Discussion Paper: Developing the Psychiatry Workforce Plan

NSW GOVERNMENT

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Introduction

The NSW Government is undertaking a ten year reform of mental health care to 2024.

The *NSW Strategic Framework and Workforce Plan for Mental Health 2018-2022 : A Framework and Workforce Plan for NSW Health Services* provides overarching guidance for NSW Health strategic action in mental health to 2022. The Framework and Plan are actions arising from reform of mental health care and also respond to policy directions in the *Fifth National Mental Health and Suicide Prevention Plan 2018-2022*.

The *NSW Mental Health Workforce Plan 2018-2022* is the eighth enabler of the *NSW Strategic Framework for Mental Health 2018-2022*.

The development of a **Psychiatry Workforce Plan** is a key action of the *NSW Mental Health Workforce Plan 2018-2022* strategy to grow and support a skilled psychiatry workforce in line with forecast health service demand and delivery requirements (Strategy 4.5).

This Discussion Paper seeks feedback from stakeholders on themes identified and will inform development of the Plan and its strategies.

The Ministry welcomes written submissions on the proposals contained in this document. We are interested to hear your thoughts and have posed a number of questions in this document. The questions will help us understand what impact options and approaches would have (a summary of questions is provided at the back of the document).

2. Psychiatry workforce

a. Overview

Between 2012 and 2017 the number of psychiatrists in Australia increased by 16 per cent to 3,369 psychiatrists. Psychiatrists made up about 9.8 per cent of all specialist employed medical practitioners[1] in Australia.

During the same period the number of psychiatrists in NSW increased by 14 per cent to 1,045.

In 2017 the average total hours worked by psychiatrists in Australia was 38.8 hours and in NSW 38.5 hours. The average clinical hours worked per week by psychiatrists was 32.2 hours in Australia and 31.8 hours by psychiatrist in NSW.

In 2017 the Australian psychiatry workforce was highly urbanised with 88 per cent of psychiatrists working in major cities. In comparison 71 per cent of the population was located in major cities. This distribution differs from the overall medical practitioner workforce, with the location of psychiatrists more skewed towards less remote locations than all medical practitioners. Table 1 shows the number of psychiatrists per capita in Australia by remoteness.

Table 1	Psychiatrists FTE in Australia per 100,000 population
Major cities	16.2
Inner regional	6.4
Outer regional	4.9
Remote	6.2
Very remote	2.1

Source: AIHW *Mental health services in Australia* Web Report October 2019

The psychiatry workforce is a small but critical key component of the NSW Health mental health workforce providing high quality mental health services to the community. The psychiatry workforce, including psychiatrists, trainees and Career Medical Officers(CMOs), comprises about 10 per cent of the NSW Health mental health workforce.

In 2017, the most common work setting for psychiatrists in NSW was private practice (41%), followed by the public sector (33%), and a mix of public and private (26%).

The local psychiatry workforce across NSW comprises different combinations of Staff Specialists, Visiting Medical Officers (VMOs), CMOs, locums and trainees to best meet service demand.

The locally trained psychiatry workforce has been supplemented by the recruitment of overseas trained doctors to both specialist and junior medical officer positions.

b. Staff specialists and Visiting Medical Officers in NSW

The rural specialist psychiatry workforce is largely a VMO workforce. Some rural and regional psychiatry services are provided by psychiatrists using a Fly-in Fly-out Model (FIFO).

In comparison, in metropolitan areas the specialist psychiatrist workforce is mainly a Staff Specialist workforce, supplemented by VMOs.

Many Staff Specialists work less than full time. In 2019 there were 398 Staff Specialist psychiatrists providing 276.6 Full Time Equivalent (FTE) services.

