NSW Branch Pre-Budget Submission
2025-2026

Prioritising the next generation

The Royal Australian & New Zealand College of Psychiatrists

Your Health in Mind

Table of contents

1. Acknowledgement of Country

We acknowledge Aboriginal and Torres Strait Islander Peoples as the First Nations and the Traditional Owners and Custodians of the lands and waters now known as Australia. We recognise and value the traditional knowledge held by Aboriginal and Torres Strait Islander Peoples and honour and respect the Elders past and present, who weave their wisdom into all realms of life – spiritual, cultural, social, emotional, and physical.

1.1 Acknowledgement of Lived 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.

2. About the Royal Australian New Zealand College of Psychiatrists

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) is the principal organisation representing the medical specialty of psychiatry in Australia and New Zealand providing access to Fellowship of the College to medical practitioners. The RANZCP has approximately 8500 members bi-nationally. The NSW Branch represents over 2000 members, including over 1400 qualified psychiatrists.

The NSW Branch offers a substantial resource of distinguished experts – academics, researchers, clinicians, and leaders dedicated to developing expertise in understanding the risk factors of mental disorders, treating individuals and families, developing models of care and promoting public health measures that will reduce the personal suffering, loss of potential and huge economic costs caused by mental disorders in our community.

3. Message from the Chair

Over the last decade, the psychiatry workforce crisis has been worsening and gaps in service delivery have been widening. Vacancies for public sector psychiatrists, including at some of Sydney's largest and most high-profile hospitals, have dramatically increased. Currently, 30% of Staff Specialist positions across the State are unfilled. These gaps are being papered over with an unprecedented use of locum or short-term Visiting Medical Officer (VMO) contractual staff at double or triple the daily rate for a Staff Specialist. This loss of clinical leadership and continuity of care from permanent staff has major impacts on the quality of patient care. It also diminishes the quality of training and supervision for the next generation of psychiatrists. We have already seen a major shift in the career trajectory of our trainees, with four out of five noting they plan to leave NSW Health after completing training. This will have important consequences for the future of public mental health care. In essence, we have been spending more but receiving less, and we strongly urge the government to act now to reverse this trend.

An ageing workforce in the public mental health sector

In addition to the exodus of psychiatrists from the public sector, we note that our remaining workforce is ageing and a high number of psychiatrists in both metropolitan and non-metropolitan areas signal an intention to retire in the next decade (3). The average age of a public sector psychiatrist is above 53 and approximately 30% of the psychiatry workforce is aged 60 or over (30.6% in metropolitan areas and 29.2% in non-metropolitan areas). Of those psychiatrists aged 60 or over, in metropolitan areas 69% are expected to retire in the next 3-5 years and in non-metropolitan areas 47% are expected to retire in the next 3-5 years (See Figure 1).

Trainees disillusioned by the public mental health sector

Specialist medical training is based on an apprenticeship model where trainees (junior doctors) work under the supervision of a psychiatrist for a series of six-month rotations. Trainees learn specific skills and are assessed on a range of competencies during this time. The current work force crisis has led to a fragmentation of the training experience, with trainees reporting having up to five different temporary supervisors in one six-month rotation. In some areas, such as child psychiatry, trainees cannot access rotations due to a lack of psychiatrists to provide supervision.

Trainees report disillusionment with the public sector due to the lack of supervisors and temporary nature of senior staffing. Senior staff shortages also significantly impact the workload of trainees. This is not only demoralising, but a disincentive to anyone considering a career in public mental health. NSW Health modelling shows that 14-16 new psychiatrists are required each year in the public system and 45-49 advanced trainees to meet community need in 2035. Only 20% of the 55 new psychiatrists in 2024 will take up roles in public mental health services. That is well short of what is required to meet community need.

There are additional structural challenges that impede the quality of training in NSW. In particular, we note that when NSW Psychiatry Training Networks were introduced in 2006, each training network had about 30 trainees. Now, 20 years on, each network has between 70 and 165 trainees, without additional staffing or structural changes to support this dramatic increase. This submission implores that an urgent review of this training structure is required.

