Healthcare Management Advisors

AUSTRALIAN GOVERNMENT DEPARTMENT OF HEALTH, DISABILITY AND AGEING

Evaluation of the Psychiatry Workforce Program

FINAL REPORT

26 MARCH 2026

HMA

OUR VISION

To positively impact people's lives by helping create better health services

OUR MISSION

To use our management consulting skills to provide expert advice and support to health funders, service providers and users

KBC Australia

This project is being undertaken in collaboration with KBC Australia.

HMA acknowledges Traditional Owners of Country throughout Australia and recognises the continuing connection to lands, waters and communities.

We pay our respect to Aboriginal and Torres Strait Islander cultures, and to Elders both past and present.

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ABBREVIATIONS

Abbreviation	Definition
ACEM	Australasian College for Emergency Medicine
ACRRM	Australian College of Rural and Remote Medicine
AGPT	Australian General Practitioner Training
AIDA	Australian Indigenous Doctors' Association
AMSA	Australian Medical Students Association
ANZCA	Australian and New Zealand College of Anaesthetists
AST	Advanced Specialist Training
ATSIHiCP	Aboriginal and Torres Strait Islander Health in Clinical Practice
CAP	Child and Adolescent Psychiatry
CL	Consultant Liaison
CPD	Continuing Professional Development
DoT	Directors of Training
FATES	Flexible Approach to Training in Expanded Settings
FIFO	Fly-in-fly-out

Abbreviation	Definition
FTE	Full-time equivalent
GP	General practitioner
HETI	Health Education and Training Institute
HMA	Healthcare Management Advisors
IRTP	Integrated Rural Training Pipeline
KEA	Key evaluation area
KPI	Key performance indicator
LHD	Local health district
M&E	Monitoring and Evaluation
MBS	Medicare Benefits Schedule
MM	Modified Monash (Model)
NSW	New South Wales
NT	Northern Territory
PGY	Postgraduate year
PICS	Private Infrastructure and Clinical Supervision

ABBREVIATIONS

Abbreviation	Definition
PIF	Psychiatry Interest Forum
PWP	Psychiatry Workforce Program
RACGP	Royal Australian College of General Practitioners
RANZCOG	Royal Australian and New Zealand College of Obstetricians and Gynaecologists
RANZCP	Royal Australian and New Zealand College of Psychiatry
RPL	Recognition of prior learning
RPTP	Rural Psychiatry Training Pathway
SIMG	Specialist International Medical Graduate
STP	Specialist Training Program
WA	Western Australia

EXECUTIVE SUMMARY

The Department of Health, Disability and Ageing (the Department) engaged Healthcare Management Advisors (HMA) in 2023 to:

> *Undertake an independent evaluation of the Psychiatry Workforce Program (PWP). The evaluation will include an assessment of the implementation, appropriateness, and effectiveness of the PWP.*

This document is the **final report**, an output of Stage 5 of this evaluation project. It sets out the evaluation process, findings and recommendations.

ABOUT THE PWP

Recommendations from the Productivity Commission's Inquiry into Mental Health 2020 formed the basis of the PWP. Funding for the PWP stems from the 2021–22 federal budget investment into the National Mental Health and Suicide Prevention Plan 2021.

Of note, *Recommendation 16: Increase the efficacy of Australia's mental health workforce,* raised actions that included measures to increase the number of psychiatrists through a national plan with a priority focus on those practising outside of major cities (Action 16.2). Other actions aimed to promote mental health as a career option (Action 16.7).

These recommendations and other insights from the inquiry informed the development of the PWP, which was announced as part of the 2021–22 federal budget.

The PWP aimed to attract and support psychiatry training (including rural and remote locations) and foster Indigenous trainees' successful completion of fellowship. The PWP also aimed to alleviate stage 2 training bottlenecks by funding Child and Adolescent Psychiatry (CAP) and Consultant Liaison (CL) posts in health services.

The goal of the PWP was to improve access to high-quality mental health care for all Australians, with a particular focus on those living in rural and remote areas. This was to be achieved across four objectives:

- increase the psychiatrist workforce, particularly in rural and remote areas across Australia
- increase the number of Aboriginal and Torres Strait Islander psychiatry trainees
- promote psychiatry to medical graduates through early engagement of medical students
- develop a nationally recognised postgraduate vocational qualification in psychiatry for medical practitioners, including general practitioners (GPs) and emergency medicine specialists.

The Royal Australian and New Zealand College of Psychiatry (RANZCP) received $39.5 million to implement the PWP over four years (2021–22 to 2025–26). The PWP funding covers four key activities outlined below.

Training posts

The program funded new training posts that were not previously funded and that met one of the following criteria:

- one full time equivalent (FTE) PWP-funded trainee located in MM2–7 locations
- provide services to Aboriginal and Torres Strait Islander communities
- CL (stage 2 mandatory rotation)
- CAP (stage 2 mandatory rotation).

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The program also funded a 0.33 FTE supervisor allowance per PWP trainee post. PWP posts were only open to current RANZCP trainees and Specialist International Medical Graduates on the pathway to the RANZCP fellowship.

Support the development of a Rural Psychiatry Training Program (RPTP)

The PWP funded two key projects under the RPTP that aim to expand opportunities for supporting training in regional, rural, and remote locations, as follows:

- develop regulations for remote supervision, including remote case review and online clinical team meetings
- broaden settings and regulations in which consultation liaison and child and adolescent psychiatry can be provided

Psychiatry Interest Forum (PIF)

The PWP funded PIF activities to encourage more medical graduates to pursue a career in psychiatry through early engagement with medical students.

Postgraduate Certificate in Clinical Psychiatry

RANZCP was funded through the PWP to develop a nationally recognised Postgraduate Certificate in Clinical Psychiatry for medical practitioners.

PROJECT APPROACH TO EVALUATE THE PWP

This evaluation was both formative and summative, assessing the implementation of PWP by RANZCP and identifying and evaluating short-term outcomes. This evaluation was limited to short-term outcomes, as the program only commenced first-round rotations in 2022. Psychiatry trainees were expected to achieve RANZCP fellowship and begin their specialist career pathway within a few years after the completion of the evaluation. The evaluation aimed to ascertain:

- short-term outcomes such as changes in training and workforce capacity, attitudes, and knowledge among program participants
- progression towards medium-term outcomes of the program
- lessons learned to improve future program design/implementation

The evaluation of PWP employed a mixed-methods approach, with both qualitative and quantitative data informing the analysis to address the monitoring and evaluation (M&E) framework questions. It was undertaken in a staged approach over a 24-month period. It commenced in October 2023 and culminated in a final report in November 2025.

Limitations

This evaluation was limited to the assessment of the intended short-term outcomes of PWP, reflecting the recency of the program, with the first-round of trainee rotations occurring in 2022. It is anticipated that psychiatry trainees who undertook PWP-funded training posts will achieve RANZCP fellowship and begin their specialist career pathway a few years after the completion of this evaluation. Similarly, the Postgraduate Certificate in Clinical Psychiatry commenced in 2024, with completion for the first cohort of enrolled participants not expected until 2026, which falls beyond the timeframe of this evaluation. Where possible, consideration was given to progression towards medium-term outcomes. However, the evaluation timeframe did not allow for the assessment of long-term outcomes.

