Rural Psychiatry Roadmap 2021–31

A pathway to equitable and sustainable rural mental health services

The Royal Australian and New Zealand College of Psychiatrists

January 2021

Acknowledgement of Country

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) acknowledges and pays respect to the Traditional Custodians of the lands collectively known as Australia, and to Elders, past, present and future. We pay respect to the people of the Kulin Nation as the Traditional Custodians of the land on which the RANZCP's head office stands.

In recognition that we are a bi-national college, the RANZCP acknowledges Māori as tangata whenua and Treaty of Waitangi partners in Aotearoa, also known as New Zealand.

Abbreviations

Term	Definition
ACRRM	Australian College of Rural and Remote Medicine
AHA	Australian Healthcare Associates
AMC	Australian Medical Council
ASGS	Australian Standard Geographic System
BTC	Branch Training Committee
CAP	child and adolescent psychiatry
CAT	Certificate of Advanced Training
C–L	consultation–liaison psychiatry
COVID-19	coronavirus disease 2019
CPD	continuing professional development
DoAT	Director of Advanced Training
DoT	Director of Training
FEC	Formal Education Course
FIFO	fly-in fly-out
FTE	full-time equivalent
IMG	International Medical Graduate
IRTP	Integrated Rural Training Pipeline
IT	information technology
MEL	Monitoring, Evaluation and Learning
MOU	memoranda of understanding
NRGP	National Rural Generalist Pathway
OSCE	Objective Structured Clinical Exam
PIF	Psychiatry Interest Forum

Term	Definition
RA	Remoteness Areas
RACGP	The Royal Australian College of General Practitioners
RANZCOG	The Royal Australian and New Zealand College of Obstetricians and Gynaecologists
RANZCP	The Royal Australian and New Zealand College of Psychiatrists
RCS	Rural Clinical Schools
RITP	Regional Integrated Training Program
RPTP	Rural Psychiatry Training Pathway
RTH	Regional Training Hub
SIMG	Specialist International Medical Graduate
STP	Specialist Training Program

Defining ‘rural’

In relation to this roadmap, the RANZCP uses the following classification systems to define rurality.

In **Australia**, the classification that applies to the RANZCP Fellowship Program is the Australian Statistical Geography Standard - Remoteness Areas (ASGS-RA) (2016). The ASGS-RA is a measure of relative access to services with the following structure:

ASGS-RA 1 – Major Cities of Australia

ASGS-RA 2 – Inner Regional Australia

ASGS-RA 3 – Outer Regional Australia

ASGS-RA 4 – Remote Australia

ASGS-RA 5 – Very Remote Australia.

Rural locations are classified as RA 2–5 locations.

The ASCS-RA classification is used in the funding of Australian training programs such as the Specialist Training Program and the Integrated Rural Training Pipeline.

In New Zealand, urban/rural locations are defined on a population basis as follows:

Major urban area – 100,000 or more residents

Large urban area – 30,000 to 99,999 residents

Medium urban area – 10,000 to 29,999 residents

Small urban area – 1,000 to 9,999 residents.

Rural areas represent land-based areas outside urban areas and are classified as rural settlements or other rural.

All New Zealand RANZCP 2020 Semester 1 training positions were in urban locations classified either as major, large or medium urban areas.

What do we mean by ‘rural’?

The term ‘rural’ is used in this roadmap to include *all* regional, rural, and remote locations.

Scope of this document

While the RANZCP covers Australia and New Zealand, this roadmap proposes the initial development of the Rural Psychiatry Training Pathway (RPTP) in Australia.

Implications for New Zealand

In New Zealand, the RANZCP-administered training schemes exist in major urban centres across the country, with training in satellite areas overseen by a major centre. At this stage, a dedicated RPTP in New Zealand may not appear viable given the very small number of trainees in satellite locations; however, there may be potential to adapt the core concepts outlined in this roadmap to support the expansion of training opportunities.

Further consideration of these possibilities is outside the scope of this roadmap but represents a potential future avenue of exploration for the RANZCP, in collaboration with training programs and stakeholders in New Zealand.

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Foreword

It is our pleasure to present The Royal Australian and New Zealand College of Psychiatrists' (RANZCP) *Rural Psychiatry Roadmap 2021–31: A pathway to equitable and sustainable rural mental health services*.

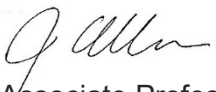
This is a visionary roadmap that sets out a strategic direction and practical recommendations that, actioned over the next decade, will see the establishment of dedicated and sustainable regional, rural and remote training pathways to Fellowship. In this way, the roadmap will help to address the current disparity in mental health outcomes for the large and diverse population of Australians and New Zealanders who live outside urban centres.

Inequitable access to psychiatric care has been highlighted as a significant shortcoming of the Australian mental health care system. The recent *Productivity Commission Mental Health Inquiry Report* highlighted that the number of psychiatrists per capita in Australia and New Zealand falls short of many developed countries, and that people living in regional, rural and remote areas are disproportionately affected by a lack of access to specialist mental health care. The commission recommended that a national plan be developed to increase the number of generalist psychiatrists practising outside major cities. Restructuring and reforming training pathways and addressing the undersupply of trainees in rural areas are also identified as priorities in the draft *Australian Government National Medical Workforce Strategy* released in January 2021.

This roadmap outlines the RANZCP's proposal for change, emphasising how building the rural psychiatry workforce will require the development of a dedicated Rural Psychiatry Training Pathway (RPTP) to Fellowship. This roadmap focuses on expanding opportunities for aspiring psychiatrists to live, train and practise rurally, as well as optimising the support available for those who take up these opportunities. The roadmap not only defines the key elements of the rural training pathway but provides actionable recommendations to all stakeholders and partners that, when implemented, will lay strong foundations for better access to psychiatrists in rural Australia and New Zealand.

The roadmap has been developed through a comprehensive scoping project, conducted in late 2020. The project sought to: develop a clear picture of the current rural psychiatry workforce; understand how psychiatrists and trainees are attracted and supported to work in rural areas; and explore opportunities to expand training and support for the rural psychiatry workforce. The project involved extensive consultation, with input from more than 200 representatives of governments, health services, medical education and workforce stakeholder groups, as well as psychiatrists and trainees with involvement or an interest in rural psychiatry practice. We thank each of these individuals for their thoughtful contribution. We would also like to acknowledge the oversight and direction provided by the project Steering Group and thank them for their insights, which have been crucial to shaping this roadmap.

Importantly, effective implementation of this roadmap will require a commitment to collective action and close partnership from the RANZCP, all levels of government, public and private health services, education, and regulatory bodies. The RANZCP looks forward to working with these partners over the coming decade to build and support a sustainable rural psychiatry workforce, so that the extent to which people in our community have access to timely and appropriate psychiatric care is not dictated by their postcode.



Associate Professor John Allan
RANZCP President

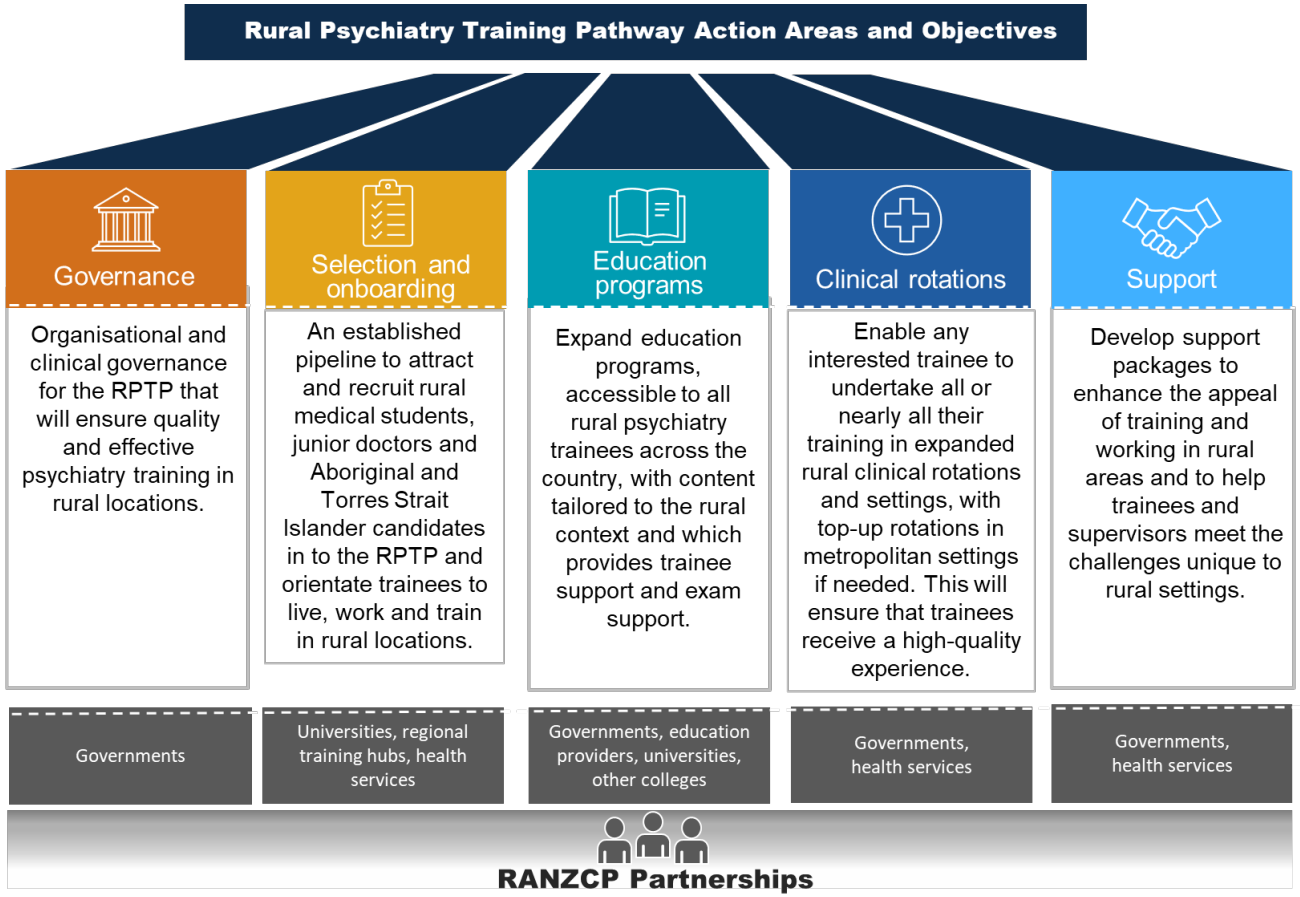
Associate Professor Mathew Coleman
Chair, Scoping Project Steering Group

1 Executive summary

This roadmap provides a 10-year plan to build the Rural Psychiatry Training Pathway (RPTP) to RANZCP Fellowship. This overview outlines:

- RPTP Strategic Plan
- RPTP Action Plan

1.1 Responsibilities and partnerships are described more fully in Sections 5–9 RPTP Strategic Plan



1.2 RPTP Action Plan

RPTP Action Plan		
Area	**Within**	**the RANZCP will:**
Governance	1 year	1 establish RPTP bi-national governance arrangements and rural representation within the current RANZCP committee structure 2 review current competency-based Fellowship regulations to enhance RPTP pathway 3 appoint an RPTP National Director, co-ordinator and administrative support 4 initiate partnerships required to develop the RPTP, including with national, state and territory governments, health services, health regions, workforce planning bodies, universities, regional training hubs and other colleges 5 develop initial funding and sponsorship proposals to deliver the RPTP
	2 years	6 develop Rural Director of Training positions and seek funding within each jurisdiction to support these positions 7 develop an RPTP implementation plan, in consultation with key stakeholders, to commence the RPTP from 2023 8 develop a Monitoring, Evaluation and Learning (MEL) framework for the RPTP
	3 years	9 develop data collection and reporting capability to support RPTP delivery, monitoring and evaluation 10 create and promote a positive rural and generalist Fellowship culture across the RANZCP membership
	4 years to 10 years	11 conduct a mid-term review of RPTP progress in 2026 12 formally evaluate the RPTP by 2031
Selection and onboarding	1 year	13 amend selection regulations and develop selection criteria to prioritise rural applicants for the RPTP 14 amend selection regulations to prioritise eligible Aboriginal and Torres Strait Islander applicants for the RPTP 15 develop and deliver an RPTP communications and promotion strategy 16 consider the inclusion of a dedicated rural stream within the current Psychiatry Interest Forum (PIF) program for medical students and junior doctors
	3 years	17 deliver rural readiness workshops for trainees 18 deliver rural readiness and supervision workshops for Specialist International Medical Graduates (SIMGs) 19 work with governments and health services to develop an RPTP information hub, including available rural training posts and jobs 20 facilitate buddy arrangements for new rural trainees with current trainees
	4 years to 10 years	21 continue to develop and promote the rural training pipeline through partnerships with universities, regional training hubs, health services, and other education and medical agencies

Area	Within	the RANZCP will:
Education programs	1 year	22 establish a rural exam support program for rural trainees, particularly for written exams and Objective Structured Clinical Exams (OSCEs)
	2 years	23 improve access to research and quality improvement project opportunities and support/supervision for rural trainees undertaking Scholarly Projects
	3 years	24 establish a strong rural trainee peer support network 25 increase rural supervisor levels to support exam preparation programs, exam delivery and assessments 26 develop rural education modules for existing FECs that meet the RANZCP curriculum requirements, provide rurally appropriate content, and promote remote, multi-disciplinary team-based and generalist learning
	4 years to 10 years	27 complete and implement the review of Formal Education Courses (FECs) to incorporate RPTP strategies and activities 28 examine the potential for rural education collaborations with GP colleges
Clinical rotations	1 year	29 develop networked arrangements to expand rural training opportunities, including to leverage and enhance connections with and within the private sector 30 develop regulations for remote supervision, including remote case review and online clinical team meetings
	2 years	31 broaden settings and regulations in which consultation–liaison (C–L) and child and adolescent psychiatry (CAP) can be provided, recognising cumulative rotations and competencies across a range of settings
	3 years	32 advocate to increase service funding for additional rural training posts or specialised teams in high-need rural locations 33 conduct rotation forward planning with individual trainees and at the health service/regional/jurisdictional level 34 build supervisor capacity in new training locations or where there is insufficient supervision capacity to expand training opportunities 35 streamline post planning, allocation and accreditation processes 36 facilitate the development of portable employment and education arrangements to enable trainees to move within and between states/territories 37 ensure there is greater transparency of decision-making and advice in the allocation of Specialist Training Program/Integrated Rural Training Pipeline (STP/IRTP) positions
	4 years to 10 years	38 build capacity to expand rural training to smaller rural centres through access to supervisors and networked arrangements 39 develop and support pathways for rural trainees to undertake subspecialist training rotations in metropolitan locations
Support	3 years	40 develop a comprehensive support package for rural trainees 41 develop a comprehensive support package for rural supervisors 42 ensure that appropriate infrastructure (dedicated education facilities and information technology (IT)) is available to ensure rural trainees have access to education, supervision and peer support 43 provide retention incentive packages for rural trainees, including incentives to remain in a rural location after Fellowship, and Transition to Practice programs 44 develop a comprehensive support package for rural psychiatrists
	4 years to 10 years	45 continue to develop supports for the rural psychiatry workforce.