Historically, NSW has had the highest number of applicants for psychiatry training of all Australian jurisdictions. However, in 2021, the Victorian Government mandated that all PGY 1 & 2 doctors would complete a psychiatry rotation to strengthen the Victorian psychiatry workforce. We know that having such an experience of psychiatry is the single most important determinant for those deciding on a career in psychiatry. As a result, Victoria had substantially more applications for psychiatry trainee positions than NSW in 2023 (200 versus 135). This submission will draw on the Victorian approach to trainees and highlight where NSW would benefit from the Victorian example of increasing junior doctor rotations, strengthening trainee network structure, and incentivising psychiatry as a profession.

Rural and remote psychiatry workforce

The shortage of psychiatrists is even more perilous for rural and remote communities. With State

government funding, the RANZCP has run a highly successful Rural Psychiatry Project for three years. This program has demonstrated that supporting trainees to live in a region and develop connections with community reaps enormous benefits in attracting and retaining trainees and psychiatrists in the bush. The program now supports approximately 50 rurally-based trainees and regional centres are developing the capacity for trainees to complete all their training requirements in the bush, negating the need for travel to metropolitan areas. This is a major development for NSW. Ongoing support of rural trainees is critical in ensuring the success of rural training pathways and an extension of the funding for this project is essential.

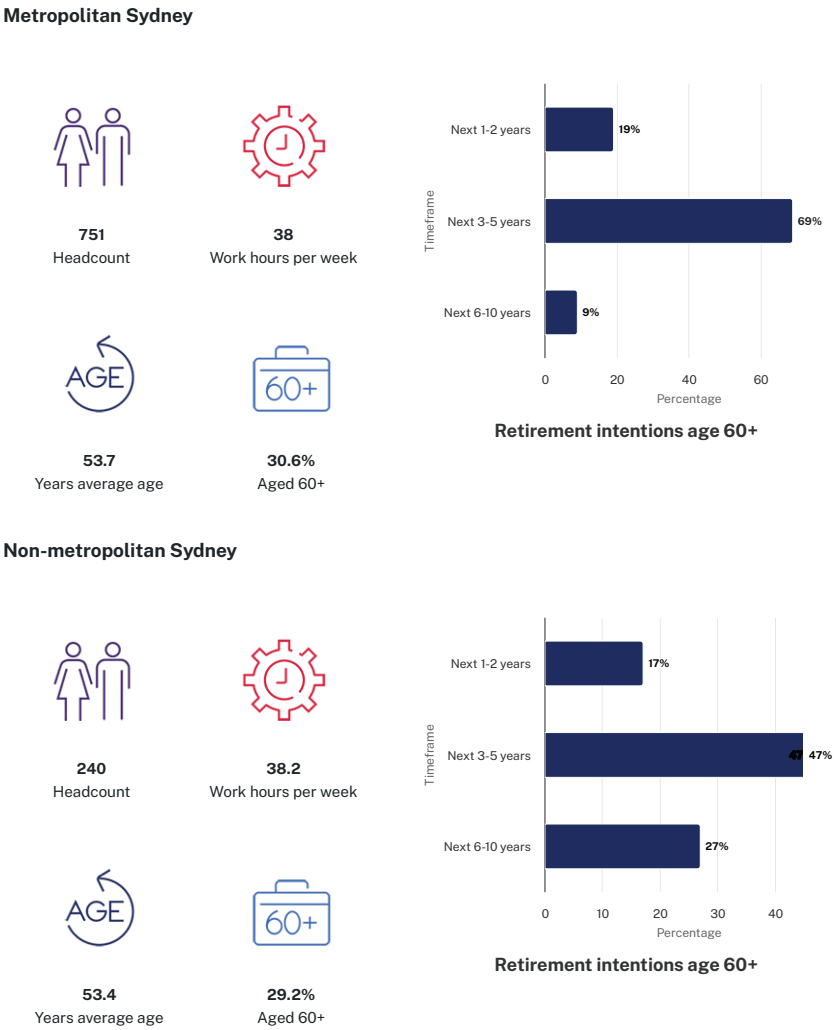
The mental health needs of children and young people