1 Australian Institute of Health and Welfare. (2019). *Mental health services in Australia*. Retrieved from https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia

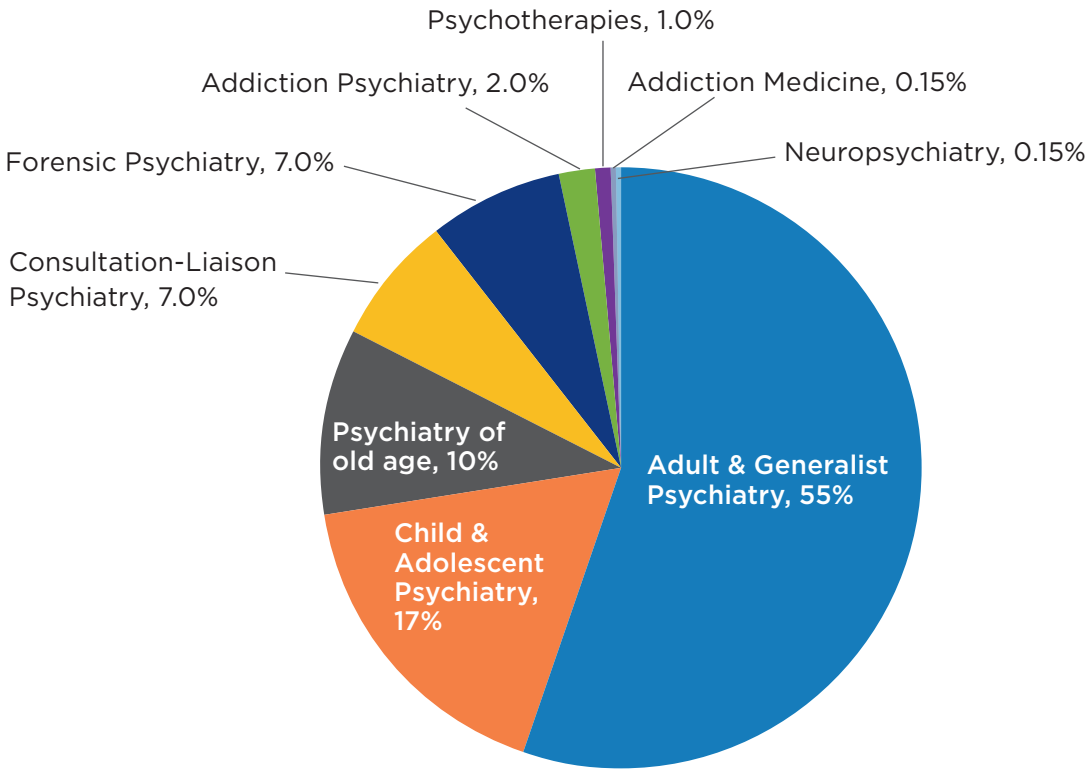
Many VMO psychiatrists have appointments at more than one Local Health District or Specialty Network. In 2019 there are 260 VMOs with 304 appointments across NSW Local Health Districts and Specialty Networks. The distribution of Staff Specialists and VMOs by Local Health District and Specialty Network as at July 2019 is shown in Table 2.

NSW Health Staff Specialist and Visiting Medical Officer(VMO) psychiatrist workforce by LHD/SNs

Table 2	Staff Specialist		VMO
	FTE	**HC**	
Central Coast	9.2	14	13
Far West	0	0	8
Hunter New England	38.6	46	20
Illawarra Shoalhaven	16.4	18	18
Justice	26.1	43	19
Mid North Coast	4.4	5	15
Murrumbidgee	0	0	21
Nepean Blue Mountains	13	17	10
Northern NSW	7	8	18
Northern Sydney	36.4	71	17
South Eastern Sydney	37.5	60	8
Southern NSW	0	0	20
Sydney Children's Hospital Network	10.5	15	5
Sydney	53.7	71	5
South Western Sydney	20.2	29	34
Western NSW	3	4	41
Western Sydney	43.2	59	5

The subspecialist areas of practice of the NSW Health Specialist psychiatry workforce is shown at Figure 1. The largest number of psychiatrists provide services in adult and generalist psychiatry.

Figure 1: Subspecialties of the NSW Health Psychiatry Workforce



Fractionation of the NSW Health psychiatry workforce

Stakeholder feedback on Staff Specialists working less than full-time and the mixed Staff Specialist and VMO workforce model was both positive and negative. Fractionation supports individual psychiatrists to experience the benefits of working both in the public and private sectors. Some psychiatrists reported that the only way they could achieve time for non-clinical duties, such as research, was to work in a less than full-time capacity in the public sector. This assists in keeping these psychiatrists working in the public health system rather than leaving it completely.