2 Introduction

Rural and Indigenous communities in Australia and New Zealand have long suffered poorer mental health status and access to mental health services. This has been exacerbated by an under-investment in rural mental health services, as well as a metro-centric medical education system that is predominantly designed to deliver training to meet the needs of metropolitan communities.

Change is desperately needed to address the inequalities in mental health status and service provision that exist between rural and metropolitan areas, to redress severe psychiatry workforce shortages in rural areas and raise the profile of rural training opportunities

2.1 Rural Psychiatry Training Pathway

This roadmap provides a **10-year action plan to build the Rural Psychiatry Training Pathway (RPTP) to RANZCP Fellowship.**

The roadmap has been developed through an extensive consultation process – conducted by Australian Healthcare Associates on behalf of the RANZCP – that included:

- stakeholder interviews, resulting in input from more than 200 stakeholders across Australia and New Zealand
- release of a public consultation paper
- 5 workshops involving 52 government, psychiatry, university and regional training hub participants, held in states across Australia, to seek feedback on the draft roadmap.

The RPTP is designed to enhance the quality of generalist psychiatry training while opening up greater opportunities for rural trainees to achieve RANZCP Fellowship in rural locations.

Rural communities are typically spread over larger geographical areas with less access to subspecialty services and need psychiatrists with generalist skills to meet whole-of-population mental health needs. Given that all psychiatrists are trained as generalists, rural communities provide an ideal training ground for trainee psychiatrists.

The RPTP is not a separate RANZCP Fellowship pathway. Rather, it is designed to enhance the current RANZCP Fellowship Program by supporting trainees to achieve RANZCP Fellowship in a rural setting.

Recognising the nature of rural psychiatry practice, the RPTP will focus on rural generalist and Indigenous psychiatry, while offering rural subspecialty and Certificate of Advanced Training (CAT) rotations wherever services, supervision and support are available.

While the RPTP aims to provide all training end-to-end in a rural location as far as practicable, it may be that some rotations – particularly subspecialty rotations – are only available in metropolitan centres. The RPTP will facilitate and support rotations to metropolitan centres, enabling trainees to return to their rural 'home base' when completed.

The RPTP will also provide opportunities for metropolitan-based trainees to undertake rural rotations if they become interested in exploring rural opportunities or experiencing a 'tree change' or 'sea change'.

Through these means, the RPTP will play a key role in growing the rural generalist psychiatrist workforce and expanding services for rural communities.

3 Why change is needed

3.1 Rural mental health

People living in rural areas have, on average, shorter lives, higher levels of disease and injury, higher prevalence of some chronic conditions and disability, higher rates of unsafe alcohol and illicit drug use, and greater exposure and vulnerability to natural disasters and the impact of climate change (National Rural Health Alliance 2017, Australian Institute of Health and Welfare 2019a).

While the prevalence of mental illness is similar to that seen in urban areas, rates of suicide and self-harm are higher in rural areas (Garvan Research Foundation 2015, Australian Institute of Health and Welfare 2019a), and further increase with degree of remoteness (Harrison & Henley 2014). For example, Australians living in remote and very remote parts of the country are about *twice as likely* to die by suicide than those in major cities (Australian Institute of Health and Welfare 2019a).

The observed mental health inequalities in rural areas may also reflect poorer access to, and use of, health services. Access can be challenging due to distance and financial cost. In addition, high levels of stigma and a reluctance to seek help with mental health also inhibit people from accessing treatment (Garvan Research Foundation 2015, National Rural Health Alliance 2015, Rural Doctors Association of Australia 2018).

Indigenous mental health

In both Australia and New Zealand, there is a need for more focus on mental health services for Indigenous peoples, especially in rural and remote areas (RANZCP 2019).

Both Aboriginal and Torres Strait Islander and Māori populations have a higher prevalence of mental health disorders than the general population. In Australia, rates of suicide – as well as mental health problems more broadly – are significantly higher for Aboriginal and Torres Strait Islander peoples than in the wider community (Productivity Commission 2020).

In addition, Indigenous peoples represent a higher proportion of the population in rural areas – for example, in Australia, Aboriginal and Torres Strait Islander peoples represent 2% of the population living in major cities, but 48% of the population living in very remote areas (Australian Bureau of Statistics 2018).

Acute rural psychiatry workforce shortages

Only 14% of Australian psychiatrists work rurally, but 29% of the population – around 7 million people – live in regional, rural and remote areas (Australian Bureau of Statistics 2017, Australian Health Practitioner Regulation Agency 2020).

The discrepancy is even more pronounced in relation to the number of full-time equivalent (FTE) psychiatrists. On a FTE basis in Australia, almost 9 out of 10 FTE psychiatrists work in major cities, meaning only 10% of the FTE psychiatric workforce works in regional areas. In 2018, there were 16.0 FTE psychiatrists per 100,000 population in major cities, 6.9 in inner regional areas, 5.7 in outer regional areas, 6.7 in remote areas and 3.1 in very remote areas (Australian Institute of Health and Welfare 2019b).

Enhancing the rural psychiatry workforce is also imperative to improving mental health outcomes for Indigenous peoples. In addition to the general barriers to care noted above, access to, and use of, mental health services may be further limited by a lack of culturally appropriate services. In part, this shortage is likely due to the under-representation of Aboriginal and Torres Strait Islander

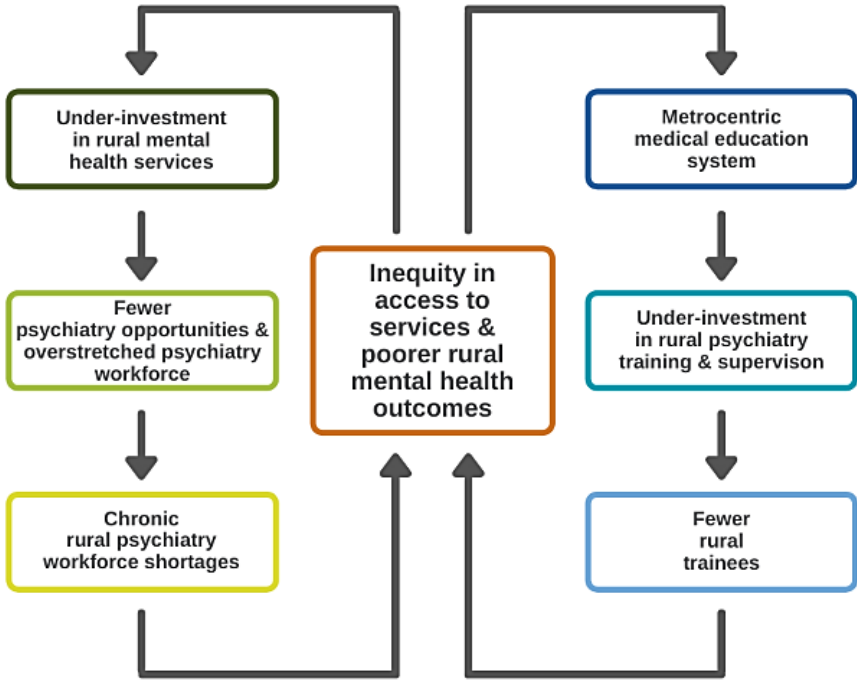
(and Māori) peoples in the mental health workforce (Australian Institute of Health and Welfare 2017).

Cycle of rural psychiatry disadvantage

Rural and Indigenous communities in Australia and New Zealand have poorer mental health status and less access to mental health services.

This has created a cycle of rural psychiatry disadvantage (Figure 3-1) where under-investment in rural mental health and psychiatry services results in fewer work and training opportunities for psychiatrists and trainees, and has been exacerbated by a medical education system that is predominantly designed and delivered in metropolitan areas to meet the needs of metropolitan communities. Together, this has led to psychiatry workforce shortages and, as a result, there are fewer available services for those living and working in rural areas.

Figure 3-1. Cycle of rural psychiatry disadvantage



Change is desperately needed to address the inequalities in mental health status and service provision between rural and metropolitan areas.

Greater investment in rural psychiatry training is key to redressing workforce shortages. Initiatives such as the Extending the Regional Medical Training Pipeline to Psychiatry in Queensland (see Section 3.3) show what greater investment in rural training can achieve.

3.2 Training psychiatrists

Current psychiatry training reflects a health and medical education system that is metrocentric, and that fails to recognise the generalist benefits afforded by rural training (ACRRM 2014). Most psychiatry

services are located in large cities, are narrowly focused and are perceived to be of better quality to those offered in rural settings.

Furthermore, medical schools and training programs for specialists are mostly metropolitan based, forcing many students and trainees from rural areas to relocate to capital cities for medical training. Understandably, many of these students and early career doctors build lives, families and careers in cities and do not return to rural communities. This has contributed to a concentration of psychiatrists in metropolitan areas, and the negative perceptions of rural professional offerings and opportunities.

Building the rural training pipeline

While this situation is gradually changing with greater investment in rural clinical schools (RCSs) and medical education in rural locations, there is a dearth of opportunities in postgraduate specialist medical education and training in rural locations.

For students completing their basic medical degrees in rural locations, emerging evidence shows that investment in rural training is producing positive outcomes in the quality of the training, in student results and in positive benefits for rural communities (ACRRM 2014).

Rural psychiatry training

Overall, 88% of Australian accredited metropolitan and rural training posts in rotation 1, 2020, were funded predominantly by the states and territories or privately, with 12% funded through Australian Government-funding streams.

In rotation 1, 2020, there were 194 trainees based in rural locations (14% of all Australian psychiatry trainees). However, 96 of the 194 (almost 50%) were working in Australian Government-funded STP or IRTP posts, suggesting an under-investment in rural mental health services and training opportunities at the state and territory level (RANZCP 2020). Rural training is therefore heavily reliant on investment from the Australian Government for training positions.

Improvements in training opportunities and mental health services will need significant state government investment, in conjunction with continued support from the Australian Government.

While the majority of training positions are in the public sector, there are opportunities in the private sector that are supported by Australian Government STP funding. There is also the potential to expand rural training opportunities in the private sector.

Supervisor shortages

Funding for additional rural supervisors and support – including dedicated time for supervision – is essential if training opportunities are to be expanded in rural areas.

Any expansion of rural training opportunities is heavily reliant on having supervisors available in rural locations. The current rural 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 (FIFO) 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.

National Rural Generalist Pathway

In 2021, the Australian College of Rural and Remote Medicine (ACRRM) and the Royal Australian College of General Practitioners (RACGP) commenced the National Rural Generalist Pathway (NRGP).

The NRGP seeks to improve the availability of health care in rural and remote areas, including general practice, emergency, mental

health and other components of specialist care (National Rural Generalist Taskforce 2018). It provides GP trainees with a defined and supported pathway to undertake their generalist training in rural and remote areas.

This roadmap is designed to complement and link in with the introduction of the National Rural Generalist Pathway (NRGP) by providing psychiatry expertise to build the mental health component of the NRGP.

Rural psychiatrists play an important role in providing support to rural GPs, including supervision of GPs undertaking advanced skills in mental health. A more stable rural psychiatry workforce provides a better foundation for rural generalist GP training and supervision in mental health. Improving the rural psychiatry workforce in parallel with the NRGP will therefore enhance delivery of the ACRRM and RACGP NRGP training.

3.3 Reform environment

Major mental health and medical workforce reforms are currently underway in Australia, and the roadmap has been developed with these in mind. It is closely aligned to the recommendations and priorities outlined below. These reforms should also be considered as the RPTP is established, and when the roadmap or its implementation is reviewed and revised.

The *Draft National Medical Workforce Strategy* (Department of Health 2020), includes recommendations applicable to the RPTP such as: using comprehensive data and evidence to inform medical workforce planning; enabling training to be primarily undertaken in rural areas where possible; allowing greater flexibility in how supervision, accreditation, and assessment requirements are met; building the generalist capability of the medical workforce; and establishing coordinated training pathways and portability of entitlements across different settings.

The *Mental Health Inquiry Report* (Productivity Commission 2020), suggests a national plan be developed to increase the number of practising psychiatrists, particularly outside major cities, and highlights the need to consider models of remote supervision for trainees in rural areas.

The *National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan* (The Aboriginal and Torres Strait Islander Health Workforce Working Group 2011) sets out strategies to bolster recruitment and retention of Aboriginal and Torres Strait Islander health professionals, provide culturally safe workplaces, and ensure data collection and monitoring capability is sufficient for workforce planning and monitoring of cultural safety targets.

The Future Health Workforce – Psychiatry Report (Department of Health 2016) which identified issues in the under-supply of psychiatrists, access to C–L and CAP posts and supervisor capacity. The report suggested consideration be given to

introducing a remote supervision model, and to strategies enabling trainees and supervisors to access more training and support.

In New Zealand, key strategies relevant to this roadmap include *New Zealand's Mental Health and Addiction Workforce Action Plan 2017–2021* (Ministry of Health 2018), *Framework for developing New Zealand's health workforce* (Ministry of Health 2019a), *Ola Manuia: Pacific Health and Wellbeing Action Plan 2020–2025* (Ministry of Health 2020), *Every Life Matters He Tapu te Oranga o ia Tangata: Suicide Prevention Strategy 2019–2029 and Suicide Prevention Action Plan 2019–2024 for Aotearoa New Zealand* (Ministry of Health 2019b).

Impact of COVID-19

COVID-19 has highlighted that system change can be enacted rapidly. A culture of adaptability has been embraced, which has seen the swift introduction of new models of care, remote education and supervision practices and increased levels of outreach work via telehealth. This suggests that a contemporary approach to the use of IT and remote technology – one that would enable an RPTP to be established and thrive – is very possible.

Psychiatry training can have a real impact

In this context, reform to develop dedicated rural psychiatry training pathways can have a major impact in supporting real workforce change, resulting in direct improvements in services for rural communities.