This submission highlights the critical shortage of child psychiatrists in NSW and the growing demand for mental health services for young people. It is estimated that only 27% of young people with a severe mental health condition have seen a psychiatrist (6). We know that prevention and early intervention are the cheapest and most effective forms of mental health care (7). Moreover, mental illness in childhood can have enduring consequences and is a strong predictor of morbidity in adult life, including educational and occupational impairment and youth suicide. The RANZCP proposes an Integrated Continuum Connect and Care Model that provides timely access to services that are specific to the needs of children and young people.

There is the real risk that if we fail to address these significant and systemic problems, we are jeopardising the future of mental health care in NSW. We must ensure mental health care in NSW is sustainable for this decade and into the next.

Dr Pramudie Gunaratne
Chair
RANZCP NSW Branch Committee

Figure 1: Projected retirement rates of NSW psychiatrists



4. Executive Summary

The RANZCP proposes the following spending priorities for the next budget.

4.1 Training Networks

This 2025-2026 Pre-Budget Submission (the Submission) will outline the urgent need to attract trainees and reinvigorate the trainee experience. We will discuss the role of Psychiatry Training Networks and our view that the current arrangements no longer meet the needs of NSW as we strive to make public sector psychiatry sustainable for the remainder of this decade and into the next.

The RANZCP calls for an urgent review of the current Psychiatry Training Network arrangements and redesign that ensures networks are:

- an appropriate size
- are appropriately funded in a sustainable way
- have appropriate governance and
- comprehensively support rural training as well as metropolitan training and subspecialty training

Cost - The RANZCP estimates an investment of $150,000 for consultation, review, codesign and economic costing.

4.2 NSW Rural Psychiatry Project

The RANZCP is calling for renewal of the successful Rural Psychiatry Project to increase the number of psychiatrists working in rural and remote communities.

Cost: $175,000 including costs to facilitate additional trainees and additional activities to include rural psychiatrists.

4.3 Child and Adolescent Mental Health Services

The RANZCP is proposing an Integrated Continuum Connect and Care Model that provides timely access to services that are specific to the needs of children and adolescents.

Roadmap development will cost $700K per year x 2 years including consultant fees to run the workshops and sector consultations.

Cost: $1.4M

For the development of the implementation and evaluation plan, and modelling to measure the economic impact of the new model of care. This is a model designed for seamless access to child and adolescent services early in a child's life and to prevent more complex and crisis interventions. The model is also designed to avoid duplication of services.

Cost: $400K

The Submission was developed in consultation with members of the NSW Faculty and Section Subcommittees, members of the NSW Branch Committee, people with lived experience, and other stakeholders.

5. Psychiatry Training Networks in NSW

Training networks were introduced in 2006 to address the difficulties that Area Health Services were having in trying to fill positions in regional areas. At the time, training was completed in Sydney so very few trainees were willing to leave the city to take up a regional post.

The introduction of networks gave registrars the opportunity to participate in rotations across city and regional health services. The model included funding for a 'host' Sydney based Area Health Service, and a Director of Training (DoT), whose role it was to ensure that workforce needs were being met, especially in regional areas.

The RANZCP believes that while the networks were ideally suited to the jurisdictional governance of Area Health Services, since devolving to Local Health Districts (LHDs) serious governance, capacity, and geographic concerns have emerged that we believe should be addressed by a comprehensive review of the role of networks.

5.1 The current NSW network model

There are five Psychiatry Training Networks, each of them consisting of metropolitan, regional, and rural locations. The Health Education and Training Institute (HETI) is responsible for network governance and each network consists of multiple LHDs from metropolitan, outer metropolitan and regional areas (see Table 1).