However, negative effects of this fraction of the workforce were also identified through the consultation. For the psychiatrists who remained full-time the 'burden' of being the backstop in the department increased and contributed to them feeling burnt out with the increased work and responsibility. Fractionation was also felt to have a negative impact on medical engagement, leadership, training and mentoring and support for the broader mental health workforce. It was reported that fractionation , as it operates currently, does not support continuity of care between hospital and community services, with part-time specialists usually working in either the hospital inpatient unit or community.

A factor in the negative perception of fractionation may be the lack of coherent models for the utilisation of a part-time workforce. These models are never really designed, rather they develop based on the individual psychiatrist's preferences.

Questions:

What are the strengths, and challenges of a fractional psychiatrist workforce?

What are the key requirements for designing a fractional workforce to support psychiatrist engagement, continuity of care, teaching and equitable distribution of workload across the specialist workforce? Can systems be designed to provide continuity of care with a fractionated workforce?

Fly-in fly-out workforce

As noted, some rural and regional psychiatry services are provided fully or partially by a fly-in fly-out (FIFO) workforce model. There is evidence that the FIFO model is a sustainable option and has preserved a number of rural mental health services. Some FIFO arrangements are short term, but a number are long term with VMO FIFO psychiatrists providing long term ongoing services in rural and regional locations.

There are mixed and sometimes opposing views about the role and value of FIFO models of service. Many consider the two services as mutually exclusive; services are provided either through FIFO services or the resident workforce. However other views propose a blended model of FIFO and resident workforce as a viable and desirable option.

Features of the FIFO model that are attractive to the individual psychiatrist include: providing the psychiatrist with a different case mix to the usual metropolitan public and private work they do; FIFOs are well renumerated; it is usually easier to work across both the hospital and community sectors in rural areas and provide continuity of care.

In many locations the FIFO psychiatrist workforce has provided a critical mass of senior workforce which has supported the recruitment of resident Staff Specialists to the mental health service. Many of the Staff Specialist psychiatrists recruited to rural and regional areas are Specialist International Medical Graduates (SIMGs). The support provided to SIMGs by FIFO VMO psychiatrists has been important in supporting their transition to working in the Australian healthcare setting. If the FIFO service is discontinued this can put pressure on the resident staff specialists as they no longer receive the professional support from their colleagues and there is a reduction in roster flexibility and the ability to cover planned and unplanned leave.

FIFO psychiatrists also support training in rural regions. Feedback indicates that this model has provided trainees with good experiences and that trainees have enjoyed learning about different ways of working, in addition to the in-house experience in the rural hospital system.

Some stakeholders perceive the FIFO workforce as mercenary and a temporary, rather than long-term, solution to the provision of psychiatry services. However in some Local Health Districts they are appointed on a long-term basis and receive quinquennial appointments. Stakeholder feedback is that when quinquennial appointments occur FIFO psychiatrists commit to the health service and a viable and sustainable psychiatry service is delivered.

One of the ongoing challenges identified with the FIFO workforce is a lack of understanding of how best to use it and engage it to deliver psychiatry services.

Questions:

What are the strengths and challenges of the FIFO model?

Is the FIFO model a sustainable option for provision of a rural and regional psychiatrist workforce?

c. Career Medical Officers

According to Stafflink data in July 2019 there were 35 CMOs working in psychiatry in NSW Health. The distribution of CMOs by Local Health District and Specialty Network is outlined in Table 3.

NSW Health psychiatry Career Medical Officers

Table 3	CMO	
	FTE	**HC**
Central Coast	1	1
Far West	0	0
Hunter New England	4.5	5
Illawarra Shoalhaven	1	1
Justice	1	1
Mid North Coast	0	0
Murrumbidgee	1	1
Nepean Blue Mountains	2	2
Northern NSW	0.4	1
Northern Sydney	2.6	3
South Eastern Sydney	0	0
Southern NSW	1	1
Sydney Children's Hospital Network	0	0
Sydney	0	0
South Western Sydney	2.4	4
Western NSW	5	5
Western Sydney	11.4	14

Psychiatry trainees

In May 2019 there were 456 psychiatry trainees employed across the five psychiatry training networks. This was an increase of 1.5 per cent from May 2018.