Two case studies (see next page) highlight how change is possible through investment, increased governance, and support for rural psychiatry training. Extending the Regional Medical Training Pipeline in rural Queensland introduced rural Directors of Training (DoTs) to build rural training capacity. The NSW Rural Psychiatry Project built regional training capacity in Orange, Central Coast, Dubbo and Broken Hill, resulting in a marked increase in psychiatry trainees and psychiatrists in these regions.

Case Study 1: Extending the Regional Medical Training Pipeline in rural Queensland

Around 10 years ago, the Queensland Government became increasingly concerned about the growing shortfall of psychiatrists across the state, and the pronounced impact on regional and rural areas. Evidence suggested that the two most effective ways to increase the regional and rural medical workforce were to increase the number of rural people entering medicine, and to increase the number of regional and rural medical training opportunities.

A key part of the Queensland Government's response was to provide workforce initiative funding for an increase in the DoT support for psychiatry training in regional Queensland, with 0.5 FTE for each of the state 'clusters' (northern, central and southern) and a particular focus on enhancing the support of regional training in collaboration with the statewide post graduate training program. This included a key position based in Townsville to provide targeted support for North Queensland trainees, replacing support previously provided from Brisbane.

These regional DoT positions have facilitated the development of a regional training network targeting regional trainee needs. In particular, this has included preparation for written and clinical exams, provision of psychotherapy supervision and training, and developing scholarly expertise such as clinical research and continuous quality improvement projects. The initiative has also stimulated collaboration with other regional initiatives – such as the regional training hubs – to produce increasing numbers of medical students and junior doctors recruited from, trained in and working in the regions, extending the medical training pipeline from general into specialist training and practice in Northern Queensland.

Queensland's regional DoT initiative has demonstrated that regional trainees, and the health services and clinicians that nurture them, face distinct challenges but can also leverage specific resources if they are provided with dedicated executive and administrative support.

Case Study 2: NSW Rural Psychiatry Project

The NSW Rural Psychiatry Project was established in 2002 to support psychiatrists working in rural NSW and to further allow for the local expansion of this workforce (Australian Health Ministers' Advisory Council 2010). Funding was provided for a project coordinator and project support. Priority was given to rural placements, with scholarships available for doctors who chose to do more than one rotation in a rural area.

NSW's Network B consists of Northern Sydney, Central Coast, Orange, Dubbo and Broken Hill. When the project commenced in 2006, there were 10 accredited posts across this network, including 2 posts at Orange and 6 to 8 posts on the Central Coast. There were no accredited posts at Dubbo or Broken Hill.

Within 14 years the numbers of accredited posts have increased substantially to a total of 37. These include 2 posts at Dubbo, 1 post at Broken Hill, 11 posts at Orange and 23 posts on the Central Coast. This initiative also had a significant long-term effect on the local psychiatry workforce. To date, Orange has had 7 locally-trained psychiatrists graduate as RANZCP Fellows, with 6 still working locally. Over the next two years, Orange is due to have one more trainee graduate every six months.

Key findings from this project included the following:

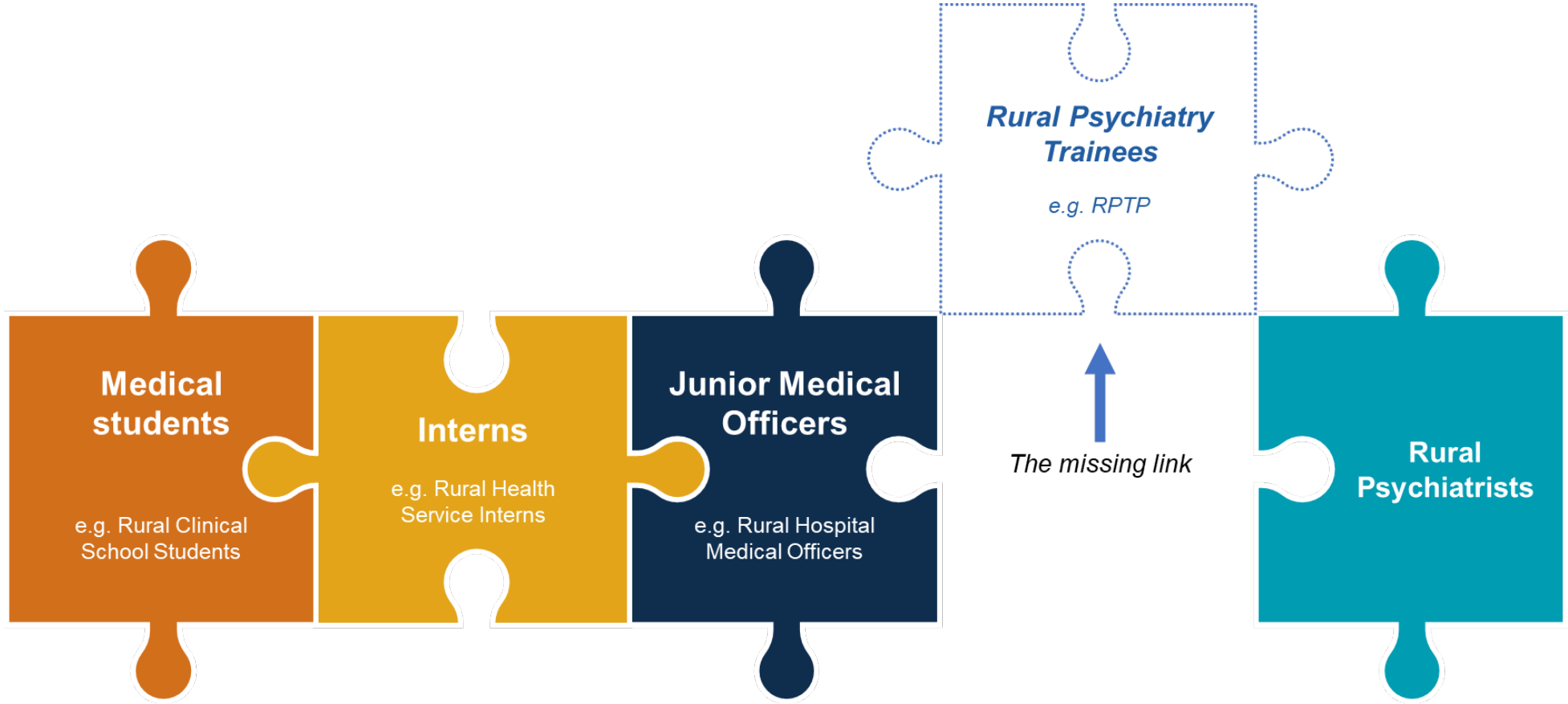
- Health services need to have a long-term view regarding the workforce
- Strong clinical direction is needed to advocate for the psychiatry service, obtain funds and put in applications for posts (STP)
- Support for the Clinical Director is required to avoid burnout
- Targeting psychiatrists that are based rurally and providing them good supervision and quality training attracts more trainees to the area
- Growth in trainee numbers helps bring some security to the consultant workforce.

3.4 Developing end-to-end rural training

Building a rural pipeline that provides end-to-end training (basic medical training, pre-vocational and vocational generalist, and specialist psychiatry experience) in rural locations will support the increase in rural psychiatrists.

However, in the current pipeline, rural psychiatry training is the missing link to the provision of end-to-end training for rural students and junior doctors interested in psychiatry training (Figure 3-2); filling the gap strengthens the pipeline along its entirety. Increased available rural psychiatry trainees enables further expansion and development of junior doctor and medical student experiences, teaching and supervision. This missing link can be solved by the introduction of the RPTP.

Figure 3-2: Rural psychiatry pipeline – the missing link



4 Rural Psychiatry Training Pathway

The RPTP will enhance the quality of generalist psychiatry training and open up greater opportunities for trainees to achieve RANZCP Fellowship in rural locations.

The RANZCP Fellowship Program trains psychiatry generalists; that is, psychiatrists with a broad range of skills across the lifespan, who have undertaken training within a range of hospital and community settings and who are best equipped to provide the broadest possible range of care and interventions to meet the mental health needs of a community.

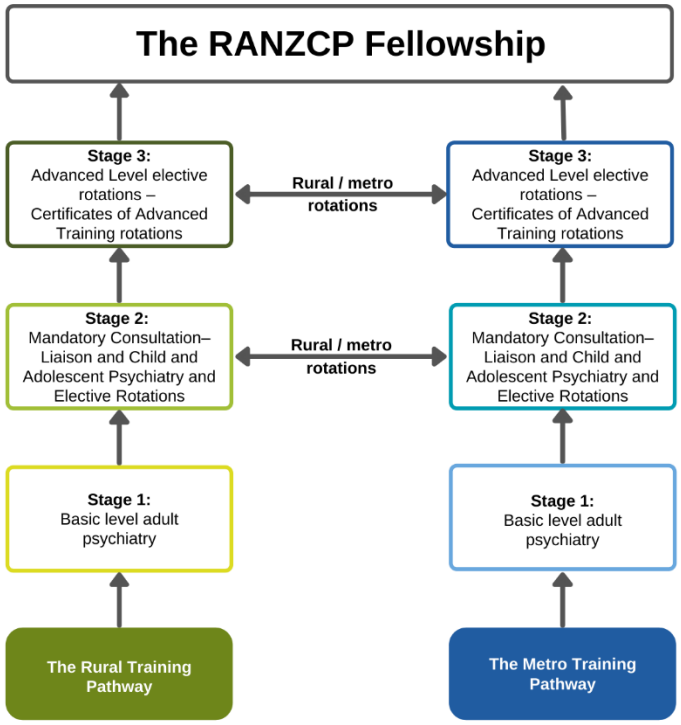
Given that rural communities have less access to subspecialist psychiatry services, training in rural locations can provide excellent generalist training opportunities. Recognising the nature of rural psychiatry practice, the RPTP focuses on rural generalist and Indigenous psychiatry, while also offering rural Certificate of Advanced Training (CAT) rotations wherever services, supervision and support are available.

The goal is to provide all training in a rural location as far as practicable. However, it may be that some rotations, particularly subspecialty rotations, are only available in metropolitan centres. Trainees will be assisted to access metropolitan rotations where needed and to return to their rural 'home base' when completed.

The RPTP will also provide the opportunity for metropolitan trainees to undertake rural rotations if they become interested in exploring rural opportunities, want to enhance their generalist Fellowship training, or want to experience a 'tree change' or 'sea change'. The end goal of both the rural and metropolitan pathways is to complete the RANZCP Fellowship Program (Figure 4-1).

While the focus of the RPTP will be on psychiatry registrars, it is recognised that all doctors are life-long learners. Where a Fellow in a rural area is interested in upskilling in an area of community need, the RPTP can also provide opportunities for them to undertake post-traineeship training. Similarly, it is recognised that SIMGs also play a key role in providing services in rural communities, and this roadmap includes some support for SIMGs. However, addressing all the issues in SIMG training is outside the scope of this roadmap and requires dedicated attention.

Figure 4-1: Rural and metropolitan pathways to RANZCP Fellowship

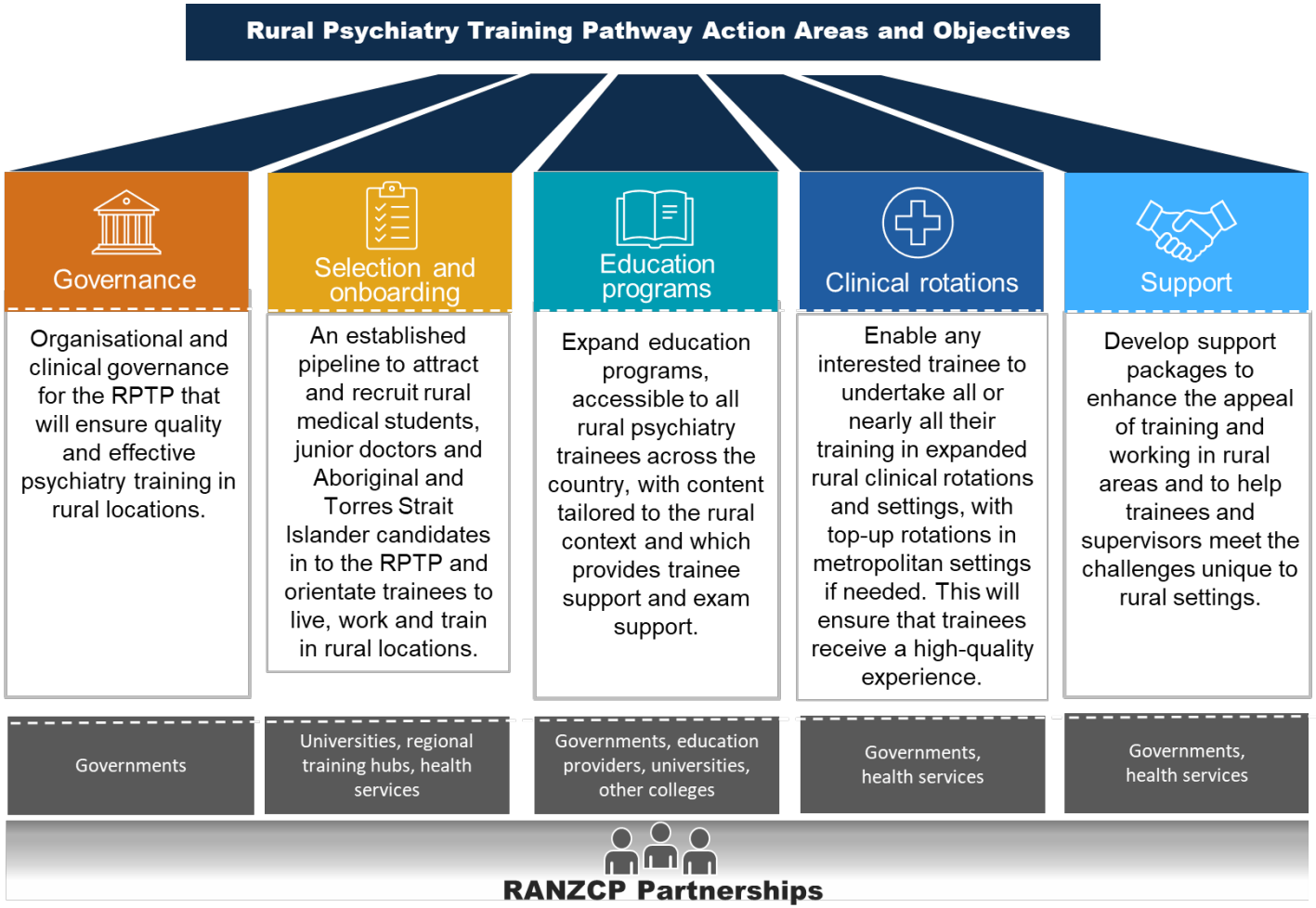


4.1 Overview

This roadmap provides a **10-year action plan** to build the Rural Psychiatry Training Pathway (RPTP) to RANZCP Fellowship.