Each network has a host LHD which receives NSW Health funding for a Director of Training (DoT), Special Coordinator of Training (SCoT), and an Educational Support Officer (ESO).

NSW also has Subspecialty Psychiatry Training Networks in the following seven subspecialties:

1. Addiction
2. Adult
3. Child and Adolescent
4. Consultation-Liaison
5. Forensic
6. Old Age
7. Psychotherapy

Directors of Advance Training (DoATs) are responsible for sub-specialty training across all LHDs and networks.

The RANZCP funds Branch Training Committee Secretariat Support (BTCSS) (1.4FTE) however the Branch Training Committee (BTC) Chair role is an unpaid role. The resources and time allocated to the BTC Chair role is absorbed by the employing LHD.

The NSW BTCSS funding arrangement is an anomaly; staff are employed and funded by the respective Department of Health in all other Australian jurisdictions.

5.2. Why we believe a review of the NSW Psychiatry Training Networks is required

In 2006, when networks were introduced, each network had about 30 trainees. Now, 20 years on, each network has between 70 and 165 trainees, without any additional DoT time, or structural changes to support the dramatic increase.

NSW needs a mental health system that is agile and responsive to provide the care that people need across a state that has additional challenges due to its size and geography.

These are some of the challenges that the network training model is failing to meet:

- NSW governance arrangements are complicated, multilayered and create duplication and inefficient use of scarce psychiatry resources
- The once fit-for-purpose network arrangements are no longer fit for purpose and inhibit rather than promote psychiatry training and workforce growth in NSW
- NSW is being left behind by other jurisdictions like Victoria who employ efficient use of technology and human resources to grow their psychiatry workforce
- A review of the arrangements that have been in place for nearly 20 years is required. The review should develop a snapshot of the current state of the NSW psychiatry training program and propose alternatives that are appropriate, acceptable and cost effective. It should:
  - Be led by NSW Health
  - Be conducted in 2025-26
  - Learn from other best practice models

- Consult with all stakeholder groups with a stake in psychiatry training and codesign solutions
- Bring a business case to government for funding of the agreed model in 2026-2027

The NSW Psychiatry Training Networks have become burdened by governance complexities, they are starved of resources, and are buckling under the weight of having by far the highest number of trainees in the country (632 doctors in psychiatry training in 2024).

The governance and other issues impacting NSW Psychiatry Training Networks that need to be urgently addressed include:

- There are multiple LHDs within each network therefore reaching a consensus on important decisions such as how many positions should be made available for trainees and what types of positions is challenging.
- The network structure invites conflicts of interest when the host LHD employs a DoT who is expected to make impartial decisions that impact multiple LHDs.
- DoTs having responsibility for both workforce, and for ensuring that all trainees are being trained well is an inherent conflict of interest. These responsibilities should be separated as they are for other successful models such as the one employed in Victoria. DoTs should focus exclusively on training and the quality of the trainee training experience.
- Due to lack of overarching governance of the networks and conflicts of interest between training and service delivery, there has been an uneven growth in registrar positions. There are many more adult psychiatry positions than child and adolescent or clinical-liaison terms which are compulsory terms. This has led to bottlenecks in the training system which have not yet been resolved.
- The network training committees are not recognised training committees of the RANZCP (only the Branch Training Committee is recognised). This means many decisions are referred to the Branch Training Committee (BTC) instead of being resolved by the network training committee. This needs to be resolved by solutions such as delegation of decisions to local training committees.
- There are also issues related to the performance management process of DoTs which is complicated by the lack of transparency given to the non-employing LHDs who have no input into the process.
- In addition to the governance complexities, networks are not serving the interests or welfare of trainees, particularly in the way that trainees are expected to move vast distances within their networks at very short notice. A network includes an inner-city location, outer metro locations and regional areas (see Table 1). Trainees often have as little as 4 weeks-notice to move from one location within their LHD to another.

Table 1: NSW has five Psychiatry Training Networks.