Of the trainees, 84 per cent were working full-time, 12 per cent were working part-time and four per cent were on interrupted training.

Psychiatry team structures

Many psychiatry inpatient clinical teams have a very flat structure with the team comprising consultants and trainees, without any prevocational trainees. The team structures do not mirror those of many surgical and medical teams which usually consist of consultants, trainees and prevocational trainees (interns and postgraduate year two). As a result of these structures prevocational trainees are often not exposed to psychiatry practice before making a specialist career decision.

It is reported that often consultants do the work of trainees and psychiatry trainees often do the work of prevocational trainees. This detracts from the experience of both the consultant and psychiatry trainee.

Question:

What are the enablers and barriers to developing a more tiered psychiatry workforce structure?

Rural Generalist

A Rural Generalist is defined as "a medical practitioner who is trained to meet the specific current and future healthcare needs of Australian rural and remote communities, in a sustainable and cost-effective way, by providing both comprehensive general practice and emergency care and required components of other medical specialist care in hospital and community settings as part of a rural healthcare team"[2].

The NSW Rural Generalist Medical Training Program provides a mental health training pathway for rural generalist trainees.

Question:

Is there a role for the Rural Generalist in provision of mental health services in rural communities?

Psychiatry workforce modelling

The NSW Ministry of Health modelling of the NSW psychiatry workforce indicates that under all demand scenarios additional trainees are required to ensure that the workforce can meet future workforce requirements to 2030.

The workforce modelling undertaken is based on current models of care and changes in the models can impact on workforce requirements. The workforce modelling is also based on current hours worked by clinicians therefore any changes in the hours worked can impact on the workforce requirements.

The NSW modelling aligns with national modelling of the psychiatry workforce which shows that at a national level the demand for psychiatrists will exceed supply and there is a projected shortage of 74 FTE psychiatrists in 2025 and a shortfall of 124 FTE in 2030[3].

2 National Rural Health Commissioner Communique 1 July 2018
3 The NATIONAL HEALTH WORKFORCE DATASET (NHWDS)- Psychiatry Fact Sheet

3. Recruitment and Retention

Despite the overall growth in the psychiatry specialist and psychiatry trainee workforces in recent years, most mental health services have identified ongoing challenges in recruiting and retaining both specialist psychiatrists and trainees. These challenges are greater in outer metropolitan Sydney and rural and remote locations.

In July 2019 Local Health Districts and Specialty Networks reported the following psychiatry vacancies:

- Staff Specialist positions - 35.41 FTE vacant. At the time of reporting 46.4 per cent of the vacant positions were filled by locums
- VMOs - 6 positions vacant. At the time of reporting 17 per cent were filled by doctors on a temporary appointment.
- CMO positions - 7 FTE vacant. At the time of reporting 71.4 per cent were filled by locums.
- Junior Medical Officer positions- 42.4 FTE vacant. Of these 36.5 FTE were accredited trainee positions. It was reported that 35.4 per cent were filled by locums and 31 per cent were filled by locums and/or increasing hours of part-time staff.

Some feedback indicated that filling outer metropolitan Sydney positions was sometimes as challenging, if not more challenging, than filling rural or regional positions.

The NSW Ministry of Health requires all trainees to undertake a rural rotation and trainees receive an allowance, travel and accommodation when undertaking rural rotations, however there are no similar requirements and arrangements for trainees undertaking an outer metropolitan rotation.

It was also noted that increasing medical student training in outer metropolitan Sydney has not yet translated to an increased entry of medical graduates into psychiatry training in these locations.

The survey and consultation identified a number of positive aspects about working in the public mental health service, including: the opportunity to work as part of a team, leave and Training, Education and Study Leave (TESL) entitlements, superannuation, opportunities for teaching, research and training, collaboration with the broader system, networking opportunities and professional support.