Figure 4-2 provides an overview of the RPTP's 5 action areas and key partner responsibilities. The development of the RPTP will rely on the formation of key strategic partnerships and collaborations to attract the modest investment needed to deliver the roadmap action plan. This will include partnerships with national, state and territory governments, health services, universities, rural training hubs and other colleges such as ACRRM and the RACGP.

Figure 4-2: Rural Psychiatry Training Pathway



4.2 Aims and objectives

While the pathways to Fellowship may vary between jurisdictions, the RPTP proposed in this roadmap is designed to enhance Fellowship training to:

- enable trainees to complete all, or nearly all, of their RANZCP Fellowship psychiatry training in rural areas
- support the growth of a sustainable rural psychiatry workforce and drive improvements in the mental health of rural communities
- support local workforce planning by aligning training with community need
- create and promote a positive rural and generalist culture across the RANZCP membership
- ensure the delivery of quality generalist training experiences for RANZCP Fellowship, tailored to the rural setting to capitalise on the diverse professional opportunities, the goodwill to improve rural services and the rich generalist, subspecialist and multidisciplinary team-based training experiences that exist in rural areas
- ensure training reaches beyond regional centres to enable participation of smaller and more remote rural health services, clinics and Aboriginal and Torres Strait Islander health services
- provide a seamless and streamlined experience for rural trainees across all stages of Fellowship training
- ensure that rural trainees have equitable access to training resources, including access to resources available to metropolitan trainees
- report on the increase in rural trainee and psychiatry workforce as a result of the RPTP.

The **objectives** of the RPTP are to:

- enhance the rural footprint within the culture and structure of the RANZCP
- attract and support those who have a rural background, rural training experience and an interest in rural psychiatry practice to live, work and train in rural locations
- attract and support Aboriginal and Torres Strait Islander applicants interested in rural practice
- build networked arrangements to expand rural and Indigenous training opportunities, including the mandatory rotations in C–L, CAP and other subspecialty areas
- deliver quality generalist Fellowship training in rural locations for rural trainees
- attract the funding, support and resources needed to deliver the RPTP
- provide more remote supervision arrangements and training opportunities
- build vital peer support for trainees, supervisors and Specialist International Medical Graduates (SIMGs)
- embrace technology, remote education and telehealth solutions in training program delivery.

The RPTP will be supported by the enhanced use of technology and remote supervision arrangements in approved circumstances. The COVID-19 pandemic has demonstrated the potential of technology, remote education and telehealth opportunities in closing the gap between rural and metropolitan clinical and training settings. This demonstrates that what was perhaps once considered impossible is now possible.

Establishing the RPTP is not without its challenges. Systemic barriers and bottlenecks currently stifle psychiatry training in rural areas. The RANZCP will be required to positively support, promote and enhance rural training and psychiatry practice in all its endeavours.

The coordination, advocacy and support of RPTP trainees must be provided by dedicated rural DoTs. The lack of availability of mandatory rotations, particularly in CAP and C–L, as well as access to some CAT rotations and experiences, must also be addressed as a priority.

Further funding, partnership and collaboration is needed to address these systemic barriers and bottlenecks, including between:

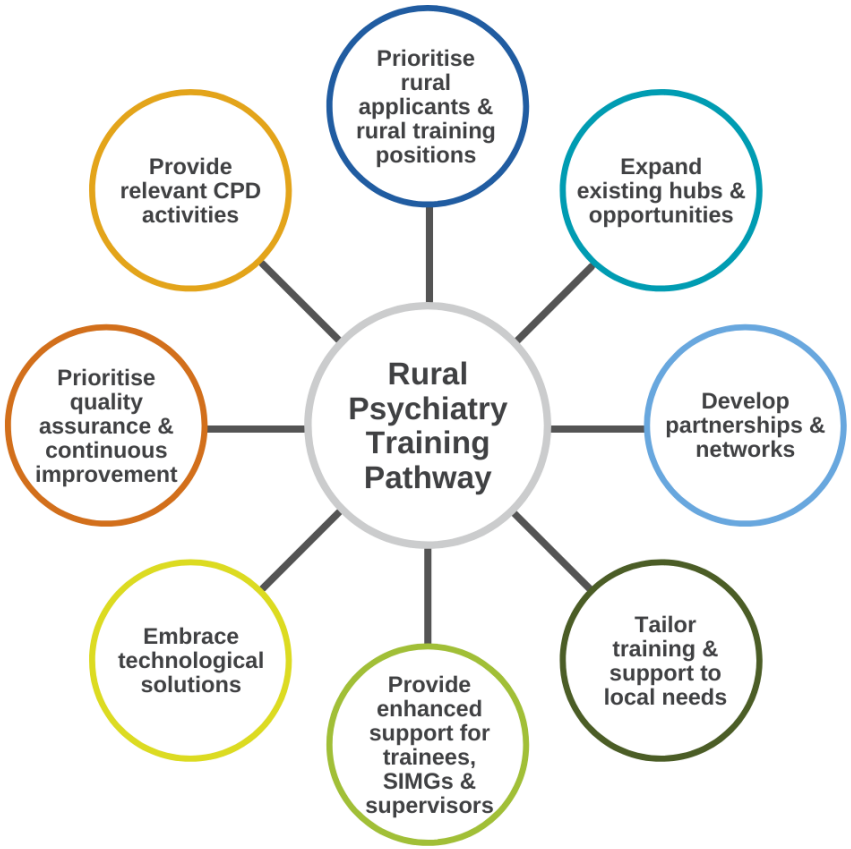
- the RANZCP, which sets quality standards and curriculum and coordinates the delivery of Fellowship training for psychiatrists
- the Australian Government, which supports the funding of rural training positions
- planning authorities (i.e. states and territories), which fund DoTs and public health services
- public and private health services, which fund psychiatry training positions, supervision and support
- medical education providers, which deliver rural medical education for medical students, junior medical staff and RANZCP trainees.

4.3 Principles

Achievement of these objectives will be underpinned by a commitment to the following **principles**, as summarised in Figure 4-3:

- Prioritising rural applicants and rural training positions.
- Building on and expanding existing training locations and opportunities (including training posts and supervision opportunities) in public, private, not-for-profit and Aboriginal and Torres Strait Islander health service settings, expanding rural training capacity in a sustainable way.
- Developing genuine partnerships with governments, health services, mental health professionals and other agencies to facilitate networked rural training delivery across different regions.
- Adopting an approach that enhances quality and content, while allowing training and support to be tailored to local needs, recognising diversity in geography, mental health service systems, and cultural and community characteristics and contexts.
- Providing enhanced support for trainees, SIMGs and supervisors to ensure the recruitment and retention of a dedicated, highly skilled and highly motivated rural workforce.
- Embracing technology and telehealth to provide innovative solutions to improve service access, education opportunities, supervision, and workforce and trainee support.
- Prioritising quality assurance and continuous improvement activities, informed by data-driven monitoring and review of RPTP processes and outcomes, to ensure all Australian Medical Council (AMC) and RANZCP training standards are met.
- Providing access to relevant CPD activities to support the rural psychiatry workforce to meet generalist education needs.

Figure 4-3. RPTP principles



4.4 Outcomes and KPIs

In implementing the RPTP, agreed key performance indicators (KPIs) must be established to measure progress and outcomes. KPIs will centre on measuring:

- increases in the distribution of psychiatry trainees into rural locations
- increases in participation in the RANZCP Fellowship Program by trainees of rural origin and Aboriginal and Torres Strait Islander background
- changes in the number and clinical range of training positions in rural locations across jurisdictions
- reductions in bottlenecks in key clinical rotations such as C–L and CAP
- increases in the distribution of generalist psychiatrists, and some subspecialist psychiatrists, into rural locations
- increases in the number of rural supervisors
- increases in particpation of rural supervisors in Fellowship education, training and assessment activities
- increases in particpation of rural Fellows and trainees in RANZCP committee membership and governance.

4.5 Action Plan

The roadmap action plan is organised into 5 action areas, with activities and timeframes specified for each (Table 4-1). Each action area is discussed in detail in Sections 5 to 9.

Table 4-1: RPTP Action plan

RPTP Action Plan		
Area	**Within**	**the RANZCP will:**
Governance	1 year	1 establish RPTP bi-national governance arrangements and rural representation within the current RANZCP committee structure
		2 review current competency-based Fellowship regulations to enhance the RPTP pathway
		3 appoint an RPTP National Director, co-ordinator and administrative support
		4 initiate partnerships required to develop the RPTP, including with national, state and territory governments, health services, health regions, workforce planning bodies, universities, regional training hubs and other colleges
		5 develop initial funding and sponsorship proposals to deliver the RPTP
	2 years	6 develop Rural Director of Training positions and seek funding within each jurisdiction to support these positions
		7 develop an RPTP implementation plan, in consultation with key stakeholders, to commence the RPTP from 2023
		8 develop a Monitoring, Evaluation and Learning (MEL) framework for the RPTP
	3 years	9 develop data collection and reporting capability to support RPTP delivery, monitoring and evaluation
		10 create and promote a positive rural and generalist Fellowship culture across the RANZCP membership
	4 years to 10 years	11 conduct a mid-term review of RPTP progress in 2026
		12 formally evaluate the RPTP by 2031
Selection and onboarding	1 year	13 amend selection regulations and develop selection criteria to prioritise rural applicants for the RPTP
		14 amend selection regulations to prioritise eligible Aboriginal and Torres Strait Islander applicants for the RPTP
		15 develop and deliver an RPTP communications and promotion strategy
		16 consider the inclusion of a dedicated rural stream within the current Psychiatry Interest Forum (PIF) program in the planned evaluation of this program
	3 years	17 deliver rural readiness workshops for trainees
		18 deliver rural readiness and supervision workshops for Specialist International Medical Graduates (SIMGs)
		19 work with governments and health services to develop an RPTP information hub, including available rural training posts and jobs
		20 facilitate buddy arrangements for new rural trainees with current trainees
	4 years to 10 years	21 continue to develop and promote the rural training pipeline through partnerships with universities, regional training hubs, health services, and other education and medical agencies

Area	Within		the RANZCP will:
Education programs	1 year	22	establish a rural exam support program for rural trainees, particularly for written exams and Objective Structured Clinical Exams (OSCEs)
	2 years	23	improve access to research and quality improvement project opportunities and support/supervision for rural trainees undertaking Scholarly Projects
	3 years	24	establish a strong rural trainee peer support network
		25	increase rural supervisor levels to support exam preparation programs, exam delivery and assessments
		26	develop rural education modules for existing FECs that meet the RANZCP curriculum requirements, provide rurally appropriate content, and promote remote, multi-disciplinary team-based and generalist learning
	4 years to 10 years	27	complete and implement the review of FECs to incorporate RPTP strategies and activities
		28	examine the potential for rural education collaborations with GP colleges
Clinical rotations	1 year	29	develop networked arrangements to expand rural training opportunities, including to leverage and enhance connections with private health services
		30	develop regulations for remote supervision, including remote case review and online clinical team meetings
	2 years	31	broaden settings and regulations in which consultation–liaison (C–L) and child and adolescent psychiatry (CAP) can be provided, recognising cumulative rotations and competencies across a range of settings
	3 years	32	advocate to increase service funding for additional rural training posts or specialised teams in high-need rural locations
		33	conduct rotation forward planning with individual trainees and at the health service/regional/jurisdictional level
		34	build supervisor capacity in new training locations or where there is insufficient supervision capacity to expand training opportunities
		35	streamline post planning, allocation and accreditation processes
		36	facilitate the development of portable employment and education arrangements to enable trainees to move within and between states/territories
		37	ensure there is greater transparency of decision-making and advice in the allocation of Specialist Training Program/Integrated Rural Training Pipeline (STP/IRTP) positions
	4 years to 10 years	38	build capacity to expand rural training to smaller rural centres through access to supervisors and networked arrangements
		39	develop and support pathways for rural trainees to undertake subspecialist training rotations in metropolitan locations
Support	3 years	40	develop a comprehensive support package for rural trainees
		41	develop a comprehensive support package for rural supervisors
		42	ensure that appropriate infrastructure (dedicated education facilities and IT) is available to ensure rural trainees have access to education, supervision and peer support
		43	provide retention incentive packages for rural trainees, including incentives to remain in a rural location after Fellowship, and Transition to Practice programs
		44	develop a comprehensive support package for rural psychiatrists
	4 years to 10 years	45	continue to develop supports for the rural psychiatry workforce.

4.6 Detailed strategic recommendations

The timeframe for the success of this pathway will rely on increased investment by all parties. The RANZCP has responsibility for the standards, coordination and delivery of the RANZCP Fellowship Program; while trainee positions, employment conditions, supervision and support are reliant on government-funded health services.

This roadmap requires not just commitment but RANZCP-led partnerships and collaborations with national, state and territory governments, workforce planning bodies, health services, universities and regional training hubs. Without further strengthening of partnerships and investment, the RPTP will not be possible.

RANZCP

The **RANZCP** will establish the RPTP governance and staffing arrangements, revise regulations, enhance education programs and lead partnerships and collaborations to deliver the RPTP. Specifically, the RANZCP's responsibilities will include the following:

Governance

- Establish bi-national governance arrangements for the RPTP within the current RANZCP structure.
- Ensure greater rural representation on relevant RANZCP committees.
- Review current competency-based Fellowship regulations to enhance the RPTP pathway.
- Appoint RANZCP RPTP program champions and staff, including an RPTP National Program Director, an RPTP coordinator and administrative support. The RANZCP will also develop Rural Director of Training positions and seek funding within each state or territory to support these positions.
- Initiate partnerships required to develop the RPTP, including with national, state and territory governments, health services, health regions, workforce planning bodies, universities, regional training hubs and other colleges. These partnerships will also ensure that future workforce initiatives and reforms – including in medical workforce data collection activities and the National Medical Workforce Strategy (NMWS) – are taken into consideration in the development of the RPTP.
- Develop funding and sponsorship proposals to deliver the RPTP. This includes:
  - seeking government funding for components of the RPTP program (see strategic recommendations for the Australian Government, state and territory governments and health services below)
  - exploring the potential for RPTP sponsorship arrangements or collaborations with national mental health organisations (such as Beyond Blue or the Black Dog Institute) and private mental health service providers.
- Develop an RPTP implementation plan, in consultation with key stakeholders, to commence the RPTP in Australia from 2023. The implementation plan will include a rotations gap analysis and strategies for establishing jurisdictional arrangements for the implementation of RPTP. Consultations with relevant New Zealand RANZCP members will be conducted to consider how the concepts in this roadmap can be adapted for the New Zealand context.
- Develop a Monitoring, Evaluation and Learning (MEL) framework for the RPTP.