Hunter New England Training
Newcastle Mental Health Services, Lake Macquarie Mental Health Services, Hunter Valley Mental Health Services, Psychiatry of Old Age Service, Consultation Liaison Psychiatry, Child & Adolescent Mental Health Services (CAMHS), Neuropsychiatry Services, Psychiatric Rehabilitation Services (including Forensic), Psychotherapy, Peel Mental Health Services (Tamworth), Tablelands Mental Health Services (Armidale), Manning Mental Health Services (Taree), HNET Education.

Northern Sydney Central Coast
Bloomfield Hospital (Orange), Broken Hill Hospital, Coral Tree Family Services, Dubbo Hospital, Dudley Private Hospital, Gosford Hospital and Community Services, Greenwich Hospital, Hornsby & Ku-ring-gai Hospital, Justice Health, Macquarie Hospital, Northern Beaches Hospital, Northside Clinic, Outreach Support for Children & Adolescents, Royal North Shore Hospital, Ryde Community Health Centre, Wyong Hospital & Community Health Centres.

Sydney West and Greater Southern
Aboriginal Medical Service Western Sydney, Albury Hospital, Blacktown Hospital, Blacktown & Mt Druitt Community Health Services, Blue Mountains Hospital, Children's Hospital at Westmead, Cumberland Hospital, Goulburn Hospital, Leeton Medical Centre, Lithgow Hospital, Nepean Hospital, Nepean Child & Youth Community Mental Health, St Joseph's Hospital, Wagga Hospital, Westmead Hospital.

South Eastern Sydney Illawarra
Byron Bay Hospital, Justice Health & Forensic Mental Health Network, Lismore Base Hospital, Prince of Wales Hospital, Shellharbour Hospital, Shoalhaven Hospital, St George Hospital, St Vincent's Hospital, Sutherland Hospital, Sydney Children's Hospital, The Tweed Hospital, Wesley Private Hospital Kogarah, Wesley Private Hospital Ashfield, Wollongong Hospital.

Sydney South West North Coast
Bankstown Hospital, Braeside Hospital, Bowral Hospital, Brain & Mind Centre (Camperdown), Campbelltown Hospital, Camperdown CHC, Canterbury CHC, Coffs Harbour Base Hospital, Concord Centre for Mental Health, Concord Repatriation General Hospital, Croydon CHC, Kempsey Hospital, Liverpool Hospital, Marrickville CHC, Rivendell & Walker Child & Adolescent Units, Redfern CHC, Professor Marie Bashir Centre, Royal Prince Alfred Hospital, Port Macquarie Hospital, St John of God Private Hospital (Burwood).

- The burden on the RANZCP BTC is unsustainable. The RANZCP BTC oversees all trainees, provides guidance to the DoTs, DoATs, SCoTs and the many trainee supervisors, as well as responsibility for the content and delivery of Formal Education Courses (FECs). As the resourcing for DoTs, DoATs, SCoTs and supervisors diminishes, it infringes even more on BTC secretariat support resources which we have already identified as being stretched to the limit.

Conversely, the Victorian network, governance and funding arrangements for training are much simpler than those in NSW. The Victorian Department of Health (DoH) funds the Victorian Psychiatry Training Committee (VPTC) Chair and DoTs.

The next section of this submission will compare the streamlined Victorian training model with the current NSW model.

5.3. Comparison. The Victorian Psychiatry Training Network Program

After NSW, Victoria has the next highest number of psychiatry trainees. In January 2024, Victoria had 579 doctors in psychiatry training in Australia. The network and governance arrangements in Victoria are simpler than those in NSW.

- Victoria has three geographically based networks or training regions (NSW has five), each with a mix

of metropolitan and rural settings. The distance between metropolitan and 'rural' settings in Victoria may only require 1-2 hours driving from one to the other.