However a number of challenges were also identified including:

- an increasing workload and increasing after hours requirements on psychiatry, which was considered greater than for other specialities;
- specialist and trainee shortages exacerbated workload issues
- feelings of disempowerment by senior staff
- lower trainee remuneration compared to other states and territories
- psychiatry trainee remuneration compared with other specialities, which require longer service prior to entry on training programs
- erosion of non-clinical time and opportunities to participate in research, teaching, supervision and mentoring
- poor workplace culture
- fragmentation of patient care as a result of workforce shortages
- perception of increasing bureaucracy that distracts from patient care
- the cost of the two Sydney-based mandatory Formal Education Courses(FEC) (Hunter New England Local Health District has its own, less expensive FEC).

It was also noted that there is a stigma of both mental illness and psychiatry in both society and medical professionals. This increases the challenge in promoting psychiatry as a career choice.

Questions:

Are there actions and activities that are currently impacting on recruitment and retention of the psychiatry workforce?

What are key actions and activities that could improve recruitment and retention of the psychiatry workforce?

Models of care and innovation

The consultation identified that there has been a change in the scope of services provided in the public mental health services. The public health system has moved from providing acute and chronic psychiatry services to focusing on provision of acute care only. Non-acute and chronic mental health services are increasingly being provided by private and non-government organisations outside of the public health system. This has an impact on the role of the psychiatrist in the NSW Health public

mental health service and on the provision of training in the public health psychiatry service.

Stakeholders consider it is vital to develop innovative mental health models of care and new ways of working to ensure that NSW Health mental health services continue to provide integrated and effective care to meet mental health care needs of the community.

With the increased focus on acute services there is also a greater emphasis on the provision of acute psychiatric services after hours, particularly to support mental health patients presenting to Emergency Departments after hours. Most often these afterhours services are provided by on call psychiatrists (Staff Specialists and VMOs) and trainees doing after hour's rostered overtime or on call. Providing these afterhours services can be a burden, particularly where there are existing staff vacancies.

Consultation identified a number of flexible and innovative models of care, to provide extended hours care (such as evenings and weekends) and rostering in Emergency Departments to support these changing models of care.

Questions:

What is the role of the psychiatrist in this changing public mental health service model? What needs to be considered to meet and support this changing role?

Are there innovative models to support provision of acute after hour's psychiatry services that could be considered?

What are the barriers to implementing extended hours care models?

4. Education, training and research

a. Medical student and prevocational psychiatry experience

Clinical exposure to specialties is one factor that can inform speciality career choice. Positive experiences in a speciality, either as a medical student or postgraduate year one or two doctor (PGY1/2 prevocational), may encourage a junior doctor into that speciality. Conversely, a poor experience during the rotation may confirm which specialities a junior doctor does not want to pursue.

Medical students usually undertake psychiatry rotations late in their medical training program and usually after significant exposure to medicine and surgical specialities. The 2018 final year medical students Medical Schools Outcomes Database (MSOD) survey collects information from final year medical students from all medical schools across Australia. In response to the question on preferred specialty of future practice psychiatry ranked eighth, behind adult medicine, surgery, general practice and anaesthesia which respectively ranked first through to fourth[4].

Lack of exposure to specific specialties, such as psychiatry, as a prevocational doctor may result in these specialities not even being considered as a viable career option. The Medical Board of Australia does not require interns to complete a psychiatry rotation. While there are some accredited psychiatry prevocational terms, doctors in their first two postgraduate years overwhelmingly have greater exposure to surgery, medicine and emergency medicine than psychiatry.

Questions:

What could be done to promote psychiatry as a preferred speciality of practice to medical students?

Are there opportunities to grow the PGY1/2 terms in psychiatry? Are there innovative models supporting quality experiences for prevocational doctors undertaking psychiatry rotations.

4 Medical Deans Australia and New Zealand (2019) *Medical Schools Outcome Data Base National Data Report* 2019, Table 23

b. Vocational Psychiatry training in NSW

In 2005 five Psychiatry Training Networks were established to support the delivery of the psychiatry training program in NSW. The training networks link rural, regional and metropolitan hospitals and community health centres to support basic and generalist psychiatry training in NSW. The network composition was based largely on the then Area Health Services boundaries. Since the networks were established there have been significant changes including:

- Area Health Services were replaced by smaller Local Health Districts and Specialty Networks
- Establishing new training sites in psychiatry, particularly in rural and regional sites and the private sector
- Growth in the total number of psychiatry training positions
- The RANZCP introduced a new training program in 2013 to replace the 2003 program.