The evaluation was limited to existing data collected and reported by PWP training posts and RANZCP. Participation in the consultation process by stakeholders was voluntary, including PWP training posts, psychiatry trainees,

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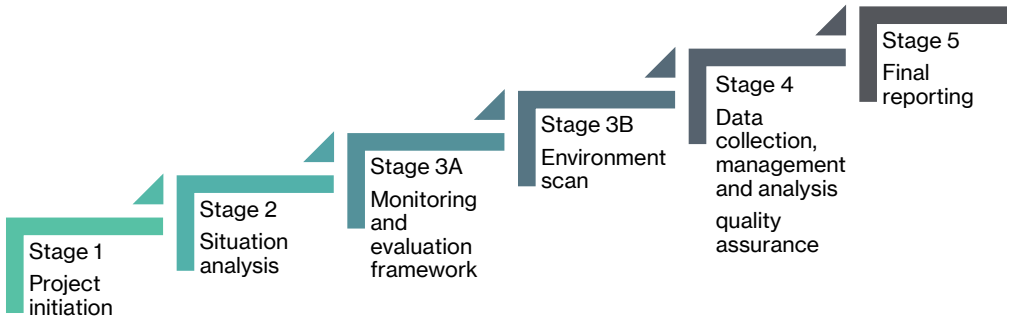
and PIF members. This meant any workforce and/or financial benefits realised by PWP training posts were qualitatively reported. Despite this, nearly 60% (17 out of 30) of the training posts participated in the consultation process, providing a representative sample.

The use of a counterfactual/comparison group was not feasible for this evaluation due to the complexity and impact of other funding arrangements for psychiatry training that co-occur at health services participating in the PWP. This presented challenges to accurately estimate what would have happened in the absence of the PWP and to attribute impacts solely to the PWP. In addition to other sources of funding, doctors' career and training pathways are influenced by many other factors, including personal choice.

Figure ES1.1 presents a high-level overview of the project approach to evaluating PWP

Figure ES1.1



Stage 1 initiated the project, confirming the scope, tasks, stakeholder engagement, risk management plans, and communication protocol for the project's lifecycle. The sections below provide a more detailed description of Stages 2 to 5.

Stage 2: Situation analysis

The **situation analysis** encompassed a desktop review that assessed all relevant aspects of the PWP, including program documentation, policy reports and papers, program requirements and reporting, and other relevant information, as well as identifying other relevant mental health training programs.

Stage 3A: M&E framework

The situation analysis informed the development of the **M&E framework and logic model** (see Appendix A). The M&E framework presented the key evaluation area questions, sub-questions, and indicators. These were mapped to the corresponding data sources and analysis approach.

Stage 3B: Environmental scan

The **environmental scan** focused on the broader mental health medical training context in which the PWP was implemented. It involved a comprehensive review of documentation (including peer-reviewed and grey literature, and jurisdictional funding mechanisms) and extensive consultation with the sector. The list of sector stakeholders consulted is presented in Appendix B.

Stage 4: Data collection and analysis

Quantitative and qualitative data were collected from program administrators, participants and stakeholders (the list of participants is presented in Appendix B). Qualitative data were thematically analysed. Quantitative data were analysed for activity uptake and expenditure over time.

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Value-for-money analysis

The **value-for-money** approach designed by Julian King[1] was used to assess the cost effectiveness and value of the PWP. The value-for-money judgement was undertaken by the evaluation team as independent evaluators, based on standards rubrics (see Appendix C).

Stage 5: Final report

The final report (this document) synthesised evidence from the environmental scan and data collection and analysis stages to draw out salient findings and address the evaluation questions, including recommendations to inform the future policy directions of the PWP.

FINDINGS

The findings from the completed and analysed evaluation activities have been synthesised against the key evaluation areas (KEA) of the M&E framework. The sections below summarise the findings for each KEA.

KEA 1 Implementation: Understand whether the PWP has been implemented successfully as planned

The evaluation assessed whether the PWP was implemented successfully as planned.

1. To what extent has the PWP been implemented as intended?

   The PWP was implemented as intended, according to the key activities and performance indicators outlined in the grant agreement. All 30 training posts were allocated in accordance with the funding criteria. Trainee occupancy ranged from 80% to 97%, and supervisor occupancy ranged from 93% to 100% over the evaluation period.

   A Postgraduate Certificate in Clinical Psychiatry was developed and launched in September 2024, offering two intakes per year (subject to the capacity of RANZCP fellows to supervise and assess participants). The PIF expanded its activities delivered, along with its membership base.

   Guidelines for remote supervision and expanded settings for undertaking stage 2 mandatory training rotations were developed to advance the RPTP (deliverables 30 and 31 under the RPTP Roadmap).

2. To what extent has the PWP reached the target population?

   Allocation of training posts has exceeded the performance indicators outlined in the grant agreement. Seventy per cent (70%) of training posts were located in MM2–7 (almost half (49%) were located in MM4–7), with most providing some level of services to Aboriginal and Torres Strait Islander communities (90% or more). Training posts with a stage 2 mandatory rotation ranged from 33% to 40%; other psychiatry sub-specialties included Aboriginal and Torres Strait Islander health/mental health, adult psychiatry, addiction, psychotherapy and forensic psychiatry. Although open to all medical practitioners at postgraduate year 5+, the Certificate in Clinical Psychiatry was primarily targeted towards general practitioners (GPs) and emergency medicine fellows. At the time of reporting (September 2025), two cohorts of 28 medical practitioners (postgraduate year 5+) in total had enrolled in the Postgraduate Certificate in Clinical Psychiatry; comprising 19 GPs and nine career medical officers or physicians. Information on the remoteness of

[1] Julian King Economic Evaluation and Value for Money Available at https://www.julianking.co.nz/vfi/econ/

enrolments or their work with Aboriginal and Torres Strait Islander populations (identified priority areas) was not available.
The PIF only began collecting rural origin status for new applicants in 2025. Therefore, the evaluation was unable to ascertain if its rural membership base had expanded.
The development of the remote supervision and expanded setting guidelines was not focused on attracting a target population.

3. How has policy shaped the implementation of the PWP?

   The National Rural Generalist Pathway and the Rural Psychiatry Roadmap 2021–2031 are key initiatives designed to attract and support healthcare providers in rural areas. The PWP has progressed work to expand psychiatric training and service delivery in rural and remote areas through additional training posts, training levers (remote supervision and expanded settings for CL and CAP), and strengthening (non-psychiatry) medical practitioners' mental health skills.

4. How is success measured for Aboriginal and Torres Strait Islander graduates?

   The PWP did not fund an activity aimed at increasing Aboriginal and Torres Strait Islander trainees, nor were there any initiatives specific to the PWP targeting them. The RANZCP developed a support network for all Aboriginal and Torres Strait Islander psychiatry trainees, funded by the Specialist Training Program (STP). Psychiatry trainees who identify as Aboriginal and/or Torres Strait Islander did not opt in to engage in the evaluation consultation process.

KEA 2 Appropriateness: relevance of the PWP to the needs of rural communities and psychiatry trainees

The evaluation assessed the appropriateness of the PWP for addressing the needs of rural communities and psychiatry trainees.

1. To what extent does the PWP address the need for psychiatry services in regional, rural and remote communities?

   The PWP provided opportunities to boost psychiatry services in rural and remote areas across a range of health settings, including those serving First Nations communities. However, most stakeholders consulted conceded that the benefits would be limited to the PWP's funding period. They would also be subject to other external stressors in more remote areas, such as workforce attrition and greater geographical distance to consumers. The development of the remote supervision guidelines was an important first step toward building rural capability and capacity through the remote supervision of rural trainees, where appropriate. This has the potential to enhance psychiatric services in rural areas in future.