- Many activities in Victoria are localised to the Regional Training Committee (RTC) or DoT level (e.g. orienting trainees, training supervisors). This improves local responsiveness and streamlines the statewide governance role of the Victorian Psychiatry Training Committee (VPTC).[1]
- The Victorian Department of Health takes responsibility for its psychiatry training program governance and implementation by funding the local workforce roles as well as the VPTC Chair (0.2 FTE) and Secretariat Support (0.8 FTE), which is not the case in NSW. The burden of these positions is carried by the RANZCP NSW Branch and this is unsustainable.
- In Victoria, recruitment for trainee vacancies is undertaken at the local level and applicants can apply to multiple organisations and participate in multiple job interviews.
- Victoria has IT solutions that streamline the sharing of information, self-help, and recruitment processes.
- The Victorian Psychiatry Training Network Program, in response to recommendations from the Royal Commission into Victoria's Mental Health System, received funding for an expansion of training posts, supervision support and workforce roles.
- NSW is under-resourced and well below minimum staffing standards established by the RANZCP which requires 0.5 FTE DoT (or equivalent) for every 20 trainees. Currently NSW has 1 DoT per Network to cover 624 trainees statewide with the assistance of 5-7 Site Coordinators of Training (SCoTs) per Network at either 0.1 or 0.2 FTE.
- NSW also has fewer DoATs and DoAT Education Support Officers (ESOs) than Victoria.

1 The Victorian Psychiatry Training Committee (VPTC) is the equivalent of the NSW BTC.

5.4. Base training network programs in regional areas

The Federal government and the RANZCP have moved significantly away from a persuasive policy approach taken some 20 years ago to convince people to take up regional posts. It was subsequently proven that if people had little or no connection to a region then it was highly unlikely that if they took up a position in a regional area they would stay. Different solutions are required.

Orange and Northern NSW have both demonstrated that adopting an approach of supporting trainees to live in a region is far more successful than relying on rotations from metropolitan regions. Networks that are based in regional areas and are resourced to support trainees will lead to a greater number of trainees in regional settings and a greater number retained as psychiatrists.

5.5. Rural Psychiatry Project

In 2021, the NSW Government commissioned the RANZCP to run a program to support rural trainees and psychiatrists, supporting their work in the bush, with the aim of retention but also making rural training and work more attractive. Supporting rural trainees is critical in ensuring the success of rural training pathways. Increasingly, regional centres are developing the capacity to have trainees complete all their training requirements in the bush, negating the need for travel to the metropolitan areas. This is a major development for NSW.

The RANZCP has focussed on rurally based trainees, the program has built momentum and initiatives have been well-received. The cohort feel well-supported and have been enthusiastic about the program. The previous iteration of this program was similarly successful, but funding ran out in 2016, and the momentum gained from that investment stalled. With the ever-increasing issues around workforce in rural and regional areas, it is essential that competent programs such as this receive ongoing funding.

To extend existing funding that expires 30 June 2025	**$100,000**
To include the costs associated with additional trainees	**$ 50,000**
To extend activities that include rural psychiatrists	**$ 25,000**
Total:	**$175,000**

6. Child and Adolescent Mental Health Services

The development of a sustainable psychiatry workforce is crucial to addressing existing shortages in Child and Adolescent Mental Health Services (CAMHS). Currently NSW is well below the recommended 18.2FTE number of mental health clinicians required for a CAMHS (5). Some CAMHS have as few as 2.6FTE. None have more than 10FTE.

In Australia, one in seven children are reported as experiencing a mental health disorder, a figure that was compounded by the increase in demand for mental health services for children and young people during the COVID-19 pandemic (6). It is estimated that only 27% of young people with a severe mental health condition for a 12-month duration have seen a psychiatrist (6).

Acute mental health needs in children and adolescents are often characterised by serious symptoms that require swift attention and targeted interventions. Evidence shows prevention and early intervention are the cheapest and most effective forms of mental health care (7). Ensuring children and adolescents are assessed at these early stages by primary, secondary and tertiary care providers and then directed to the support most suited to their needs will require a commitment by government to address the significant supply and demand gap already referred to in this submission (8).