Consultation has identified a number of challenges concerning psychiatry training within NSW. The changes that have occurred to the psychiatry training program and the training networks no doubt have contributed to these challenges. The issues identified include:

- Poor and limited cooperation between Local Health Districts and training networks concerning trainee rotations. It was felt that the current shortage of trainees contributed to this issue.
- Trainee perceptions of limited transparency and inconsistency in decision-making regarding term rotations
- Distribution of trainees across the networks
- Access of appropriate terms for trainees for each stage of training
- The consistency and clarity of governance of Networks and key staff such as Site Coordinator of Training (SCoT), Directors of Training and Directors of Advanced Training was not always clear; particularly with regards to responsibilities to RANZCP relative to Networks and Local Health Districts

The Health Education and Training Institute is undertaking a review of the current operations of the Psychiatry Training Networks and is undertaking separate consultation. That review is considering how the Psychiatry Training Network governance can be strengthened and how the training network structures and allocation of trainees can be optimised to improve the quality of training and ensure equity and efficiency for trainees. It is anticipated that HETI's review will address a number of the issues raised as part of the current consultation for the Plan.

Cost of training in NSW

The RANZCP requires all trainees to undertake a Formal Education Course. Formal Education Course providers are accredited by the College. The cost of the training in NSW was reported to be considerably higher than in other states and territories.

Lower remuneration

This together with the lower remuneration of NSW trainees compared to those in other states and territories was felt to create a significant financial burden for trainees and was considered an issue in the recruitment and retention of trainees.

The RANZCP allows trainees to enter the psychiatry training program in their second postgraduate year. Other college training programs require applicants to have completed two or three postgraduate years before entering speciality training. To meet the award classification of registrar, a medical officer must have at least three years' experience in a public hospital. Currently Medical Officers in the psychiatry training program who do not have three postgraduate years are not immediately classified as registrars as they do not meet the award requirements.

Questions:

What are the advantages of trainees entering the training program in their second postgraduate years? Are there any disadvantages?

Rural training

In 2013, with the introduction of the new training program, the RANZCP removed the requirement for psychiatry trainees to undertake a rural rotation as part of their training requirements.

Rural exposure for trainees has significant workforce benefits, and benefits trainees by providing them exposure to different training environments. Evidence also indicates that rural exposure at both undergraduate and postgraduate levels increases interest in pursuing rural practice in the future.

Therefore it was determined that as requirement of employment to a NSW psychiatry training network all trainees must undertake a minimum three month rural rotation as a condition of their employment.

Questions:

How can rural psychiatry training be supported?

Supporting training and wellbeing

The *Your Training and Wellbeing Matters Survey* is an initiative of the JMO Wellbeing Plan. The survey measures trainee wellbeing, experience of bullying, training and supervision experiences.

The survey indicates that more work needs to be done to support psychiatry trainee wellbeing and training. Table 4 compares survey responses from all NSW Health Junior Medical Officers with responses from NSW Health psychiatry trainees.

Table 4	NSW Health	Psychiatry trainees
Wellbeing index	54%	49%
My hospital values my health and wellbeing	55 %	39%
My hospital site supports junior doctor training	74%	69%
Morale is good in my team	68 %	59%
I have time most working days to have a meal break	52%	62%
I feel physically safe within the hospital environment	89%	72%
Staff members, including junior doctors, are treated fairly and with respect regardless of their position	64%	55%
My hospital has effective processes for monitoring workload and managing surges	35%	26%

c. Career Medical Officer Professional Development

The CMOs are a small but important part of the medical workforce providing mental health services. A 2018 survey of CMOs working in psychiatry in the public and private sectors identified that more than half of respondents had worked as a CMO for 11 years or longer[5].

Feedback and survey findings indicate that CMOs can find it difficult to attend education and professional development, as they are often required to backfill psychiatrists and trainees to attend conferences and training. CMOs professional development needs may be different to those of trainees in the College accredited training program. There may not always be programs or training available to address the development needs of the CMOs.

Questions:

How can the professional development needs of the CMO psychiatry workforce be better supported?