- Develop data collection and reporting capability to support selection of trainees, RPTP program delivery, performance monitoring and evaluation.
- Create and promote a positive rural and generalist culture across the RANZCP membership and explicitly outline the College's social contract and commitment to rural communities.
- Evaluate the progress and outcomes of the RPTP by conducting a:
  - mid-term review of RPTP progress in 2026
  - formal evaluation of the RPTP by 2031.

Selection and onboarding

The **RANZCP Education Committee** will:

- amend selection regulations and develop selection policies and selection criteria to prioritise eligible rural applicants for the RPTP
- amend selection regulations to prioritise eligible Aboriginal and Torres Strait Islander applicants for the RPTP.

The **RANZCP** will:

- develop an RPTP communications and promotion strategy
- consider the inclusion of a dedicated rural stream within the current Psychiatry Interest Forum (PIF) program for medical students and junior doctors
- design and deliver rural readiness workshops for trainees
- design and deliver rural readiness and supervision workshops for SIMGs
- work with governments and health services to develop an RPTP information hub, including listings of available rural training posts and jobs. This may involve linking in with information initiatives being undertaken in some states and territories with regional training hubs
- facilitate buddy arrangements for new rural trainees with existing trainees
- continue to develop and promote the rural training pipeline through partnerships with universities, regional training hubs, health services, and other education and medical agencies.

Education programs

The **RANZCP Education Committee** will:

- ensure that rural trainees can access education materials and resources available in metropolitan centres
- improve access to research and quality improvement project opportunities, support and supervision for rural trainees undertaking Scholarly Projects
- develop rural education modules for existing FECs that meet the RANZCP curriculum requirements, provide rurally appropriate content and promote remote, multi-disciplinary team-based and generalist learning
- expand grant opportunities to subsidise the cost of attending education and training events for rural trainees and psychiatrists.

The **RANZCP Committee for Exams** will:

- establish a rural exam support program for trainees, particularly for written exams and Objective Structured Clinical Exams (OSCEs).

The **RANZCP** will:

- improve rural networks and access to research opportunities and support with Rural Clinical Schools and universities
- examine the potential for collaborations with other colleges (including ACRRM and RACGP) to facilitate joint education activities and the development of a rurally focused Diploma of Psychiatry
- facilitate the establishment of strong rural trainee and supervisor/examiner networks by developing peer support channels such as online forums, study groups and social networking sites
- establish professional development opportunities for rural supervisors interested in upskilling as examiners.

Clinical rotations

The **RANZCP Education Committee** will:

- develop regulations for remote supervision, including remote case review and online clinical team meetings
- explore opportunities to expand C–L and CAP rotations into new settings, recognising cumulative rotations and competencies across a range of settings and the feasibility of trainees undertaking these rotations in either Stage 2 or Stage 3 generalist levels to improve access to research opportunities and support
- streamline post planning, allocation and accreditation processes.

The **RANZCP** will:

- work with governments and health services to:
  - develop networked arrangements to expand rural training opportunities, and leverage and enhance connections with the rural private sector. This will include subspecialty rotations to metropolitan areas where needed
  - increase service funding for additional training posts or specialist teams in high-need locations
  - broaden settings in which C–L and CAP can be provided
  - build supervisor capacity in new training locations or where there is insufficient supervision capacity to expand training opportunities
  - facilitate the development of portable employment and education arrangements to enable trainees to move within and between states and territories.
- work with governments, health services and medical planning bodies to conduct regional and jurisdictional workforce and training planning for the rural psychiatry workforce
- work with governments to ensure there is greater transparency in decision-making and advice on the allocation of STP/IRTP positions.

Support

- Advocate to national, state and territory governments and health services for comprehensive support packages for rural trainees, supervisors and psychiatrists.

Australian Government

It is proposed that the **Australian Government:**

- develop a partnership agreement with the RANZCP to develop a funding model that ensures the RPTP represents value for money. The partnership agreement may include funding to:
  - support the appointment of RANZCP RPTP national program management to coordinate, implement and administer the RPTP
  - enhance current STP/IRTP funding agreements to enable the creation of additional training positions and supervision for the RPTP
  - expand the rural supervisor workforce, for example, through additional supervisor payments for RPTP positions where psychiatrist supervision is currently lacking or unavailable, particularly in smaller, more remote training settings. Payments should cover supervision time, travel and associated rural supervision costs, and provide an incentive to attract supervisors to targeted locations. Additional payments are likely to be time-limited until workforce expansion is achieved
  - provide additional support for psychiatrists to take on exam preparation, delivery and assessment roles
  - support rural components of formal education programs, including subsidies for rural trainees to attend workshops and events
  - support data collection and reporting capability activities that may also align with National Medical Workforce Strategy and data requirements
  - facilitate the delivery of rural readiness workshops for trainees and SIMGs
  - support the development and delivery of the online information hub.
- consider funding additional trainee positions in Aboriginal and Torres Strait Islander health services
- invest in rural training networks to enable more trainees to undertake their clinical rotations entirely or almost entirely in regional and rural locations
- provide retention incentive payments to trainees who remain in a rural location after qualifying as a Fellow, including financial incentives and Transition to Practice programs.

State and territory governments

It is proposed that **state and territory governments**:

- provide additional funds for the appointment of dedicated rural DoT positions in their jurisdictions. The role, base location and geographic coverage of the rural DoT positions need to be developed by states and territories in consultation with the current DoTs, Branch Training Committees (BTCs) and rural training centres
- provide dedicated funding for additional psychiatry positions in rural areas, with associated targets detailed in the National Partnership Agreement on Health Services. Such positions should be available at rates at least proportionate with metropolitan areas, per capita of the population. Funding should include:
  - additional positions in state-funded services or additional teams (including psychiatrists, supervisors, and trainee positions) in public health services in locations where there are no supervisors or where there is not sufficient capacity. Supervisor funding should cover supervision time, travel and associated rural supervision costs, and incentives to attract supervisors to targeted locations
  - ongoing additional supports for rural psychiatrists, including continuing professional development (CPD), networking and research support
  - increased incentives for rural psychiatrists through competitive salary packages (and relocation costs), access to locum services and travel support for CPD.
- work with national governments to improve the capability and capacity of rural mental health services to supervise and train psychiatry trainees, including offering more mandatory, elective and advanced clinical rotations in locally appropriate settings
- support intra- and inter-jurisdictional rural networks to expand training opportunities
- support the delivery of rural readiness workshops, including providing content on state- or territory-specific issues
- provide 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
- improve data collection and reporting across services to support continuous improvement
- streamline post planning, allocation and accreditation processes (in collaboration with the RANZCP and rural DoTs)
- build capacity to expand rural training to smaller and more remote locations (in collaboration with the RANZCP and rural DoTs)
- ensure infrastructure (facilities and IT) is available to enable effective access to education, supervision and peer support for rural trainees
- consider the introduction of multi-year trainee contracts across all states and territories that include dedicated time for education and support activities.

Health services

It is proposed that **health services**:

- provide dedicated regional and rural psychiatrist training positions and ensure they are adequately funded
- fund new training opportunities in collaboration with rural DoTs
- ensure that all new rural trainees receive training in cultural safety and the specific mental health risk factors for the local community
- assist in finding housing for trainees and their families, and consider how to support employment for a trainee's partner to enable couples to be recruited and retained in regional, rural and remote locations
- ensure access to and uptake of peer networking opportunities
- ensure access to locums to cover psychiatrist leave, including leave for professional development and networking
- provide protected time for trainees to attend conferences and networking events
- allocate protected time for supervisors to provide supervision and engage in training and exam preparation and delivery
- develop networked arrangements to expand training opportunities.

Universities and Regional Training Hubs

It is proposed that **universities and Regional Training Hubs (RTH)**:

- work in partnership with the RANZCP to promote the RPTP to prospective trainees
- work with the RANZCP to promote and support the Psychiatry Interest Forum for medical students and junior doctors
- link medical students and junior doctors interested in psychiatry with the rural DoTs and the RPTP program team
- support and particpate in the development of rural psychiatry training information and opportunties
- improve access to research opportunities and support.

5 Action Area 1: Governance

Organisational and clinical governance for the RPTP that will enhance the quality and effectiveness of psychiatry training in rural locations.

5.1 Why do we need to change?

While the RANZCP has responsibility for **coordinating, establishing, and maintaining training and supervision standards and delivering the RANZCP Fellowship Program**, the funding and establishment of rural training positions, supervision and trainee support is **heavily reliant on government-funded health services**.

The RANZCP **regulations** govern the delivery of the RANZCP Fellowship Program, which is a competency-based Fellowship. Trainee ability is assessed across 7 medical domains (medical expert, communicator, collaborator, leader, health advocate, scholar and professional). The RANZCP competency system is based on the CanMEDS framework developed by the Royal College of Physicians and Surgeons of Canada (Royal College of Physicians and Surgeons of Canada 2015). Trainees must undertake activities that demonstrate to their supervisors that they have increasing experience and expertise and will eventually meet competency standards to become 'entrusted' to conduct a professional activity.

In Australia, the RANZCP Fellowship Program is **delivered through RANZCP-administered state and territory schemes**, which are based at public health service locations and are provided with the financial and infrastructure support of each state and territory. In New South Wales and Victoria, training programs are delivered regionally (5 regions in NSW and 3 regions in Victoria); elsewhere, training programs are delivered on a state- or territory-wide basis.

RANZCP Branch Training Committees (BTCs) in each state and territory are responsible for selecting trainees and overseeing the delivery of the RANZCP Fellowship Program in their jurisdiction.

BTCs work closely with state or territory government-funded DoTs or Directors of Advanced Training (DoATs). Directors are responsible for ensuring that all aspects of the RANZCP Fellowship Program and the Certificate of Advanced Training run smoothly, and that the quality of training is maintained.

Overall, 90% of RANZCP training positions are funded predominantly through state and territory health services and private services. However, in rural locations, almost 50% of **rural trainee positions are funded** by the Australian Government through the STP and IRTP. The STP and IRTP support specialty training beyond metropolitan public tertiary teaching hospitals, in expanded settings including rural, regional, remote, private, and community, as well as Aboriginal Medical Services.

The concentration of psychiatrists, DoTs, trainees and training positions in metropolitan areas has meant rural locations have had to **compete with metropolitan areas for trainees, training positions, influence and resources**.

In the larger states, BTC representation is overwhelmingly metropolitan based. Some stakeholders consulted in the development of this roadmap reported that this meant that metropolitan needs were implicitly prioritised. Stakeholders also reported that **a lack of rural representation on key RANZCP committees and Faculties** could lead to rural perspectives and

needs being overlooked when it comes to the planning and delivery of psychiatry training.

Further, stakeholders indicated that rural workforce shortages act to reinforce **negative perceptions of rural practice**, with a view that rural practitioners face social and professional isolation, unsustainable clinical workloads, and less access to professional development and career opportunities. There is also a perception that rural training is of poorer quality. These perceptions are reportedly being further reinforced by peers and senior staff in metropolitan settings, some of whom were seen to be actively discouraging trainees from applying to rural placements.

5.2 What is needed?

The development of an RPTP will require a national approach, while also working in collaboration with jurisdictional training programs and the RANZCP Training and Education committees. A unified structure is needed to develop, implement, promote, monitor and evaluate the RPTP. Ensuring that rural Fellows, supervisors and trainees are represented on RANZCP committees will support this unified structure.

The success of the RPTP is both dependent on, and will contribute to, a culture in which rural and metropolitan training opportunities and quality are perceived as equal. Rural stakeholders highlighted that **cultural change** is urgently needed to shift perceptions of rural training and practice, and to build engagement with the RPTP. They felt there was a need to promote both the personal and professional benefits of living and training rurally, the latter including greater breadth of experience, responsibility and autonomy, access to senior colleagues, engagement with the broader health system, and leadership and management opportunities.

While effective establishment, operation and governance of the RPTP will not require significant overhaul of the RANZCP workforce, it will not be feasible within existing staff capacity. Therefore, dedicated leadership and administrative resources will be required to establish the RPTP, including the appointment of an **RPTP National Program Director** who will have oversight and accountability for the development, implementation and ongoing operation of the RPTP within the RANZCP. A key requirement of this role will be the capacity to engage with funding partners, BTCs, DoTs, DoATs and health services, as well as understand the governance and quality assurance requirements of the RANZCP. An RPTP coordinator would provide project support, and additional administrative resources will also be required to sustain the considerable work involved in developing and implementing the RPTP.

The RPTP team will need a strong focus on developing partnerships and collaborative working arrangements within the RANZCP and with external stakeholders such as national, state and territory governments, health services, health regions, workforce planning bodies, universities, regional training hubs and other colleges.

In addition, the development and implementation of the RPTP is reliant not only on these stakeholders' relationships with the RANZCP, but on the establishment of strong partnerships between all parties. External stakeholders may therefore need to develop and maintain collaborations that are independent of the RANZCP. Formal partnership agreements, memoranda of understanding (MOU) or other contractual arrangements may help to develop and communicate a shared understanding of these working relationships. It is important to note that RPTP partners and their roles will likely evolve over time, for example, in response to broader mental health and medical workforce reforms.

Rural DoTs will also play a key role in establishing the RPTP. The outcomes of Queensland's regional DoT initiative (see Case Study 1 in Section 3.3) demonstrate that applying a rural DoT lens to the RANZCP Fellowship Program within rural settings helps ensure program fidelity and integrity. Given jurisdictional differences in DoT structure, it is suggested that state and territory governments work

with DoTs, BTCs and rural health services to plan the most appropriate base and geographical coverage for rural DoT responsibilities.

Broadly speaking, it is envisaged that, in addition to the existing DoT role, **rural DoTs** will also advocate for and facilitate the development of new training positions and develop linkages with metropolitan services to increase rotation opportunities. These rural DoT positions are key roles that will require additional investment and support; securing additional funding from state and territory governments for rural DoTs will be essential to ensure all aspects of the RPTP program run smoothly and the quality of training is maintained within and across jurisdictions and stages of training.

Finally, a systematic and enhanced **data capability** will be required to support RPTP delivery, monitoring and evaluation. This will enable the RANZCP to understand RPTP progress and outcomes and refine the program or its implementation accordingly. Comprehensive RPTP data are required to inform continuous improvement activities within the RANZCP, formal evaluation of the pathway and its implementation, and reporting on KPIs to funding bodies and other partners.