2. What are the needs of psychiatry trainees to support them through training in rural areas?

   The consulted stakeholders viewed access to training and education for curriculum activities as critical for all rural and remote trainees, regardless of specialty or training program funding source. Online and in-person training sessions and activities were cited to enable peer connections and foster professional networks. Several psychiatry trainees also cited access to, or mechanisms for, a comprehensive training experience as important. Some trainees also suggested the need for relocation support in some instances.

3. How does the PWP support trainees completing rotations in the regional, rural and/or remote locations?

   PWP is not a professional support program but a funding program that includes salary contributions for psychiatry trainees and supervisors. Professional support for rural and remote trainees is the primary responsibility of the local training network and/or the accredited health service responsible for the trainee's employment and training. RANZCP sets the training standards, runs the fellowship training program, provides educational resources, and professional representation. Additionally,

RANZCP offers a confidential member advice line for all RANZCP members to discuss professional matters, fellowship, or training in confidence. This support is provided to all RANZCP trainees and is not specific to PWP.
The consultation process highlighted several areas that need strong consideration to support specialist trainees in rural and remote areas. These included peer connections and support, accommodation and financial assistance, and access to education and training, including clinical exposure to ensure a comprehensive training experience.

4. How does the PWP complement and build upon existing training programs (STP, IRTP, Military and Veteran Psychiatry Training Program, and state/territory-funded programs) and support psychiatry training posts?

   The PWP directly targets bottlenecks in psychiatry training (stage 2 mandatory rotations) and funds supervision, a point of difference from other Commonwealth-funded programs. Health services tended to have a mix of funding streams for trainees, including state/territory funding, STP and IRTP, alongside PWP funding. Several health services consulted described the PWP's flexibility, enabling end-to-end training alongside other funded training rotations. One health service stated that the supervision funding component of PWP enabled the recruitment of an additional psychiatry consultant to their service, further enhancing their psychiatry service capacity.

5. How will the postgraduate certificate in clinical psychiatry complement training provided through the mental health Advanced Specialist Training (AST) and other mental health postgraduate programs undertaken by GPs or emergency medicine specialists?

   A comparative analysis of other mental health training targeted at medical practitioners demonstrated that while the Royal Australian College of General Practitioners (RACGP) and the Australian College of Rural and Remote Medicine (ACRRM) advanced training in mental health is focused on the rural setting, the RANZCP Certificate is independent of remoteness. The RANZCP Certificate focuses on learning clinical skills applicable to diverse clinical scenarios, with a primary emphasis on developing general clinical skills rather than specific diagnoses, age groups, or clinical settings. Conversely, academic-focused mental health training emphasises theoretical and research-based learning rather than clinical skills. Continued monitoring of participation in the Certificate, compared with mental health AST and other mental health training programs, is required to further understand if there is an overlap between cohorts and the level of ongoing demand.

KEA 3 Effectiveness: effectiveness of the PWP in achieving intended outcomes

The evaluation assessed the effectiveness of the PWP to achieve the intended short-term outcomes, and progress towards medium-term outcomes.

1. How effective is the PWP in achieving desired program outcomes in the short and medium-term? What are the key contributing factors to achieving the outcomes?

   Program stakeholders reported that supervisor funding, other federally funded specialist training programs, and stage 2 mandatory rotations were critical enablers in supporting trainees' quality and experience of fellowship training.
   The sustained capacity of the health sector to train psychiatry trainees was associated with continued PWP (and other Commonwealth) funding. The supervision funding was found to have boosted supervision capacity in various formats (direct clinical supervision and psychotherapy cases). Commonwealth funding was cited to have minimal influence on workforce planning at the jurisdictional level and is drawn on by individual health services to address funding/training gaps.
   The Postgraduate Certificate in Clinical Psychiatry has garnered substantial interest from medical practitioners, especially GPs. While there

has been sufficient demand for two intakes per year, the number of intakes to the Certificate is limited by the capacity of RANZCP fellows to support training.

2. What is the awareness of, and support for, the PWP? Is there sufficient understanding about its intended outcomes?

   Awareness of PWP as a discrete, funded program was limited to psychiatrists, funded posts (health services), psychiatry workforce units within state/territory health departments, and psychiatry Rural Directors of Training (DoTs). PIF members and psychiatry trainees who completed a PWP-funded rotation consulted during the evaluation were unaware of the funding sources for psychiatry fellowship training. This was expected since the source of post funding is not typically discussed with trainees, nor is it information they require to undertake the post.

3. To what extent has early engagement of medical graduates resulted in increased interest and recruitment in psychiatry as a career through the expansion of the RANZCP PIF?

   The PIF was found to be an important vehicle for RANZCP to build knowledge and interest among doctors in pursuing a career in psychiatry. The majority (up to 80%) of psychiatry trainees were former PIF members. However, a range of other factors were also reported to influence medical career pathways, such as social media, personal experience with mental health, demand for psychiatrists, and work-life balance preferences. Despite an increase in the psychiatry workforce over time, a workforce maldistribution persists. This suggests that continued focus on building a sustainable workforce pipeline in rural and remote areas is required.

4. Has the PWP successfully attracted First Nations medical students or graduates to enter psychiatry training? How can this be improved?

   RANZCP has taken a whole-of-organisation approach to encourage and support Indigenous psychiatry trainees. This includes collaborating with the Australian Indigenous Doctors' Association (AIDA) and developing a peer support network. This has likely contributed to the substantial increase in the number of Indigenous psychiatry trainees over the last few years. Continuing to work with AIDA to enable cultural safety in healthcare is a priority. PWP did not fund the network's development, and the network is open to all Indigenous trainees.

KEA 4 Efficiency: arrangements in place that allow the PWP to meet intended outcomes through an efficient use of resources

The evaluation assessed the efficiency of the PWP to achieve the intended short-term outcomes and progress towards medium-term outcomes.

1. What governance arrangements are in place for the PWP?

   RANZCP has a governance structure in place to oversee and guide training post allocations and activities, and is the decision-maker for allocating PWP posts. The Australian Government Training Programs Committee assesses training sites as eligible and scores and weights applications. The priorities of the RANZCP Branch Training Committees in each jurisdiction are also taken into consideration. Proposed training sites are submitted to the Education Committee and Executive Meetings for endorsement, after which applicants are notified of the outcome.

2. Are monitoring and evaluation mechanisms in place for the PWP, including reporting requirements?

   Adequate performance monitoring and reporting mechanisms were found to be in place to reconcile contracted obligations for PWP. However, consideration of outcome measures at the health service level may aid in a better understanding of the program's impact on the workforce and community. Outcome measures may include additional supervisor/consultant FTEs employed, additional services delivered (e.g. outreach clinics), or a reduction in locums. Similarly, the development of an overarching Activity Work Plan for the entire funded period and increased

transparency of activities that impact the program's outcomes but are not directly funded may improve the acquittal processes in the future.

3. Is the PWP accessible to clinicians who are interested in extended mental health training?

   The Postgraduate Certificate in Clinical Psychiatry is highly accessible to Australian Health Practitioner Regulation Agency (Ahpra)-registered postgraduate year 5+ medical practitioners. Uptake is likely influenced by the format (workplace-based) and practical nature of the Certificate (i.e. agnostic of health setting).

4. What are the barriers and enablers to the intended outcomes of the PWP?

   There were minimal reported or observed barriers to the PWP achieving its intended outcomes. While several program stakeholders reported challenges in attracting and retaining consultants (to supervise) in rural and remote areas, this was not specific to PWP but rather stemmed from broader workforce challenges. Similarly, the PWP generally aligned with the priorities of health services for service delivery. Additionally, other specialist training funding streams strengthen service viability and, therefore, could be considered an enabler.