5 Nash L, Meltzer M and Karageorge A. Career Medical Officers in psychiatry and addiction in NSW: description, role and educational needs. Australian Psychiatry 2019, Vol 27(5) 528-531.

d. Research and training

Mental health treatment and care is informed by innovation and research and the translation of this to clinical practice.

It is reported that recruitment into academic psychiatry is declining globally, impacting undergraduate teaching, postgraduate training and research contributions.

Consultation identified that opportunities for research and training were seen as positive aspects of working in the public psychiatry sector. However feedback also indicated that there were limited opportunities for research due to the demands of clinical practice and that some staff specialists were choosing to work less than full-time so they had time for research.

Questions:

What are the barriers and enablers to supporting psychiatrists to participate in teaching and research?

Providing training and supervision to trainees is important in developing our future workforce. Feedback found that while teaching is seen as a positive aspect of working in the public system, many supervisors report limited time to fulfil their training responsibilities due to their clinical practice demands. In the 2018 *Your Training and Wellbeing Supervisor Survey* 64 per cent of psychiatry supervisors agreed that most days they had time on their ward round for teaching and 65 per cent agreed that they had enough time during the week to fulfil their supervisor role.

Questions:

How can psychiatry supervisors be supported?

Culture and leadership

NSW Health Core values are Collaboration, Openness, Respect and Empowerment. Workplace culture is key to the wellbeing of staff and to delivering the best outcomes for patients.

Improving medical workforce culture is a key priority with NSW Health. A number of policies and initiatives are being implemented to support improvement, including the Statement of *Agreed Principles on a Respectful Culture in Medicine* and the *JMO Wellbeing and Support Plan* published in November 2017. A key to improving culture in the workplace is strong leadership driving the culture improvement process.

Feedback indicated that psychiatrists are feeling increasingly disempowered and disengaged in the workplace.

Stakeholders considered that leadership was a key element in mental health services to provide a clear direction and vision for service development, delivery and improvement. Further that psychiatry should play a key role in mental health system leadership. However, stakeholders also felt that there were no leadership pathways for psychiatrists or very few opportunities to formally learn or teach leadership skills as part of their clinical roles.

Questions:

How can psychiatrist leadership skills be developed?

What are the priority areas for development of leadership skills?

Questions:

Fractionation of the workforce

1. What are the strengths and challenges with a fractional psychiatrist workforce?
2. What are the key design requirements of a fractional workforce to support psychiatrist engagement, continuity of care, teaching and equitable distribution of workload across the specialist workforce. Can systems be designed to provide continuity of care with a fractionated workforce?

Fly in fly out workforce

3. What are the strengths and challenges of the FIFO model? Is the FIFO model a sustainable option for provision of rural and regional psychiatrist workforce?

Psychiatry team structures

4. What are the enablers and barriers to developing a more tiered psychiatry workforce structure?

Rural Generalist

5. Is there a role for the Rural Generalist in provision of mental health services in rural communities?

Recruitment and retention

6. What are key actions and activities that could improve recruitment and retention of the psychiatry workforce?
7. Are there actions and activities that are currently impacting on recruitment and retention of the psychiatry workforce?

Models of care and innovation

8. What is the role of the psychiatrist in this changed service model? What needs to be considered to meet and support this changing role?
9. Are there innovative models to support provision of acute after hour's psychiatry services that could be considered?
10. What are the barriers to implementing extended hours care models?

Medical student and prevocational psychiatry experience

11. What could be done to promote psychiatry as a preferred speciality of practice to medical students?
12. Are there opportunities to grow the PGY1/2 terms in psychiatry? Are there innovative models supporting quality experiences for prevocational doctors undertaking psychiatry rotations.

Vocational Psychiatry training in NSW

13. What are the advantages of trainees entering the training program in their second postgraduate years? Are there any disadvantages?

Rural training

14. How can rural training be supported?

Career Medical officer professional development

15. How can the professional development needs of the CMO psychiatry workforce be better supported?

Research and training

16. What are the barriers and enablers to support psychiatrists to participate in teaching and research?
17. How can supervisors be supported?

Culture and leadership

18. How can psychiatrist leadership skills be developed.
19. What are the priority areas for development of leadership skills

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