Mental illness in childhood can have enduring consequences and is a strong predictor of morbidity in adult life. The consequences can include educational and occupational impairment and youth suicide. Considerable capacity is required in child and adolescent mental health services to adequately treat those with a mental health condition (5).

Furthermore, the scope of child and adolescent psychiatric practice has evolved to encompass a broader age range, increased complexity, children and adolescents with intellectual disability or complex physical health problems, and greater involvement in specialist mental health service provision, such as child protection and youth justice. The increased scope of child and adolescent psychiatry, increases the demand for psychiatrists with specialist skills (5).

The next section of this submission suggests the development of a roadmap for an an Integrated Continuum of Connect and Care model. We believe this model will address the considerable fragmentation, duplication, and access barriers between private and public services, and state and federal governments which includes the NDIS and non-government organisations (NGOs).

6.1. Integrated Continuum of Connect and Care

The 2020 Productivity Commission Report recommended a model based on continuity of care and coordination between services as critical elements in service delivery. The goal of such a model is to integrate services along a tiered care pathway so that the child or young person is receiving services that are specific to their needs (6).

The RANZCP believes greater participation by primary and secondary health professionals will help to overcome many of the structural barriers to integrated care that currently exist.

The Integrated Connect and Care Model (see Figure 1) identifies pathways that children, adolescents and their families can take to access a range of different services dependent on their needs.

No wrong door is the referral point for triage and review. Following triage, referral is provided to a range of online or face to face resources and programs (see Figure 2). Under the model, children and young people who have needs at Level 3 or above based on the National Initial Assessment and Referral (IAR) for Mental Healthcare Tool and with complex psychosocial needs will be assigned a service navigator to ensure they receive the appropriate support (6).