KEA 5 Value for money: is the PWP value for money?

The evaluation team used the qualitative and quantitative findings from the PWP evaluation to assess the level of value for money. The overall value-for-money judgement for each key PWP activity ranged from adequate to good. What constitutes poor, adequate, good and excellent is defined in the value-for-money rubric for each PWP activity (see Appendix C).

Good value for money: the training posts and Rural Psychiatry Roadmap activities were deemed to be good value for money.

- The training posts demonstrated good outcomes, extending beyond the program's performance indicators, and increased service capacity and delivery in priority settings. Additionally, a range of indirect cost benefits is reportedly being realised by health services.
- The development of the remote supervision guidelines and expanded settings for CL and CAP in rural and remote areas were discrete, time-limited activities. They were completed within budget and endorsed by RANZCP for integration into the psychiatry fellowship training model.

Adequate value for money: the PIF and the Postgraduate Certificate in Clinical Psychiatry are deemed to represent adequate value for money.

- Although the PIF conducted the planned activities and up to 80% of psychiatry trainees were former members, the cost-effectiveness of the PIF was poor due to high administration costs. Given that a range of factors influence career pathway decisions and that psychiatry is reported to be among the top 10 specialties considered by junior doctors, the return on investment for the PIF does not represent good value for money.
- The Postgraduate Certificate in Clinical Psychiatry was developed and launched within budget. However, it is still in the early stages of implementation and there are few short-term outcomes to assess (other than enrolment figures). The outcomes of the Certificate need to be monitored as it matures, although it is anticipated that course fees will cover ongoing course delivery and administration costs.

FINDINGS AND RECOMMENDATIONS

It is essential to note that the recommendations have been formulated with consideration for the broader environment in which PWP operates. Many issues or challenges highlighted in the evaluation did not stem solely from PWP but were systemic to the specialist training sector or the broader medical workforce. As such, recommendations have not been made on where the issue should be addressed in overarching organisational policies and standards.

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The evaluation is also cognisant of broader medical training and workforce reforms underway, including the redesign of STP and actions to address recommendations from the 2023 Independent review of health practitioner regulatory settings. The outcomes of these activities will also need to be considered in relation to their impact on PWP.

Overall, the evaluation supports the continuation of PWP training posts targeting rural and remote areas, mandatory stage 2 rotations, and health services that provide mental health care to First Nations people.

As such, the objectives of PWP should be limited to the training post activity:

> *increase the psychiatrist workforce and consumer access to psychiatric care by increasing the number of training places, including in rural and remote areas across Australia*

The evaluation found that completed time-limited activities (e.g. development of remote supervision and expanded setting guidelines, and the development of the Certificate in Clinical Psychiatry) should cease. Any future funding for such activities should be assessed on its own merits. Additionally, the evaluation found that the PIF activity should be streamlined and funded by the college in future.

RANZCP takes a whole-of-organisation approach to supporting Aboriginal and/or Torres Strait Islander trainees, thus any initiatives should not be contained to a single training program.

Table ES.1.1 presents preliminary recommendations, rationale and associated findings for each PWP activity.

Table ES.1.1: Findings and recommendations

RECOMMENDATIONS	RATIONALE	ASSOCIATED FINDINGS
PWP training posts		
1. PWP should continue to fund training posts based on existing criteria and focus on increasing the psychiatrist workforce and consumer access to psychiatric care by increasing the number of training places 2. Consideration should be given to adding additional weighting towards training sites in rural and remote areas that can offer end-to-end training with PWP funding 3. Consideration should be given to adding additional weighting towards training sites that demonstrate that additional psychiatry services will be delivered with PWP funding	There is more than sufficient demand and demonstrated benefits realised from funding training sites based on the current criteria. The flexibility in the criteria complements other Commonwealth-funded training programs and adapts to the clinical service delivery models of health services. Expanded settings for CL and CAP training rotations are currently limited to trialling in rural and remote areas. This is also a point of tension in regional and metropolitan areas. CL	Finding 1. There was more than sufficient demand from eligible health services, and all PWP training posts were allocated in accordance with the funding criteria, exceeding performance indicators. A broad cross-section of posts was funded, spanning public, private, and remote settings (particularly MM2–7), stage 2 mandatory rotations, and posts focused on First Nations communities. Finding 2. Any issues reported in the attraction and retention of psychiatry trainees and supervisors in PWP-funded rotations were in the minority and not inherent to PWP but rather to broader systemic issues. Finding 13. The PWP training posts directly target bottlenecks in training (stage 2 mandatory rotations), anecdotally believed to be beneficial for health service delivery and trainees, not targeted by other training programs. Additionally, the flexibility in the funding criteria allowed it to be used in conjunction with other Commonwealth-funded

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RECOMMENDATIONS	RATIONALE	ASSOCIATED FINDINGS
4. Supervisor funding should be a separate funding element from the trainee salary contribution and subject to the following criteria: • Supervisor funding will be used to contract additional consultant FTE for direct supervision • Supervisor funding will be used to contract additional consultant FTE for psychotherapy case supervision • Supervisor funding will be used to quarantine consultant FTE for supervision in private settings	and CAP rotations should continue to include MM1–7.	training programs, enabling end-to-end training in health services/local health networks. Finding 14. Funding for supervision was viewed as a value-adding and a distinct point of difference from other fellowship training programs funded by the Commonwealth. Inadvertently, the funding allows different types of supervision to be funded (everyday oversight or psychotherapy case), based on the clinical service delivery and employment model of the health service. However, since some health services did not use it for supervision purposes, the distribution mechanism for this element requires further consideration. Finding 17. There was a high demand from the health sector to train psychiatry trainees. However, this was reported to be contingent on Commonwealth funding, including PWP, alongside state/territory-funded registrar positions. Expanded settings to undertake stage 2 rotations were suggested to create additional training opportunities. Finding 18. The provision of funding for supervision under PWP enabled some health services to expand their capacity for supervision. Additionally, funding sub-specialty training was thought to increase the likelihood of attracting and retaining consultants. Finding 19. While PWP training posts were limited to 30 positions across Australia, additional FTE enabled rural and remote health services to bolster their services to better meet community demand. This view was not limited to rural and remote services; metropolitan and large rural posts also reported an increase in service delivery capability. Finding 22. Jurisdictional planning and investment are primarily focused on developing clinical service models in response to specific local needs. Commonwealth funding reportedly had minimal influence on workforce planning at the jurisdictional level and is utilised by individual health services to address funding/training gaps. Finding 31. The PWP posts were assessed as value for money, rating good or excellent on all criteria. The posts were implemented efficiently and reportedly yielded good outcomes for rural and remote locations, as well as Aboriginal and Torres Strait Islander communities. Health services reported even greater benefits when PWP posts were used in conjunction with other federal government funding streams, such

