialist care that ensures optimal outcomes for consumers and carers with specific needs. Evident within the current psychiatric workforce are significant workforce gaps in multiple specialties: child and adolescent psychiatry, consultation-liaison psychiatry, forensic psychiatry, psychotherapy, and addiction psychiatry, as highlighted in our Victorian Branch Pre-Budget Submission (2019-20).

vii. Developing specialist skills across the sector

While there are benefits to a specialised, highly skilled workforce, these must be balanced with the need for health professionals to have expertise across the speciality and the public health system. There is an opportunity for this group to utilise these skills, be it choosing psychiatry as long-term career option, or using the skills to support people struggling with mental health issues in other specialist practices.

There are some competencies which should be key for all mental health professionals and be embedded within the system including recovery-oriented care, trauma informed care and practice, and supported decision-making. The Branch also supports broader education and inter-specialty training for medical practitioners, an identified medical workforce dilemma.

Specialised upskilling of medical practitioners in mental health care is becoming vital in the contemporary medical context to ensure doctors are equipped to provide well rounded health care for mental health patients. The RANZCP has received funding from the Federal Department of Health to develop the Certificate of Postgraduate Training in Clinical Psychiatry.

viii. Medical Academia and Clinical Research

The Branch emphasises the importance of building on existing research and evidence to improve and support the best possible health outcomes for Victorians. In addition to this, to boost the foundations for an adaptive health system that meets a gap in translational research into treatment, care, and support. It is

also considered vital that academic and clinical research is undertaken in partnership with those with a lived and living experience of mental illness or psychological distress.

The Branch agrees it is essential for joint medical academic and clinical research positions to be a feature within the public health system across specialities, including mental health. Clinical research and academic psychiatry are conducted in a range of settings to enhance the understanding of mental health disorders; to inform the effective use of pharmacological, psychological treatments and other interventions; and to improve the environments in which psychiatric treatment is undertaken. Importantly, metropolitan, rural and regional Adult Mental Health Services reported that academic psychiatry appointments are helpful from 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 the short-term and long-term provision of services.

Academic heads of departments have expressed concerns about the lack of a next generation of clinical academic psychiatrists. An issue which is likely compounding this, is a lack of academic pathways for psychiatrists and the Branch recommends addressing the scarcity of current research rotation options, and that these positions be held within each service to support ongoing active work in research, education, and training. Embedding this at all levels would help bridge evidence-practice gaps and retain clinical expertise in public health settings.

ix. Private Practice

Further attention is needed to ensure retention of psychiatrists within the public system once their training is complete, and it is critical that positions are distributed effectively. Further consideration is required to incentivise a return of those who have left.

Reasons cited by consultant psychiatrists who choose to leave the public service (and for many to work exclusively in the private system) include the minimal availability of the public system for clinical contact with consumers and carers; overwork and stress due to workforce shortages; feeling undervalued; increasing bureaucracy; lack of basic administrative support; increased risk of violence and abuse from aggressive patients; and lack of financial rewards. Currently psychiatrists are remunerated less in the public system compared to other specialists, likely also contributing to psychiatry appearing as a less attractive option. We suggest a comparison with specialities within other services – and ways to cover those and other imbalances.

Resources

Australian Government Department of Health and Aged Care Independent review of health practitioner regulatory settings.

Australian Government Department of Health and Aged Care National Medical Workforce Strategy 2021-2031

Australian Government Department of Health and Aged Care National-Mental-Health-Workforce-Strategy-2022-2032.pdf

Australian Government Department of Health and Aged Care Telehealth

Australian Government National Mental Health Commission Blueprint for Mentally Healthy Workplaces

Australian Government Productivity Commission Productivity Commission Inquiry Report (2020)

AIHW Workforce – Mental Health

AIHW Prevalence and impact of mental illness

Fair Work Commission Find an enterprise agreement.

RANZCP Breaks, part-time and withdrawal from training | RANZCP

RANZCP Productivity Commission Inquiry into Mental Health 2020 | RANZCP

RANZCP Telehealth in psychiatry

World Health Organization Building the primary health care workforce of the 21st century