Figure 1: Integrated Continuum of Connect and Care

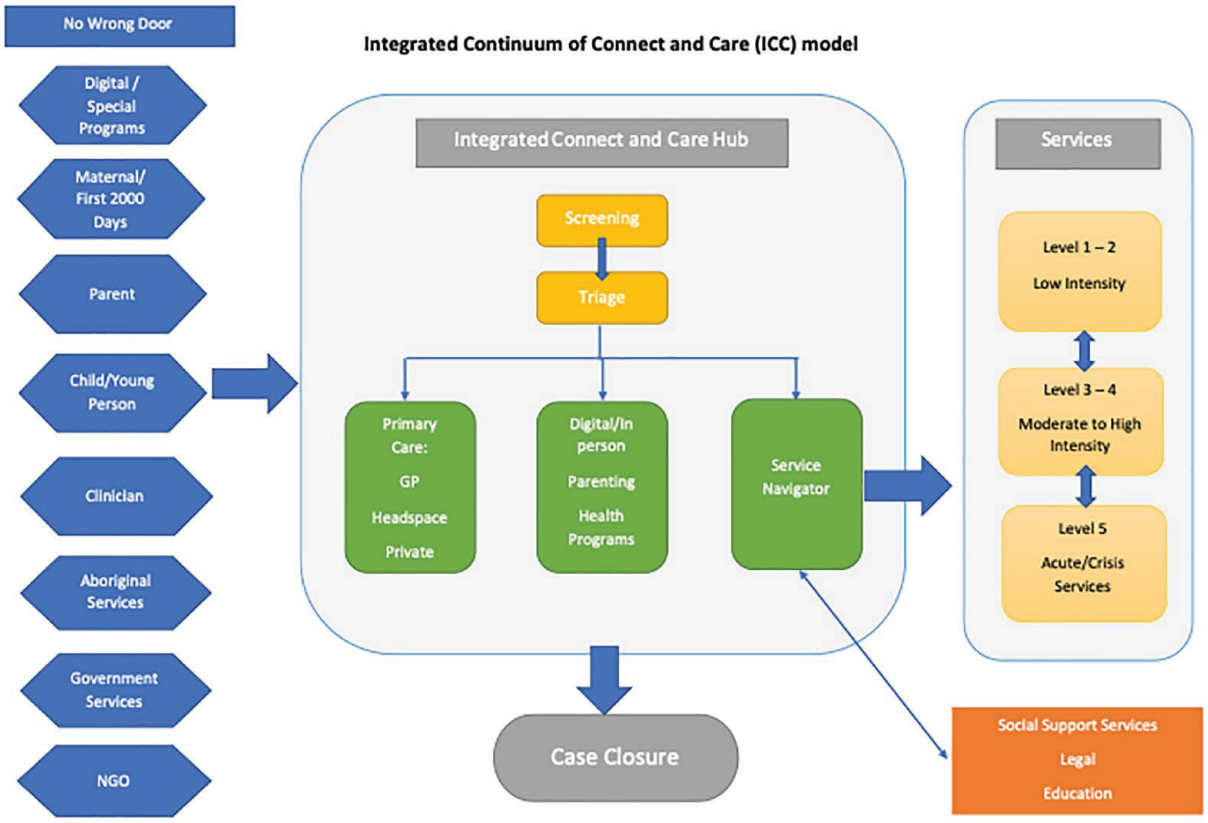
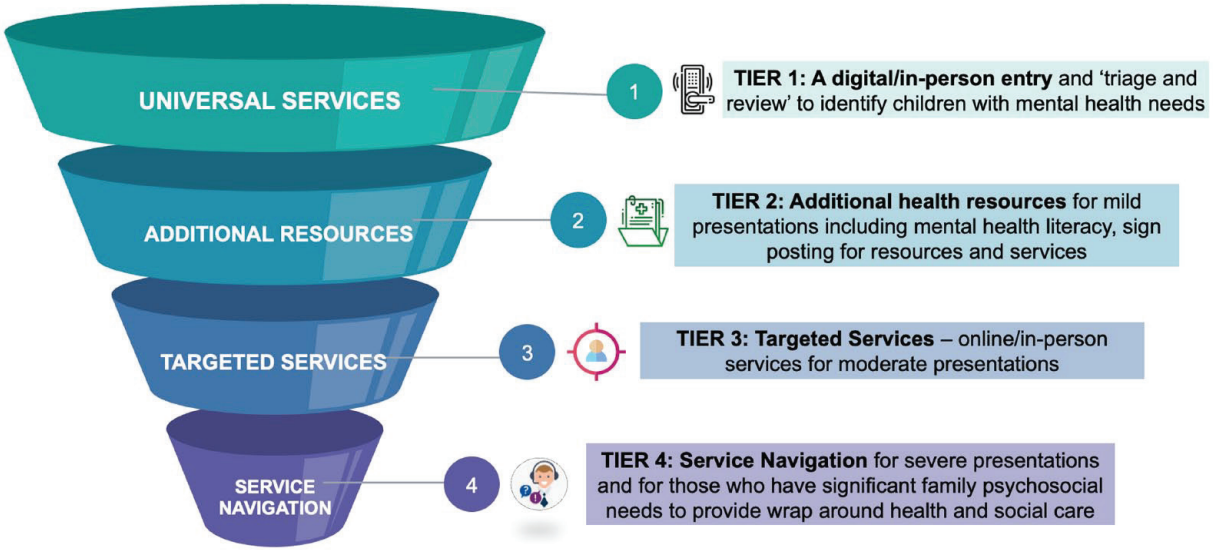


Figure 2: Tiered model of care. Follows Figure 1 Integrated Continuum of Connect and Care



In brief the development methodology for establishing a roadmap for child mental health service delivery will include:

1. Workshops requiring government departmental officials and experts to come together
2. Sector consultations on the elements - all stakeholders including GPs, paediatricians, psychologists etc
3. And then an implementation and evaluation plan

Cost: Roadmap development $700K per year x 2 years including consultant fees to run the workshops and sector consultations. $1.4M

For the development of the implementation and evaluation plan, and modelling to measure the economic impact of the new model of care. This is a model designed for seamless access to child and adolescent services early in a child's life and to prevent more complex and crisis interventions. The model is also designed to avoid duplication of services. $400K

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