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RECOMMENDATIONS	RATIONALE	ASSOCIATED FINDINGS
		as STP and IRTP. The PWP should monitor any future changes to the STP program and assess the impact that these changes will have on PWP delivery.
Progressing the Rural Psychiatry Training Pathway		
5. Consideration should be given to funding additional posts – not previously funded and that would have been unable to host psychiatry training – using remote supervision, and expanded settings for CL rotations in PWP in rural and remote areas 6. Consider a one-off, time-limited funding grant to support a CAP pilot	Further work is required to advance psychiatry training in rural and remote areas to realise the strategic vision of rural and remote workforce strategies to build a sustainable pipeline of psychiatrists. Support for psychiatry trainees in rural and remote areas extends beyond the remit of PWP. It should be incorporated into training site accreditation standards and professional support mechanisms more broadly in the colleges.	Finding 6. RANZCP successfully actioned deliverables 30 and 31 under the RPTP Roadmap as planned. Remote supervision guidelines were developed and endorsed by RANZCP. These have been piloted in Western Australia and South Australia and integrated into the psychiatry fellowship training model. Similarly, expanded settings for stage 2 CL/CAP mandatory rotations in rural and remote areas have been developed and endorsed for use; however, CAP must be trialled before a full rollout. Finding 11. The PWP has progressed work to expand psychiatric training and service delivery in rural and remote areas through additional training posts, training levers (remote supervision and expanded settings for CL and CAP), and strengthening the mental health skills of medical practitioners. Finding 33. The time-limited activity to develop a remote supervision model has been completed and piloted. RANZCP should monitor the uptake and impact of the remote supervision model as it rolls out, to ensure equivalent quality to face-to-face supervision and acceptability to health services, trainees, and supervisors. Finding 34. The time-limited activity to develop expanded settings for CL and CAP rotation has been completed, with the expanded setting endorsed. Rural pathway opportunities for CL are now available as business as usual, and CAP rotations will be piloted. RANZCP should monitor the uptake and impact of the expanded settings/pilot, to ensure equivalent quality of training and the impact on mandatory stage 2 rotation bottlenecks.
PIF		
7. The PIF should develop a targeted strategy to promote and recruit regional, rural and remote medical students and doctors to the PIF and increase access to in-person events. This may include strategies such	PIF is a useful mechanism to generate interest in psychiatry among prevocational doctors. However, there is currently no targeted strategy to promote and recruit regional, rural, and	Finding 3. The PIF primarily supported (through sponsorship) a range of internal and external activities aimed at increasing knowledge of psychiatry as a career and connecting members to RANZCP events and resources. The PIF membership base has experienced annual growth, which is likely attributed to the PIF's increased efforts to

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RECOMMENDATIONS	RATIONALE	ASSOCIATED FINDINGS
as weighting or prioritising scholarship applicants based in MM2–7. 8. RANZCP should self-fund PIF and review the PIF operational processes to streamline and use resources efficiently to continue the promotion of psychiatry as a specialty and career.	remote medical students and doctors (PGY2+) to the PIF. This would provide further clarity on the PIF approach and how it can complement or intersect with other sources of influence on career pathways, thereby improving the rural psychiatry pipeline. Given the increased interest in psychiatry as a career path since the PIF was established, it is feasible to suggest that RANZCP self-fund the PIF. The PIF operational activities (biannual member surveys, post-event evaluation surveys, etc.) and extensive sponsorship of external bodies and events warrant further review to understand the return on investment, as the current administration and staff costs appear to represent approximately 70% of PIF expenditure. Note: a complete review of the PIF expenditure is still underway and is yet to be confirmed. In addition, further work is required to understand the funding and resources attributed to the passive membership of the PIF, and what is reasonable compared to the benefits realised (for passive members and psychiatry more broadly).	broaden its external connections, primarily through sponsorships of university medical societies and AMSA events. Finding 4. The PIF sponsored approximately 5% of active PIF members (medical students and PGY1–2 doctors) to attend sponsored events each year. While around 20% of those sponsored were based in MM2–7, there was no formal process to prioritise or weight sponsorship applications from those in MM2–7. Similarly, around 10% of sponsored members identified as Aboriginal and/or Torres Strait Islander. Finding 5. A large proportion of PIF members are passive (PGY3+ are unlikely to transition to RANZCP fellowship training), which suggests that the PIF also serves as a mechanism for doctors to access information on mental health issues and treatments. Finding 20. The PIF is a platform for building knowledge and interest among doctors to pursue a career in psychiatry. Up to 80% of psychiatry trainees were reportedly PIF members; however, a range of other factors also influence the career pathways of medical students and junior doctors. Finding 21. Regionally hosted events for rural medical students and junior doctors represent a valuable opportunity to foster local relationships and workforce pipelines. Despite an increase in the psychiatric workforce over time, a maldistribution of the workforce still exists. This suggests that efforts may be best focused specifically on rural and remote cohorts, leveraging regional and rural training networks (including Rural DoTs). Finding 32. Although the PIF helps to promote awareness of psychiatry as a medical specialty, it is not delivered in a cost-efficient manner. Efforts to streamline administrative processes may improve their cost efficiency. However, the evaluation found that the PIF lacks a dedicated focus on areas of interest to the federal government (i.e. rural and remote workforce) and therefore should no longer be a federal funding priority.

EXECUTIVE SUMMARY

RECOMMENDATIONS	RATIONALE	ASSOCIATED FINDINGS
Support for psychiatry trainees		
9. RANZCP should continue to work with AIDA to strengthen links with psychiatry trainees who identify as Aboriginal and/or Torres Strait Islander. 10. RANZCP should continue to use a whole-of-organisation approach to supporting Aboriginal and/or Torres Strait Islander trainees	Support for Indigenous psychiatry trainees is not specific to individual fellowship training programs but rather provided in a whole-of-organisation approach. Providing agency to Indigenous psychiatry trainees to define what is important to them and how to connect and support their peers is important. This should extend to the support network for Aboriginal and Torres Strait Islander trainees.	Finding 9. The PWP did not fund an activity aimed at increasing Aboriginal and Torres Strait Islander trainees, nor are there any initiatives specific to the PWP that target Aboriginal and Torres Strait Islander trainees. The RANZCP developed a support network for all Aboriginal and Torres Strait Islander psychiatry trainees, funded by the STP. The PIF supported Aboriginal and Torres Strait Islander psychiatry trainees with scholarships to attend (mostly) Indigenous events. Finding 10. RANZCP and specialist colleges more broadly recognise the importance of supporting Indigenous trainees (and specialists) in colleges and health settings. Continuing to work with AIDA to enable cultural safety in healthcare is a priority. Finding 23. RANZCP has taken a whole-of-organisation approach to encourage and support Indigenous psychiatry trainees, including the development of a peer support network. While this has likely contributed to the substantial increase in Indigenous psychiatry trainees over the last few years, it is not directly attributable to the PWP.
11. RANZCP should work with potential sites designated as suitable for remote supervision or an expanded setting for CL and CAP to develop health service guidelines for hosting these types of training rotations. 12. RANZCP should continue to support the Rural DoTs to support the training (including exam preparation) and peer support networking of rural and remote trainees.	It is important for health services hosting trainees using remote supervision to be aware of their additional responsibilities in supporting and providing trainees with a safe clinical experience. RANZCP notes that the development and resourcing of these sites is the responsibility of the employing health service. However, the joint development of on-site guidelines and processes that align with RANZCP's remote supervision guidelines (and expanded settings for stage 2 mandatory rotations) will set and align expectations to foster good training outcomes. It will also aid	Finding 12. The PWP offers opportunities to enhance psychiatric services in rural and remote areas, addressing community needs. However, most stakeholders conceded that the benefits are limited to the funding period of the PWP and are subject to other external stressors in more remote areas. Finding 16. All psychiatry trainees (broadly all specialist trainees) require additional support in rural and remote areas. Access to training and education for curriculum activities is critical and also enables peer connections. Additional costs will likely be incurred associated with relocating; however, housing availability is also an issue in rural and remote areas. Additionally, governance of clinical practices to be culturally aware and appropriate is important to deliver care to Aboriginal and Torres Strait Islander communities.