Additional data to be collected include information on RPTP applicant and trainee origins and backgrounds; applicant Indigenous status; the number, EFT, location, type and sector (public or private) of RPTP positions; and details of supervisors (including FIFO supervisors).

Trainee data is currently collected and updated by the RANZCP and DoTs. Enhancements to the current data capability will require consultation with relevant RANZCP committees and DoTs, and may include improvements to the current data collection system.

5.3 Governance activities

Table 5-1: Key activities – Action Area 1: Governance

	Activity	Description
Within 1 year:		
1	Establish RPTP bi-national governance arrangements and rural representation within the current RANZCP committee structure.	The RANZCP will: • allocate responsibility for the different components of the RPTP to relevant committees (e.g. Education) • identify which committees require rural representation and determine appropriate KPIs.
2	Review current competency-based Fellowship regulations to enhance the RPTP pathway.	Consistent with the RANZCP role in determining Fellowship regulations, implementing the RPTP pathway may include the potential for amendments to competency-based regulations. In particular, consideration should be given to supporting mandatory rotations such as C–L and CAP in rural areas, to expand training settings and reduce bottlenecks (see also Activity 31).

	Activity	Description
3	Appoint an RPTP National Program Director, coordinator and administrative support.	The appointment of key staff is essential to championing and delivering the RPTP. The establishment of new, dedicated RPTP positions within the RANZCP will include a National Program Director, coordinator and administrative support role(s). The RANZCP will seek Australian Government funding to support these positions (see Activity 5).
4	Initiate partnerships required to develop the RPTP, including with national, state and territory governments, health services, health regions, workforce planning bodies, universities, regional training hubs and other colleges.	Establishing partnerships with key stakeholders is essential to the success of the RPTP. The RANZCP will: • consult with and build on existing partnerships and jurisdictional arrangements with governments, health services and other stakeholders to deliver the RPTP. This will also take into consideration emerging government rural mental health, workforce and training reforms, and initiatives that will support the RPTP development and implementation • build on existing partnerships and form new partnerships to expand the rural training pipeline, attract rural and Aboriginal and Torres Strait Islander trainees to the RPTP and develop new training positions and opportunities. This will include expanding network arrangements to deliver rotations • explore opportunities to collaborate and establish information-sharing arrangements with other medical colleges (e.g. ACRRM and the RACGP) to support joint medical education opportunities (see Activity 28) and the potential expansion of clinical rotations in general practice (see Activity 31) • explore other funding and sponsorship arrangements (see Activity 5). Formal partnership agreements, memoranda of understanding, other contractual arrangements or forums may be developed to support these working relationships. It is expected that all RPTP partners will establish and review additional partnerships (independent of the RANZCP) as required.
5	Develop funding and sponsorship proposals to deliver the RPTP.	The RANZCP will: • develop and submit a costed proposal to the Australian Government, seeking funds to support the RPTP implementation and the establishment or delivery of: – program staffing (see Activity 6) – data collection and evaluation systems (see Activity 9) – additional RPTP training positions (IRTP or by other arrangement) (see Activity 32) – rural readiness workshops (see Activities 17 and 18) – an online information hub (see Activity 19) – financial incentives to attract supervisors to targeted locations (see Activities 25, 34, and 41) – rural components of formal education programs, including subsidies for workshop or event attendance for rural trainees (see Activity 26). • explore the potential for RPTP sponsorship arrangements or collaborations with national mental health organisations, such as Beyond Blue or the Black Dog Institute, and private mental health service providers.

	Activity	Description
Within 2 years:		
6	Develop Rural Director of Training positions and seek funding within each jurisdiction to support these positions.	The RANZCP will seek funding from state and territory governments to establish and support new jurisdictionally based rural DoT positions. State and territory governments should, in turn, work with the RANZCP and rural health services to develop locally relevant roles and responsibilities for rural DoTs, including defining the appropriate geographical area that each rural DoT will oversee.
7	Develop a RPTP implementation plan, in consultation with key stakeholders, to commence the RPTP from 2023.	The RANZCP will: • develop a RPTP implementation plan that outlines key activities, timeframes and responsibilities required within the RANZCP • commence the RPTP governance changes and engage in discussions with funding partners • conduct a rotations gap analysis to identify the number and type of rotations needed to deliver the psychiatry training rotations entirely or nearly entirely in rural locations. The gap analysis will also confirm the number of additional funded positions needed. BTCs should also conduct a rural rotation gap analysis to identify trainee and post capacity, rotation gaps or bottlenecks, and the type of rotations needed to provide all mandatory and elective clinical rotations. This gap analysis could also inform the development of a timetable of training rotation opportunities across regions.
8	Develop a Monitoring, Evaluation and Learning framework for the RPTP.	The RANZCP will develop a MEL framework to support assessment of progress and outcomes against the RPTP's objectives. The MEL framework will: • incorporate a program logic model for the RPTP • develop KPIs and define how these will be measured (including what data are collected, from where, when and by whom) • outline reporting requirements • take into account the reporting requirements for the RPTP funders and partners • evolve as the RPTP is implemented.

	Activity	Description
Within 3 years		
9	Develop data collection and reporting capability to support the RPTP delivery, monitoring and evaluation.	The RANZCP will: • seek funding from the Australian Government to enhance its data collection and reporting capability so that activities may integrate with future National Medical Workforce Strategy activities, support planning and ensure performance reporting for government-funded activities (see Activity 5) • consider how the RPTP data collection and reporting systems are to enhance and be integrated into existing data collection systems • establish systems to collect and monitor the RPTP information including, but not limited to: – RPTP applicant and trainee information on rural origins and backgrounds – RPTP positions including FTE, number, type, location and public/private sector characteristics – RPTP supervisors including FIFO workforce.
10	Create and promote a positive rural and generalist Fellowship culture across the RANZCP membership.	The RANZCP will embark on a campaign of culture change, which may include developing and implementing strategies such as: • profiling the successes and achievements of rural trainees and psychiatrists who practise or supervise in rural areas • increasing rural representation on RANZCP committees • actively promote the benefits of rural training and practice to the RANZCP membership • securing agreement among RANZCP leadership and management teams to prioritise cultural change • identifying rural champions to publicly promote rural and generalist Fellowship.

	Activity	Description
Within 4 to 10 years:		
11	Conduct a mid-term review of the RPTP progress in 2026.	The RANZCP will conduct a mid-term review in 2026 to: • examine the progress of the RPTP according to the implementation plan • obtain feedback from partners and the RPTP participants (including trainees and supervisors) • assess the RPTP performance and achievements against the RPTP outcomes and KPIs • adjust the pathway, implementation plan or MEL framework as required • identify future directions for the RPTP, including opportunities to improve alignment with mental health and National Medical Workforce Strategy reforms.
12	Formally evaluate the RPTP by 2031.	The RANZCP will: • conduct a formal evaluation to: – examine the implementation, impact and outcomes of the RPTP as a whole and the outcomes for trainees who have completed their training through it. Assuming the RPTP commences in 2023, evaluation data will be available for up to 3 cohorts of psychiatrists who have completed their training through the pathway – identify future directions for the RPTP – identify any required revisions to the MEL framework to ensure its ongoing relevance. • seek funding from the Australian Government to support evaluation activities (including the development of data capability – see Activity 9). Support will be sought from national, state and territory governments in relation to medical workforce data and the National Medical Workforce Strategy.

6 Action Area 2: Selection and onboarding

An established pipeline to attract and recruit rural medical students, junior doctors, and Aboriginal and Torres Strait Islander candidates into the RPTP, and orientate trainees and SIMGs to live, work and train in rural locations.

6.1 Why do we need to change?

> 'Australia is brilliant at taking rural medical students and turning them into fantastic *urban* doctors.'
> – Government representative

Current RANZCP Fellowship Program selection criteria require that applicants have successfully completed a medical degree, have current registration as a medical practitioner and have completed at least one FTE year of general medical training.

The RANZCP does not currently apply specific criteria to prioritise selection of rural or Aboriginal and Torres Strait Islander trainees or account for the unique challenges that these applicants may face in accessing specialty training. Further, the RANZCP does not currently collect data on applicants' origins (rurality and nationality) or Indigenous status and thus is unable to monitor and report on these aspects of the trainee workforce.

Some support is available for Aboriginal and Torres Strait Islander trainees. The RANZCP and the Australian Government STP has funded financial support for Aboriginal and/or Torres Strait Islander trainees (A$6,000 per year for training costs and A$3,000 per year for access to exam preparation programs, respectively). This STP funding is available until the end of 2021.

The RANZCP Aboriginal and Torres Strait Islander Mental Health Committee was highly supportive of enhancing rural psychiatry training opportunities for Aboriginal and Torres Strait Islander peoples. Affirmative action in selection and onboarding – in addition to specific supports throughout training – were considered essential to overcome health disparities in rural Aboriginal and Torres Strait Islander communities. Current government policies to enhance Aboriginal and Torres Strait Islander health outcomes include actively increasing opportunities and training experiences for Aboriginal and Torres Strait Islander peoples to become medical specialists.

To support the growth in the rural medical workforce, other medical colleges are increasingly considering criteria to boost rural and Aboriginal and Torres Strait Islander students' participation in medical training. For example, the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) has established a Regional Integrated Training Program (RITP) for candidates who have recently worked in rural areas, or who have expressed a desire to pursue a career in rural areas.

Candidates who apply for a RITP position must satisfy at least one of a range of eligibility criteria that includes being a rural resident for a minimum of 5 years, undertaking medical education in rural locations, participation in bonded rural scholarship schemes or a minimum of 12 months' clinical experience in a rural location as a general practitioner, medical student, intern, resident or registrar.

Stakeholder consultations highlighted a number of barriers faced by junior doctors who wish to train in psychiatry in rural areas. Trainees reported difficulties finding information about rural training generally and accessing job opportunities, with some having to find their own opportunities, source posts and set things up independently.

While the RANZCP currently hosts a jobs site specific to psychiatry, not all trainees were familiar with this resource. Health services are charged a fee to advertise and, as a result, many vacant rural posts are not advertised.

Rural communities also rely heavily on SIMGs who, having not trained in Australia, may be unfamiliar with the RANZCP Fellowship Program curriculum or regulations, and may not have the professional networks that local training can help to build. As a result, SIMGs may be more likely to experience professional and social isolation than their Australian-trained peers. Cultural and language barriers may further increase feelings of isolation. The RANZCP currently runs a mentoring program for all trainees and early career psychiatrists; however, SIMGs reported that they were not well prepared for the experience of living and working in rural locations and suggested that further orientation and support was needed.

Stakeholders also noted the importance of promoting positive rural culture and training experiences as part of attracting and retaining trainees and specialists in rural areas.

6.2 What is needed?

Information about rural training opportunities should be easy for all stakeholders to find.

Affirmative selection processes for the RPTP should prioritise trainees who want to live and work in rural locations, have rural origins, have undertaken rural training or work experience, and who identify as Aboriginal and Torres Strait Islander.

Selection processes need to be clearly defined and easily accessible, so that all parties understand how they are applied and why, to provide accountability and reporting.

Importantly, data on trainee origins should be routinely collected to inform the development of relevant KPIs and monitor their progress.

For trainees who take part in the RPTP, there needs to be a strong focus on orientation and preparation programs to provide practical information about what it is like to live, work and train in rural communities. This is particularly relevant for those who are new to rural life.

Similarly, an affirmative selection process should be developed for Aboriginal and Torres Strait Islander trainees who wish to train in rural locations. Additional support and cultural considerations should be developed for these trainees. Monitoring and reporting should also be mandated for the RPTP to ensure the development of a workforce that strengthens Aboriginal and Torres Strait Islander representation.

Establishing a pipeline to attract and recruit rural medical students, junior doctors and Aboriginal and Torres Strait Islander candidates will require strong collaboration with state and territory medical workforce planners, local health regions, postgraduate medical councils, universities and, where appropriate, regional training hubs. Developing these partnerships will support the RPTP.

Enhanced communications, media content and the use of social media can also improve the profile of rural psychiatry and the RPTP. A dedicated communications effort could improve the image of rural training and practice by showcasing examples of rural innovation, trainees' successes and the quality of training opportunities and systems in rural areas.

Strengthened partnerships with university RCSs, regional medical education programs and RTHs are required to facilitate promotion of the RPTP and to help identify and support students and early career doctors who have an interest in rural psychiatry (including those who are members of the RANZCP Psychiatry Interest Forum).

Finally, trainees may benefit from additional information and support to adequately prepare for and commence their rural training. Ideally, this should include provision of structured workshops (to ensure all rural trainees are provided with essential information about rural life

and work) and unstructured peer support (to provide trainees with an opportunity to access information specific to their individual circumstances as they settle into the rural training experience).

Peer support could be provided as an expansion to the current RANZCP Mentoring Program that pairs trainees or early career psychiatrists with suitably experienced College Fellows and Affiliate members for a period of 8 months. To the extent possible, this could involve trainees being paired with a buddy based in the same region to maximise local knowledge and support.

6.3 Selection and onboarding activities

Table 6-1: Key activities – Action Area 2: Selection and onboarding

	Activity	Description
Within 1 year		
13	Amend selection regulations and develop selection criteria to prioritise rural applicants for the RPTP.	The RANZCP will: • develop affirmative selection regulations to prioritise people from rural backgrounds for the RPTP who meet the eligibility criteria for the RANZCP Fellowship Program, giving consideration to how the criteria developed by the RANZCOG could be adapted for or used in the RANZCP context • identify initial KPIs for rural selection regulations, drawing on expert opinion and any available information (including from the RANZCOG and other colleges, if appropriate) • establish systems to routinely collect data on applicants' origins and the implementation (and outcomes) of selection regulations, and to monitor progress against KPIs to inform further refinement of regulations and KPIs over time (see also Activities 5 and 9).
14	Amend selection regulations to prioritise eligible Aboriginal and Torres Strait Islander applicants for the RPTP.	The RANZCP will: • develop affirmative selection regulations to prioritise Aboriginal and Torres Strait Islander peoples who meet the eligibility criteria for the RANZCP Fellowship Program for the RPTP • identify initial KPIs for rural selection regulations, drawing on expert opinion and any available information • establish systems to routinely collect data on applicants' Indigenous status and the implementation (and outcomes) of selection regulations, and to monitor progress against KPIs to inform further refinement of regulations and KPIs over time (see also Activities 5 and 9).
15	Develop and deliver a RPTP communications and promotion strategy.	The RANZCP will collaborate with universities and regional training hubs to develop a communications and promotion strategy to increase awareness and raise the profile of the RPTP among rural medical students, junior doctors (including those currently working rurally, and those in urban areas who are interested in working rurally), SIMGs, members of the Psychiatry Interest Forum, psychiatrists and supervisors, and health services. The communications and promotion strategy could also identify and support rural psychiatrists, supervisors or trainees who are passionate about rural training to champion the RPTP (see Activity 9).