EXECUTIVE SUMMARY

RECOMMENDATIONS	RATIONALE	ASSOCIATED FINDINGS
	towards a standardised approach for health services.	
Postgraduate Certificate in Clinical Psychiatry		
13. RANZCP should take steps to achieve recognition of the Postgraduate Certificate in Clinical Psychiatry as CPD for medical practitioners by their respective colleges, including RACGP and ACRRM 14. RANZCP should explore opportunities with rural health services/networks to support the Certificate with in-kind consultant services to provide supervision to participants, to foster adoption and a skilled local primary care workforce	The launch of the Postgraduate Certificate in Clinical Psychiatry was delayed from 2023 to 2024. While the evaluation can assess the implementation and uptake of the Certificate, the impact cannot be assessed as no participants have yet completed it. The estimated felt need and impact of the Certificate for medical practitioners have been drawn from the sector as a proxy indicator. A pulse survey of enrolled participants to gain insight into the motivation and expected impact/application of the Certificate may be of added value to follow up on in future. While the 2025 pre-election commitment to mental health promised funding support for 200 participants in the Certificate, the capacity of RANZCP fellows as supervisors is a rate-limiting step to the number of participants.	Finding 7. The Postgraduate Certificate in Clinical Psychiatry was developed, endorsed and launched by RANZCP in the second half of 2024 within budget. Two scheduled intakes per year have generated sufficient demand and uptake among medical practitioners in a range of settings. Finding 8. RANZCP has not addressed the recognition of the Certificate as CPD by other relevant colleges for participants. This is a critical gap for RANZCP to consider and address. Finding 15. The RANZCP Postgraduate Certificate in Clinical Psychiatry addresses a gap in the mental health skills training landscape. It targets medical practitioners who require skills-based training and is agnostic to health settings or remoteness. Finding 24. The Postgraduate Certificate in Clinical Psychiatry has garnered substantial interest from medical practitioners, especially GPs. While there has been sufficient demand for two intakes per year, the number of intakes to the Certificate is limited by the capacity of RANZCP fellows to support training. Given that supervision payments are activity-based, there is no financial incentive for fellows to participate. Opportunities to leverage rural health services/networks to support the Certificate with in-kind consultant services, thereby fostering a skilled primary care workforce, should be explored. It is advisable to review the actual hours of input for supervisors and participants to understand any unintended outcomes or inefficiencies. Finding 30. The individual workplace-based format and practical nature of the Postgraduate Certificate in Clinical Psychiatry are likely to positively influence uptake. Finding 35. The time-limited activity to develop the Postgraduate Certificate in Clinical Psychiatry has been completed with 28 enrolled participants in September 2025. RANZCP should monitor enrolment uptake and completion rates. RANZCP may wish to consider attaining RACGP and ACRRM CPD points for the Certificate in future, noting the majority of participants are GPs. RANZCP should also monitor the number of supervisors participating, which is a rate-limiting factor. Should supervisor

EXECUTIVE SUMMARY

RECOMMENDATIONS	RATIONALE	ASSOCIATED FINDINGS
		participation drop off or become a barrier in future, RANZCP may wish to consider alternative payment structures for supervision of participants.
Program governance		
15. Future grant agreements for administering the PWP should require an overarching Activity Work Plan. This plan must schedule all funded activities across the full funding term with defined completion dates. Any additional activities that influence program outcomes but are not directly funded should be clearly identified and highlighted to ensure transparency. 16. Collection and reporting of outcome measures at the health service level, such as additional service activity, should be considered to better understand the impact on the community		Finding 25. Oversight and administration of the PWP have been integrated into RANZCP's existing governance and reporting structures. This includes processes to score, prioritise, and allocate training posts, as well as endorse Rural Psychiatry Roadmap deliverables (remote supervision and expanded settings for CL and CAP). Finding 26. Adequate performance monitoring and reporting mechanisms are in place to reconcile contracted obligations and performance indicators for PWP via biannual performance reporting. However, consideration of outcome measures at the health service level may aid in a better understanding of the program's impact on the workforce and community. Finding 27. The inclusion of activities and success measures not funded by PWP in biannual performance reports potentially distorted the magnitude of the program's success. In future, it will be essential to acknowledge and clearly distinguish between activities funded by the PWP and those that are not. Finding 28. Given some key activities were completed before the end of the funded period (2022 to 2026), planning activities across the full funding term with completion dates will improve visibility in future. Finding 29. The level of financial budget and expenditure reported was minimal. The rollover of unspent funds was not directly linked to rolled-over activities or new planned activities in the performance reports. Additionally, expenditure for activities that generate a variable outcome, such as the PIF (interest in psychiatry, transition to RANZCP fellowship training), did not differentiate between direct and indirect costs, thereby limiting a broad understanding of the program's efficiency. The administration costs of the PIF were estimated at 70%, demonstrating poor efficiency given the low complexity and risk of PIF activities and the benefits realised.

1 INTRODUCTION

The Department of Health, Disability and Ageing (the Department) engaged Healthcare Management Advisors (HMA) in 2023 to undertake an independent evaluation of the Psychiatry Workforce Program (PWP).

1.1 CONTEXT TO PWP

The PWP 2021–23 was one of a suite of measures funded by the Commonwealth under the 2021–22 Budget Mental Health Workforce packages to attract, upskill, distribute, and retain key mental health professionals to address mental health workforce shortages and maldistribution. The development of the PWP is informed by the Productivity Commission Inquiry into Mental Health (30 June 2020) and Towards a National Whole of Government approach to Suicide Prevention in Australia (August 2020). In 2021, RANZCP developed a Rural Psychiatry Roadmap 2021–31 [1] (the Roadmap) to build a dedicated Rural Psychiatry Training Pathway (RPTP).

The PWP stemmed from actions to achieve the deliverables outlined in the Roadmap). The PWP aimed to attract and support psychiatry training in rural locations and foster the successful completion of fellowship by Indigenous trainees. In addition, it aimed to contribute to building a sustainable psychiatry workforce to improve patient access to mental healthcare, particularly for those living in rural and remote areas. This was to be achieved across four objectives as follows:

- increase the psychiatrist workforce and consumer access to psychiatric care by increasing the number of training places, including in rural and remote areas across Australia
- increase the number of Aboriginal and Torres Strait Islander psychiatry trainees
- promote psychiatry to medical graduates through early engagement of medical students
- develop a nationally recognised postgraduate vocational qualification in psychiatry for medical practitioners, including general practitioners (GPs) and emergency medicine specialists.

The Royal Australian and New Zealand College of Psychiatry (RANZCP) received $39.5 million to implement the PWP over four years (2021–22 to 2025–26) through four key activities:

1. encourage more medical graduates to pursue psychiatry through early engagement with medical students through RANZCP's Psychiatry Interest Forum (PIF)
2. support the development of an RPTP and network
3. fund an additional 20 psychiatry training posts and 20 supervisors in the 2022 training year and 30 training posts and 30 supervisors from 2023 to the first half of 2026
4. develop a nationally recognised Postgraduate Certificate in Clinical Psychiatry for medical practitioners.

1.2 EVALUATION AIMS

The evaluation aimed to identify:

- short-term outcomes of the PWP, such as changes in training and workforce capacity, attitudes, and knowledge among program participants
- progress towards medium-term outcomes of the PWP
- lessons learned to improve future program design/implementation

1 INTRODUCTION

1.3 PURPOSE OF THE FINAL REPORT

The final report (this document) presents the broader contextual environment in which PWP operates, an overview of the approach used to evaluate PWP, and findings and recommendations to inform future directions of PWP.

1.4 STRUCTURE OF FINAL REPORT

The rest of the final report is structured into Part A and Part B as follows:

Part A: Evaluation approach and context

- **Chapter 2** presents a summary of the project method to evaluate the PWP and progress status
- **Chapter 3** presents a summary of the broader contextual environment in which PWP operates

Part B: Findings and recommendations

- **Chapter 4** presents findings on the implementation of the PWP
- **Chapter 5** presents findings on the appropriateness of the PWP to address the needs of psychiatry trainees and rural communities
- **Chapter 6** presents findings on the effectiveness of the PWP to achieve intended outcomes
- **Chapter 7** presents findings on the efficiency of the PWP to achieve intended outcomes
- **Chapter 8** presents the assessed value for money of the PWP
- **Chapter 9** presents recommendations to inform future directions of the PWP
- **Chapter 10** Appendices
  - **Appendix A**: Logic model and evaluation and monitoring framework
  - **Appendix B**: Stakeholders consulted
  - **Appendix C**: Value-for-money standards rubrics
  - **Appendix D**: PWP context
  - **Appendix E**: PIF activities, program and financial data
- **Chapter 11** References

PART A EVALUATION APPROACH AND CONTEXT

2 METHOD

The PWP evaluation was both formative and summative, assessing the implementation of PWP by RANZCP and identifying and evaluating short- to medium-term outcomes. The evaluation employed a mixed-methods approach, with both qualitative and quantitative data informing the analysis to address the evaluation questions. A summary of the evaluation method is provided in this chapter.

2.1 APPROACH TO MONITOR AND EVALUATE PWP

The PWP evaluation commenced in October 2023 and culminated in a final report in November 2025. It was undertaken in a staged approach over 24 months as described below.

2.1.1 Stage 2: Situation analysis

The **situation analysis** encompassed a desktop review that assessed all relevant aspects of the PWP, including program documentation, policy reports and papers, program requirements and reporting, and other relevant information, as well as identifying other relevant mental health training programs.

2.1.2 Stage 3A: M&E framework

The situation analysis informed the development of the **monitoring and evaluation (M&E) framework** (see Appendix A). The M&E framework presented the key evaluation area questions, sub-questions, and indicators. These were mapped to the corresponding data sources and analysis approach.

A logic model underpinned the M&E framework (see Figure 2.1 for the detailed logic model and Appendix A for the high-level logic model). The development of the logic model was informed by the situation analysis undertaken in Stage 2. The logic model was used to validate key evaluation areas and identify any omissions in the M&E framework.

2.1.3 Stage 3B: Environmental scan

The **environmental scan** built on the information gathered in the Situation analysis, with a focus on the broader mental health medical training context in which the PWP was implemented. It involved a comprehensive review of documentation, focusing on other funded training programs from other jurisdictions, including peer-reviewed and grey literature, as well as reports. Extensive consultation was undertaken with the sector to further understand the potential training pathways to specialist streams (including psychiatry), identify gaps or overlaps, and consider alternative models. Consultation included the following types of stakeholders:

- Specialist colleges (under the STP framework)
- Peak bodies and rural workforce agencies
- Psychiatrists
- Jurisdictional health authorities
- Chief psychiatrists

The list of sector stakeholders consulted is presented in Appendix B.

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Figure 2.1: PWP logic model (detailed)

Goal: The goal of the PWP is to improve access to high-quality mental health care for all Australians, with a focus on those living in rural and remote areas (MM 2–7)

Policy context:
- The Psychiatry Workforce Program (PWP) 2021–23 was one of a suite of measures funded by the Commonwealth under the 2021 – 22 Budget Mental Health Workforce packages.
- The development of the PWP is informed by the Productivity Commission Inquiry into Mental Health (30 June 2020) and Towards a National Whole of Government Approach to Suicide Prevention in Australia (August 2020) to address workforce shortages and to upskill the mental health and suicide prevention workforce.
- Specialist Training Program (STP) Operational Framework 2022–25

Objectives:
- To address mental health workforce maldistribution and shortages by increasing the psychiatry workforce in settings outside traditional metropolitan teaching hospitals, including regional, rural, remote and private facilities.
- To increase access to mental health services, with a focus on those living in rural and remote areas.

Inputs

- Psychiatric Workforce Program funding:
  - RANZCP program administration
  - Salary contributions for 1 FTE trainee and 0.33 FTE supervisor per training post per year (accredited health service)
  - An annual loading of $17,500 to $30,000 (ex. GST) per annum pro rata (based on Rural Loading Guidelines)
  - Private infrastructure and clinical supervision annual loading of up to $30,000 (GST exclusive) pro rata, per FTE, subject to total funds allocated
- RANZCP (including state and territory branches, committees, working groups and advisory groups)
- Accredited health services (public and private) in regional, rural and remote settings (MM 2–7)
- Current RANZCP trainees and Specialist International Medical Graduates (SIMGs) on the pathway to RANZCP Fellowship

Processes

RANZCP
- Administer PWP program and funding
- Allocate trainee posts to accredited health settings
- RANZCP develop a support network for all Aboriginal and Torres Strait Islander psychiatry trainees (funded through STP)
- Use the psychiatry interest forum (PIF) to promote psychiatry to medical students and pre-vocational doctors
- Support the Development of Rural and Remote Psychiatry Training Pathway and Network
- Develop a postgraduate certificate in clinical psychiatry for medical practitioners

Health services and private settings
- Accredited setting with supervisor to support psychiatry trainee rotation(s)
- Apply for PWP funding
- Complete and submit PWP Progress Reports and invoices

Supervisors
- Support workplace-based assessments and training for psychiatry trainees

Outputs

- Increase in funded psychiatry trainee posts across Australia (MM 2–4, 5–7)
- Increase in the number of psychiatry trainee posts in stage 2 mandatory rotation posts
- Increase in trainee posts in health settings that provide services to Aboriginal and Torres Strait Islanders
- Support network available for all Aboriginal and Torres Strait Islander psychiatry trainees
- Increase in the number of supervisors to support trainee posts
- Increase in PIF membership and activities (number over time and conversion rate)
- Complete deliverables under the Rural Psychiatry Roadmap to expand training opportunities in rural and remote settings.
- Postgraduate certificate in clinical psychiatry developed and endorsed by the medical sector

Outcomes

Short-term (1–2 years)
- Sustained capacity of the health sector to support the training of psychiatry trainees
- Sustained capacity to provide supervision of trainees
- Increased access to psychiatric care, especially in rural and remote locations across Australia
- Convert PIF members to psychiatry trainees

Medium-term (3–5 years)
- Psychiatry workforce training investment in priority areas by states and territories
- Increase in Aboriginal and Torres Strait Islander psychiatry trainees
- Sustained uptake in postgraduate vocational training in mental health
- Additional training program levers available to expand training opportunities in rural and remote settings

Long-term (5+ years)
- Sustained increase in the psychiatry workforce to address workforce maldistribution

Assumptions
- The PWP will fund new training posts that have not been previously funded through the current Specialist Training Programs administered by RANZCP
- Trainees can apply for more than one eligible rotation for PWP and STP at an accredited setting
- The Postgraduate Certificate in Clinical Psychiatry will be recognised within the health sector and by medical practitioners

External factors
- Other STP psychiatry training programs (Rural Director of Training, Integrated Rural Training Pipeline, Tasmanian Project, Specialist Training Placements and Support) also aim to address psychiatrist workforce maldistribution in regional, rural and remote settings
- Capacity of health services to support multiple specialist training posts
- Other vocational mental health training options (RACGP, ACRRM)
- Increased promotion and competition for Aboriginal and Torres Strait Islander and rural/regional students from other specialist colleges
- Recognition of extended mental health skills for GPs, emerging rural generalists
- Rural Psychiatry Roadmap 2021–31

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2.1.4 Stage 4: Data collection and analysis

Quantitative and qualitative data were collected from program administrators, participants and stakeholders that included:

- Focus groups with PIF members
- Individual discussions with psychiatry trainees
- Stakeholder consultations
  - Psychiatry trainee rotation settings (health services)
  - PWP supervisors
  - Rural Directors of Training (DoTs)
  - Regional Training Hubs
- RANZCP PWP program and financial data

The list of participants in focus groups and discussions with psychiatry trainees and program stakeholders is presented in Appendix B.