	Activity	Description
16	Consider the inclusion of a dedicated rural stream within the current Psychiatry Interest Forum (PIF) program for medical students and junior doctors.	The RANZCP will conduct an evaluation of the PIF program in 2021. This evaluation could consider ways to ensure PIF participants are supported to access the RPTP, such as establishing a rural stream within the PIF to improve awareness and strengthen the role of this forum in contributing to the RPTP pipeline.
Within 3 years		
17	Deliver rural readiness workshops for trainees.	The RANZCP will: • design workshop structure and content, including coverage of topics such as: – professional orientation – an overview of psychiatry services, state or territory health systems, as well as orientation on issues such as cultural awareness, local context, accessing support, pathways to Fellowship, exam preparation, and professional and ethical responsibilities – clinical orientation – an introduction to mental health in rural communities, as well as an introduction to working with Aboriginal and/or Torres Strait Islander peoples in a culturally safe and appropriate way. This could also include information regarding the completion of the RANZCP's mandatory Aboriginal and Torres Strait Islander mental health modules – social orientation – an introduction to creating local community connections and achieving work–life balance – support and assistance available from the RANZCP BTCs and other sources. • deliver rural readiness workshops or appoint an education provider to do so • seek support from state and territory governments and health services to ensure the design and delivery of workshops are tailored to local needs • seek funding from the Australian Government to support development and delivery of rural readiness workshops (see Activity 5).

	Activity	Description
18	Deliver rural readiness and supervision workshops for SIMGs.	The RANZCP will: • design workshop structure and content, including topic areas covered in rural readiness workshops for trainees, plus additional information on: – the Australian context and health systems such as Medicare and the Pharmaceutical Benefits Scheme – the requirements of RANZCP Fellowship supervision, training regulations, examinations and training systems. • deliver rural readiness workshops or appoint an education provider to do so • seek support from state and territory governments and health services to ensure the design and delivery of workshops are tailored to local needs • seek funding from the Australian Government to support development and delivery of rural readiness workshops (see Activity 5).
19	Work with governments and health services to develop an RPTP information hub, including available rural training posts and jobs.	The RANZCP will: • seek funding from the Australian Government to support the development and maintenance of an online information hub (see Activity 5) • design the online information hub, which will outline the RPTP, profile training and job opportunities and the support and assistance available to RPTP trainees, and include network profiles and testimonials • work with health services and RTHs to collect, input and update relevant information to ensure the RPTP information stays up to date.
20	Facilitate buddy arrangements for new rural trainees with current trainees.	The RANZCP will explore options to expand the current mentoring program to pair new rural trainees with a buddy with relevant knowledge and experience.
Within 4 to 10 years		
21	Continue to develop and promote the rural training pipeline through partnerships with universities, regional training hubs, health services and other education and medical agencies.	The RPTP will be established as part of a wider effort to encourage rural origin students to undertake their basic medical degrees and pre-vocational positions in rural areas. The RANZCP will work with partners to strengthen the role of the RPTP as a solution for medical students and junior doctors who have an interest in rural psychiatry. The RANZCP will continue to work with partners to support end-to-end training opportunities and the continued operation and viability of the rural trainee pipeline.

7 Action Area 3: Education programs

Expand education programs accessible to all rural psychiatry trainees across the country, with content tailored to the rural context, and support for exam preparation.

7.1 Why do we need to change?

During their first 3 years in the RANZCP Fellowship Program, trainees must enrol and demonstrate satisfactory participation in a RANZCP-accredited FEC of their choice. The RANZCP is currently undertaking a review of all FECs and therefore rural education programs must be assessed in the context of these ongoing considerations:

FECs are jurisdictionally based and are delivered by different providers with different structures and fees. Trainees can choose their preferred FECs, with most FECs provided by BTCs. In New South Wales, trainees can also elect to undertake their training through the Health Education and Training Institute or the Brain and Mind Centre master's program. In Victoria, Melbourne and Monash Universities offer master's and non-master's options. The South Australian BTC program is delivered remotely via videoconference and is open to interstate participants. In New Zealand, the NZ Training Committee devolves the responsibility for FEC provision to each training region. In Auckland, Wellington and Dunedin, FECs are delivered by local university departments. Hamilton and Christchurch organise and deliver their own FECs.

The cost of FECs for Australian trainees ranges from zero up to A$31,500 per year for a master's degree, while in New Zealand, FECs are provided at no charge to trainees.

Diversity in training programs can lead to variation in training quality and limited access to education opportunities for rural trainees. Rural trainees identified that the lack of access to study groups, exam preparation programs and education programs had implications for content knowledge and successful completion of assessments.[1]

Trainees were also concerned about missing out on the collegial aspects of these activities. The cost and time required to attend in-person educational events was identified as a significant barrier, with stakeholders noting that health services may not be supportive of trainees taking time off for these activities.

Trainees also reported challenges in accessing research opportunities and completing their scholarly project, including workload pressures, difficulty finding suitable research projects within the health service, and lack of research supervisors.

Further, rural practitioners currently have limited involvement in exam preparation, conduct and assessment. As such, rurally relevant content may be under-represented in exam questions and rural context not always taken into account in assessing trainees' performance. Stakeholders also noted that SIMG psychiatrists face additional challenges in supporting trainees when they have not undertaken RANZCP exams as part of the RANZCP Fellowship Program themselves.

[1] Trainees reported that few rural locations currently have access to formal exam support programs. The Northern Territory is a notable exception, as trainees there are able to access online exam support via a Melbourne-based training provider.

7.2 What is needed?

This roadmap proposes strengthening the current generalist curriculum with **rurally appropriate content**.

First and foremost, rural trainees must have ongoing access to and choice in quality FECs, and access to the same or equivalent educational materials and resources that metropolitan centres provide.

Opportunities for **collaborative and team-based education activities** with other mental health professionals could also be a component of any rural module or education program, to promote multidisciplinary team-based and generalist learning. The RANZCP could explore the potential for collaboration with ACRRM and the RACGP to develop educational opportunities for psychiatry trainees and GPs undertaking advanced training in mental health.

The development and provision of wrap-around course support is imperative to the success of the RPTP. In particular, stakeholders were almost unanimous in highlighting the need to establish a **rural exam support program**, with an emphasis on preparing trainees for centrally administered assessments (written exams and OSCEs).

Improved access to research and quality improvement project opportunities, support and supervision for rural trainees undertaking Scholarly Projects and Psychotherapy Written Cases would reduce the challenges trainees currently have in completing these requirements. The development of research-focused partnerships and information sharing across networks could provide trainees with enhanced awareness of and access to local research opportunities within the context of larger research projects.

It is also important that rural trainees are given the opportunity to connect, both remotely and face to face when possible, with peers in other rural and metropolitan locations. **Improved peer support** would enable rural trainees to share experiences and build their own professional networks to overcome social and professional isolation.

Establishment of a **rural trainee peer support network** and support for rural trainees to attend annual conferences or other educational and networking events, would assist in strengthening peer-to-peer connections and would likely be highly attractive components of a rural education program.

Finally, an **expanded education program should address the needs of supervisors** as well as those of trainees. First, there is a need to ensure equitable representation of rural supervisors among examiners and provide appropriate upskilling and support for them to take on the examiner role, support trainees in exam preparation and conduct assessments. In addition, enhanced training and support should be made available to rural supervisors overseeing Scholarly Projects and Psychotherapy Written Cases.

7.3 Education program activities

Table 7-1: Key activities – Action Area 3: Education programs

	Activity	Description
Within 1 year		
22	Establish a rural exam support program for trainees, particularly for written exams and Objective Structured Clinical Exams (OSCEs).	The RANZCP will: • produce high-quality and practical exam support materials that could be used by all trainees • explore the potential to develop and deliver an online exam support program accessible to all rural trainees to help them prepare for centrally administered assessments (written exams and OSCEs).
Within 2 years		
23	Improve access to research and quality improvement project opportunities and support/supervision for rural trainees undertaking scholarly projects.	The RANZCP will establish RPTP-specific research partnerships with universities, rural clinical schools and academic research organisations to support rural trainees to complete their research requirements.
Within 3 years		
24	Establish a strong rural trainee peer support network.	The RANZCP will develop peer support channels such as online forums, study groups and social networking sites.
25	Increase rural supervisor levels to support exam preparation programs, exam delivery and assessments.	The RANZCP will: • seek funding from national, state and territory governments and health services to provide additional support for psychiatrists to take on exam preparation, delivery and assessment roles • set KPIs to ensure equitable representation of rurally based examiners • establish professional development opportunities for rural supervisors interested in upskilling as examiners • establish a network of rural supervisors and examiners. (See also Activities 41 and 42)
26	Develop rural education modules for existing FECs that meet the RANZCP curriculum requirements, provide rurally appropriate content and promote remote, multi-disciplinary team-based and generalist learning.	The RANZCP will develop a rural education module that: • can be delivered within existing FECs • meets the RANZCP's curriculum requirements • provides rurally appropriate content • promotes multi-disciplinary team-based and generalist learning.

	Activity	Description
Within 4 to 10 years		
27	Examine the potential for rural education collaborations with GP colleges.	The RANZCP will explore opportunities to collaborate with ACRRM and the RACGP on: • joint education activities for psychiatry trainees and GPs undertaking advanced training in mental health on the NRGP • the development of a rurally focused Diploma of Psychiatry. (See also Activity 4)
28	Complete and implement the review of FECs to incorporate RPTP strategies and activities.	The RANZCP will consider the strategic recommendations and activities outlined in this roadmap in developing the final report and recommendations of the FEC review.

8 Action Area 4: Clinical rotations

Enable any interested trainee to undertake all or nearly all of their training in a rural setting, ensuring that they receive a high-quality experience.

8.1 Why do we need to change?

Currently, there are few rural locations that can provide all or almost all of the required clinical rotations required to complete the RANZCP Fellowship Program. Only a small number of large regional centres have this capacity, such as Bendigo (Vic), Orange (NSW), Cairns and Townsville (Qld), Hobart (Tas) and Darwin (NT).

The RANZCP Fellowship Program is a linear program where trainees progress through three stages as follows:

- **Stage 1 (12 months):** 12-month mandatory rotation in adult psychiatry, including 6 months in an acute setting.
- **Stage 2 (24 months):** 2 mandatory rotations involving 6 months in C–L, 6 months in CAP and 2 elective rotations.
- **Stage 3 (24 months):** 4 elective rotations. During this stage, trainees may also commence a CAT.

There are nine areas of practice available to trainees as electives: addiction psychiatry, adult psychiatry, C–L, CAP, forensic psychiatry, Indigenous psychiatry, psychiatry of old age, psychotherapies, and research.

Providing the full range of training rotations can be a challenge for rural locations, since they are required to guarantee that posts will be available for trainees for the duration of their training. Currently there is a **significant shortage of specialist psychiatrists, particularly in C–L and CAP,** for both metropolitan and rural services. This limits the training capacity of all regions, as these rotations are mandatory for Stage 2 trainees, and training regions will not take on trainees if they cannot guarantee rotations. There are also high-need locations already at capacity, where additional training opportunities are required but cannot be established without funding for additional psychiatrists, supervisors and trainees.

Furthermore, some elective rotations (e.g. forensic psychiatry) are only available in specialist, often metropolitan-based services, and rural trainees must temporarily relocate to complete these experiences – without additional supports. While some jurisdictions provide assistance for metropolitan trainees to relocate to rural locations to gain rural experience and complete rotations, there is currently no corresponding assistance available for rural trainees to relocate to metropolitan areas for rotations.

Even where rural posts are available, there is no guarantee they will be filled. In rural locations, vacancy rates vary across jurisdictions and range from 11% to 42%. There are multiple reasons why a post may be vacant, including the location not being attractive to trainees, the positions being accredited but not currently funded, a lack of available supervisor(s), or the trainee allocated to the post taking leave or a career break. This can place disproportionate pressures on local rural health service delivery if a continuous supply of trainees is not carefully planned and coordinated.

Importantly, allocation of trainees to rural posts is frequently undertaken by metropolitan-based DoTs, who may lack the knowledge of the individual trainee and local context required to ensure a positive experience and good outcomes for the trainee, supervisor, health service, and patients. This is a significant

problem for both trainees and health services who feel powerless when it comes to knowing if they will get a rotation or if a trainee will be allocated to their service.

In relation to the STP/IRTP, stakeholders reported that the current project selection and approval processes are not transparent, and could not determine whether these processes are designed to address particular priorities or to target areas of high need.

Some stakeholders also noted that it can take up to 9 months to negotiate and establish training positions, sometimes resulting in the loss of trainees who had initially expressed interest in a rural location. Further, there are considerable administrative and Fellowship program barriers for trainees to move across training regions within a state or territory, or interstate. In some locations, trainees are required to resign from their position or from the training program altogether in order to relocate, losing associated entitlements. This lack of continuity could also reduce the opportunities for the provision of end-to-end training through the RPTP.

Of all the barriers to expanding rural training opportunities, the lack of **supervisors** was most commonly raised in the consultations undertaken to develop this roadmap. Currently, trainees have a primary supervisor and other supervisors for specific clinical experiences. Primary supervisors must be working in the same location as the trainee and must be a RANZCP Fellow, while other supervisors can be College Affiliates or other medical specialists. RANZCP standards require that a trainee's primary supervisor should be the psychiatrist responsible for the care of the trainee's patients in clinical rotations. The supervisor must also work in the same clinical setting as the trainee for a minimum of 3 half days per week (or 0.3 FTE).

The shortage of supervisors in rural areas is in part due to the shortage of psychiatrists, turnover of clinicians (including locums), and workload pressures. Stakeholders observed that in locations that rely on FIFO psychiatrists, while not ideal, FIFO supervision models can work well if the supervisor is able to visit regularly and build a relationship with trainees.

Stakeholders agreed, however, that the COVID-19 pandemic has shown that it is possible to introduce remote supervision practices and increased levels of outreach work via telehealth in a way that can work for the patient, the health service and the trainee. This may be particularly useful in remote or very remote services and training opportunities.

8.2 What is needed?

Additional training positions are needed in both the public and private sectors. This will require states and territories to invest in public health services, and the Australian Government to support additional positions in rural health services, Aboriginal Medical Services and private health services. This could involve additional STP/IRTP (or other) funding, or prioritising rural or Aboriginal and Torres Strait Islander services in STP allocations. Current STP funding initiatives designed to support rural training posts could be expanded to increase training numbers.

- Under the **Rural Loading Allowance** guidelines, STP posts in regional, rural and remote areas may apply for an annual loading of up to A$30,000 (GST exclusive). This loading provides funding for resources, attendance at training courses, meetings and conferences, videoconferencing facilities, broadband access and IT upgrades, research libraries, relocation costs, travel expenses and accommodation costs.
- Under the **Private Infrastructure Clinical Supervision Allowance** guidelines, STP posts in private training settings may apply for an annual loading of up to A$30,000 (GST exclusive). This loading provides funding for infrastructure and supervision.
- The **Training More Specialist Doctors in Tasmania** project provides funding to support the training and retention of specialist doctors in the Tasmanian health system. The

RANZCP has funding under this stream for 3 FTE trainees and 1.31 FTE training supervisors, who are employed by the Tasmanian Health Service.

Stakeholders highlighted the need to ensure that all mandatory and elective rotations could be provided within the RPTP, either in a single location or in **networked arrangements** with public or private health services in other rural regions or in metropolitan areas. The development of formal partnership arrangements or MOUs would support the growth of rural training opportunities and provide certainty for a trainee that they would have access to the range of training opportunities they need.

Stakeholders saw the **sustainability of training posts** as a key consideration and suggested that larger regional hubs that had a stable workforce and existing trainees would be a good starting point for expansion. These sites could initially form the basis of hub-and-spoke models to smaller rural locations, with the potential to further develop training capacity in smaller or more remote locations in the longer term.

There is a clear need to streamline and improve the **transparency of approval and allocation processes** in order to provide greater certainty for trainees and health services alike. Rural DoTs will play an important role in this process, ensuring efficient and productive allocation of rural trainees, facilitating communication between trainees and health services, and providing opportunities for trainees to develop a rotation plan across program stages. There is also a need for improved longer-term planning for training rotations at a regional or jurisdictional level, requiring coordination and collaboration across the RANZCP, governments, health regions, workforce planning authorities and agencies.

While stakeholders noted the need to prioritise rural trainees, they also recognised that this should not be to the exclusion of opportunities for metropolitan trainees to undertake rural rotations if they wish to do so. Networked arrangements with metropolitan services and financial support and assistance for trainees to relocate as required may also facilitate these opportunities.

In order to **address the shortage of rotations** in rural areas, including the **mandatory C–L and CAP rotations**, stakeholders suggested a range of solutions, including:

- broadening the settings in which rural posts could be provided in order to increase the supply of posts, particularly for C–L and CAP rotations. This could include settings such as general practice and Aboriginal Medical Services that focus on chronic disease models of care for C–L experiences, and relevant child and adolescent and child development services for some CAP experiences and competencies
- combining part-time training opportunities across services to offer an FTE rotation
- introducing a logbook or other flexible, competency-based system to record the time spent on C–L and CAP patients in other rotations and credit it toward these mandatory rotations. This approach recognises the diverse patient populations seen in rural hospitals and in more generalist settings.

Increasing the availability of supervisors is critical to the successful implementation of the RPTP. The majority of stakeholders agreed that there is considerable potential to enhance **supervision capacity** through remote supervision in appropriate contexts (especially for Stage 2 and Stage 3 trainees) and within appropriate regulations.

Activities identified as feasible for remote supervision included case reviews and discussions, attendance at clinical and multi-disciplinary team meetings, and some supervisor feedback and research activities. An accredited model of remote supervision, such as that developed by ACRRM (2020), was suggested as a useful starting point for review. Stakeholders noted that new supervision regulations would require consideration and approval of BTCs in each jurisdiction prior to implementation.

8.3 Clinical rotation activities

Table 8-1: Key activities – Action Area 4: Clinical rotations

	Activity	Description
Within 1 year		
29	Develop networked arrangements to expand rural training opportunities, including to leverage and enhance connections with and within the private sector.	The RANZCP will collaborate with BTCs and health services to: • expand established training hubs • facilitate the provision of all rotations in a single location where possible • establish networked arrangements with public and/or private health services in other rural or metropolitan regions; this could include the development of formal partnership agreements, MOU or other contractual arrangements to develop and communicate a shared understanding of these working relationships.
30	Develop regulations for remote supervision, including remote case review and online clinical team meetings.	The RANZCP will: • initiate a review of current supervision regulations and consider adapting these to include options for remote supervision • seek BTC approval for remote supervision regulations.
Within 2 years		
31	Broaden settings and regulations in which C–L and CAP can be provided, recognising cumulative rotations and competencies across a range of settings.	The RANZCP will: • review current rotation regulations • explore opportunities to collaborate with ACRRM, the RACGP, health services and other partners to expand C–L rotations into general practice, Aboriginal Medical Services or community health settings. • explore opportunities to expand CAP into private hospitals, child and adolescent health services, child development services and child and adolescent telepsychiatry services • consider the potential to revise rotation regulations to enable competencies achieved through other rotations to be recognised.
Within 3 years		
32	Advocate to increase service funding for additional rural training posts or specialised teams in high-need rural locations.	The RANZCP will: • advocate for national state and territory governments and health services to increase service funding and fund additional training posts and supervision in high-need locations. • advocate to prioritise posts in rural and Aboriginal and Torres Strait Islander services in STP allocations.

	Activity	Description
33	Conduct rotation forward planning with individual trainees and at the health service/regional/jurisdictional level.	The RANZCP will: • work with state and territory governments, BTCs and health services to ensure the role description for rural DoTs includes conducting forward planning for rotations, in consultation with individual trainees and health services • work with governments and health services to conduct, collate and synthesise broader workforce planning activities, with a focus on building long-term capability and capacity of the psychiatry workforce • conduct a rotation gap analysis as part of developing the RPTP implementation plan (see Activity 7).
34	Build supervisor capacity in new training locations or where there is insufficient supervision capacity to expand training opportunities	The RANZCP will work with governments and health services to build supervisor capacity. This will include: • developing regulations for remote supervision (see Activity 30) • providing dedicated funding for supervisors to increase the supply of supervisors, to fund and quarantine time for supervision and assist supervisors with travel and associated costs (see also Activity 41). This could be supported by regional/jurisdictional planning processes (see Activity 33) to identify priority and high-need locations.
35	Streamline post planning, allocation and accreditation processes	The RANZCP will examine post planning, allocation and accreditation process involving BTCs, rural DoTs and health services to review processes and reduce the time taken to approve and allocate posts.
36	Facilitate the development of portable employment and education arrangements to enable trainees to move within and between states/territories.	The RANZCP will work with governments and training regions to remove the barriers that trainees face in moving between and within training regions and states and territories. This may include: • improving communication and coordination between health services and states and territories to facilitate continuity of employment and transfer of entitlements • streamlining administrative processes to enable rotations to be undertaken in other metropolitan or rural training regions while maintaining continuity of enrolment.
37	Ensure there is greater transparency of decision-making and advice in the allocation of STP/IRTP positions.	The RANZCP will: • work with the Australian Government and states and territories to ensure there is greater transparency in prioritisation and selection criteria for the allocation of STP/IRTP positions • review associated RANZCP processes and revise as required.

	Activity	Description
Within 4 to 10 years		
38	Build capacity to expand rural training to smaller rural centres through access to supervisors and networked arrangements.	The RANZCP will: • collaborate with BTCs and health services to develop training capacity in smaller and more remote rural centres • seek additional funding from national and state and territory governments and health services to support new training opportunities.
39	Develop and support pathways for rural trainees to undertake subspecialist training rotations in metropolitan locations.	While the priority for the RPTP is on rural and generalist rotations, the RANZCP will also support rural trainees who want to undertake subspecialist rotations to access training in metropolitan locations. This will be done through networked arrangements (see Activity 29) and supported by rural DoTs.

9 Action Area 5: Support

Develop support packages to enhance the appeal of training and working in rural areas and to help trainees and supervisors meet the challenges unique to rural settings.

9.1 Why do we need to change?

Entrenched workforce shortages in rural communities can place workload pressures on psychiatrists, trainees, SIMGs and health services, and many rural locations do not include incentives that might attract psychiatrists and trainees to their location.

Stakeholders consulted in the process of developing this roadmap highlighted insufficient support and resources (financial and otherwise) as key barriers to attracting and retaining a rural psychiatry workforce. They noted that salaries and associated allowances vary across jurisdictions and services and this can make some locations less appealing to both trainees and supervisors. In addition, family considerations, such as partner employment and children's education, also impact decisions to live, work or train in rural areas.

Some jurisdictions currently offer financial assistance for travel and accommodation for metropolitan trainees completing rural rotations. Similar assistance, however, is not available for rurally based trainees who must relocate to metropolitan areas to complete training requirements. Additionally, access to conferences and networking events is more challenging for those in rural locations and financial assistance to offset the associated travel and accommodation costs is limited. Further, depending on the health service's locum and backfill arrangements, rural trainees and supervisors may not always be able to secure sufficient time away from their clinical duties to travel to educational or networking events.

Rurally based supervisors also face challenges in finding dedicated time for supervision, as health services do not necessarily see supervision as a priority for service funding. They may also lack access to financial support to travel to metropolitan areas if needed to participate or train as examiners.

Stakeholders reported that, in some locations, rural education activities were hampered by poor infrastructure/IT, government regulations that limited the use of particular software or communication channels, and lack of available dedicated training rooms.

9.2 What is needed?

The expansion of rural psychiatry training opportunities depends on additional funding to incentivise trainees to take up rural posts, stay in rural areas when they complete their training, and supervise the next generation of trainees.

Consultations identified the need for a holistic approach to encouraging rural training and practice, noting that financial incentives are just one piece of the puzzle. Suggested components of comprehensive support packages included:

- multi-year employment contracts to provide greater certainty for trainees who move to rural locations
- employment packages that include salary plus benefits such as flexibility in leave arrangements, relocation assistance, accommodation, travel or vehicle assistance

- allowance for conference and networking support to assist trainees to travel for education, research or networking opportunities
- salary incentives such as rural loadings for training in areas in need
- assistance with travel and accommodation for rural trainees who need to relocate to other regional or metropolitan areas to undertake rotations.

A key element to expanding rural training opportunities is expanding the number of supervisors and ensuring trainees are provided with high-quality supervision. A critical component of a successful RPTP is, therefore, providing additional support for rural supervisors. Consultations also identified a need for comprehensive support packages for supervisors that include:

- the provision of dedicated and funded time to undertake supervision activities (see also Section 8.2)
- enabling access to and participation in professional development opportunities (including online and in-person training and peer support) (see also Section 7.2)
- allowance for supervisors to travel for education, research or networking opportunities
- salary incentives such as rural loadings to work in areas in need
- assistance with travel and accommodation for supervisors, including for FIFOs.

While out of scope for this roadmap, improving the availability of wraparound family support (such as assistance with partner employment and children's education) for all psychiatrists, trainees and SIMGs relocating to rural areas is also important and requires further consideration. Stakeholders reaffirmed the importance of partner and family support. Consideration could be given to extending programs that provide family support to rural GPs to include rural medical specialists.

The Australian Government currently provides rural retention incentives for GPs through the Rural Retention Program. Similar incentive programs could be extended to trainees to support them to remain in rural locations upon completing the Fellowship pathway. Stakeholders also saw value in establishing Transition to Practice programs that would support trainees who complete their Fellowship in rural locations to establish a practice in that location.

It is worth noting that support for psychiatrists and supervisors is not entirely in scope for this project (and is addressed in other workforce and mental health reviews) but has been included as it is fundamental to ensuring that the rural workforce has the capacity to support increased numbers of rural trainees in the early years of the RPTP. Stakeholders also suggested offering metropolitan-based psychiatrists the option of gaining additional certificates in rural locations. The necessity for this additional support may decrease as the rural psychiatry workforce expands over the course of the RPTP implementation.

9.3 Support activities

Table 9-1: Key activities – Action Area 5: Support

	Activity	Description
Within 3 years		
40	Develop a comprehensive support package for rural trainees.	The RANZCP will advocate for planning authorities and health services to consistently provide rural trainees with access to comprehensive support including: • multi-year employment contracts • employment packages • conference and networking allowance • support for travel and attendance for education events • rural salary loadings • relocation assistance. Where appropriate, support packages should be developed with transferability in mind (see Activity 36).
41	Develop a comprehensive support package for rural supervisors.	The RANZCP will advocate for planning authorities and health services to consistently provide rural supervisors with access to comprehensive support, including financial, education and peer support components, including: • dedicated and funded supervision time • access to and participation in professional development opportunities • allowance for supervisors to travel for education, research or networking opportunities • salary incentives such as rural loadings to work in areas of need • assistance with travel and accommodation for supervisors, including for FIFOs. (See also Activities 5, 25 and 34)
42	Ensure that appropriate infrastructure (dedicated education facilities and IT) is available for rural trainees to access education, supervision and peer support.	The RANZCP will work with states and territories to ensure that dedicated education facilities and IT are available. The RANZCP could consider a review process on what is needed to ensure effective rural access as part of the accreditation processes.
43	Provide retention incentive packages for rural trainees, including incentives to remain in a rural location after Fellowship, and Transition to Practice programs.	The RANZCP will advocate for the expansion of the Rural Retention Program to psychiatry trainees who remain in a rural location after qualifying as a Fellow. This also suggests that a Transition to Practice program for rural trainees be developed and implemented that supports trainees to establish a private practice and establish service provision arrangements with health services.

	Activity	Description
44	Develop a comprehensive support package for rural psychiatrists.	The RANZCP will advocate for national, state and territory governments and health services to consistently provide rural psychiatrists with access to comprehensive support including: • salary incentives such as rural loadings for working in high-need areas • relocation assistance • conference and networking allowance • family support • access to continuing professional development.
Within 4 to 10 years		
45	Continue to develop supports for the rural psychiatry workforce.	The RANZCP will work with the RPTP partners to review and revise trainee, supervisor and psychiatrist support packages as necessary, taking into consideration changing psychiatry workforce needs and broader health workforce initiatives.

10 Implementing the roadmap

This roadmap has received strong support from the RANZCP stakeholders who consider that, while ambitious, the actions it outlines are realistic and achievable.

Stakeholders recognise that there are jurisdictional and regional variations in geography, service systems, population and workforce distribution and that these will need to be taken into account in estimating the number of additional positions required. To this end, a gap analysis of rural rotations at the jurisdictional or regional level is needed to further refine the number and types of rural training positions required, and should be part of the implementation plan.

Stakeholders also noted that some actions outlined in this roadmap will take time to initiate and implement, and that progress will be greatly facilitated by additional financial investment and support from governments. However, they strongly recommended that the RANZCP should not delay implementing elements of the roadmap that can be delivered more quickly.

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The Royal Australian & New Zealand College of Psychiatrists

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