Qualitative data were thematically analysed. Quantitative data were analysed for activity uptake and expenditure over time.

Value-for-money analysis

After consideration of various economic evaluation approaches, the **value-for-money** approach designed by Julian King[2] was selected for the PWP evaluation because:

- the intended outcomes of the PWP do not focus on direct clinical or patient outcomes and relate to a mix of workforce outcomes
- the PWP outcomes have no measurable unidimensional outcome and cannot be measured as quality-adjusted life years

Julian King's value-for-money analysis is a broader construct than efficiency. It is an evaluative question about how well resources are used and whether a particular use of resources is justified.

A standards rubric was developed for each PWP activity with input from the Department (Appendix C). The definitions for poor, adequate, good, and excellent are defined for each standards rubric and for each value-for-money criterion, as follows:

- Efficiency (outputs)
- Effectiveness (outcomes)
- Environment
- Equity
- Cost-effectiveness

The value-for-money judgement was undertaken by the evaluation team as independent evaluators. The value-for-money exercise is presented in detail in Chapter 8.

2.1.5 Stage 5: Final report

The final report (this document) synthesised evidence from the environmental scan and data collection and analysis stages to draw out salient findings and address the evaluation questions, including recommendations to inform the future policy directions of the PWP.

[2] Julian King Economic Evaluation and Value for Money Available at https://www.julianking.co.nz/vfi/econ/

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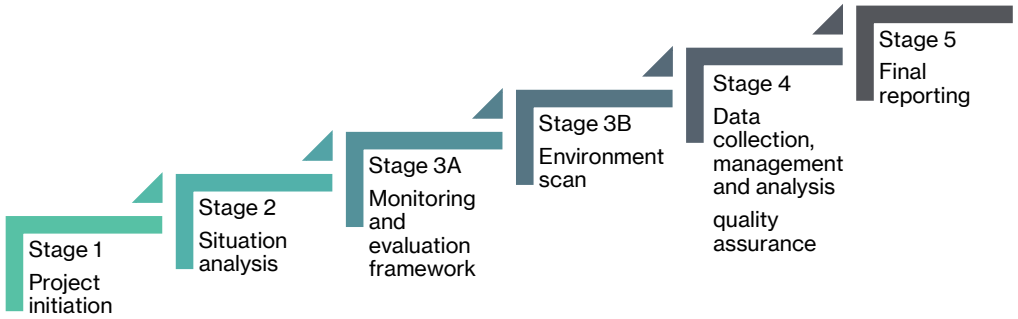
Figure 2.2 presents an overview of the project approach used to evaluate the PWP

Figure 2.2: Staged approach to evaluate PWP



2.2 EVALUATION DESIGN

This evaluation was both formative and summative, assessing the implementation of PWP by RANZCP and identifying and evaluating short-term outcomes. The evaluation was limited to short-term outcomes, as the program only commenced first-round rotations in 2022. Psychiatry trainees were expected to achieve RANZCP fellowship and begin their specialist career pathway within a few years after the completion of the evaluation. The evaluation aimed to ascertain:

- short-term outcomes such as changes in training and workforce capacity, attitudes, and knowledge among program participants
- progression towards medium-term outcomes of the program
- lessons learned to improve future program design/implementation

The evaluation identified opportunities to improve future directions of PWP based on an agreed-upon program success criterion. This evaluation also identified medium-term outcomes and indicators for longitudinal program monitoring (assumed to be the future responsibility of the program sponsors) to assess the overall success.

The evaluation of PWP employed a non-quasi experimental and mixed-methods approach, with both qualitative and quantitative data informing the analysis to address the M&E framework questions.

The M&E framework for the PWP is presented in Appendix A and was underpinned by a logic model (see Figure 2.1 and Appendix A for additional information).

The key evaluation areas (KEA) for the PWP evaluation were as follows:

- KEA 1 Implementation: understand whether the PWP has been implemented successfully as planned
- KEA 2 Appropriateness: relevance of the PWP to the needs of rural communities and psychiatry trainees
- KEA 3 Effectiveness: effectiveness of the PWP in achieving intended outcomes
- KEA 4 Efficiency: arrangements in place that allow the PWP to meet intended outcomes through an efficient use of resources
- KEA 5 Value for money: is the PWP value for money?

The analysis of each KEA and the evaluation findings are presented in Part B of this report, along with recommendations for future delivery of the PWP components.

2.3 EVALUATION LIMITATIONS

This evaluation was limited to the assessment of the intended short-term outcomes of PWP, reflecting the recency of the program, with the first round of trainee rotations occurring in 2022. It is anticipated that psychiatry trainees who undertook PWP-funded training posts will achieve RANZCP fellowship and begin their specialist career pathway within a few years after the

2 METHOD

completion of this evaluation. Similarly, the Postgraduate Certificate in Clinical Psychiatry commenced in 2024, with completion for the first cohort of enrolled participants not expected until 2026, beyond the timeframe of this evaluation. Where possible, consideration of progression towards medium-term outcomes was considered. However, the evaluation timeframe did not allow for the assessment of long-term outcomes.

The evaluation was limited to existing data collected and reported by PWP training posts and RANZCP. Participation in the consultation process by stakeholders was voluntary, including PWP training posts, psychiatry trainees, and PIF members. This meant any workforce and/or financial benefits realised by PWP training posts were qualitatively reported. Despite this, nearly 60% (17 out of 30) of the training posts participated in the consultation process, providing a representative sample.

The use of a counterfactual/comparison group was not feasible for this evaluation due to the complexity and impact of other funding arrangements for psychiatry training that co-occur at health services participating in the PWP. This presented challenges to accurately estimate what would have happened in the absence of the PWP and to attribute impacts solely to the PWP. In addition to other sources of funding, doctors' career and training pathways are influenced by many other factors, including personal choice.

3 PWP CONTEXT

This chapter presents a summary of the broader contextual environment in which PWP operated at the time of evaluation, including policy drivers.

PWP OVERVIEW

3.1 BACKGROUND

In November 2018, the federal government announced an inquiry by the Productivity Commission to improve mental health, support economic participation, and enhance productivity and economic growth. The inquiry's final report outlined key influences on people's mental health, examined the effect of mental health on people's ability to participate in the community and workplace and examined the implications of mental health on the economy and productivity [2]. The report made 21 recommendations with 103 associated actions. These were outlined across five themes:

- prevention and early help for people
- improve people's experiences with mental healthcare
- improve people's experiences with services beyond the health system
- equip workplaces to be mentally healthy, and
- instil incentives and accountability for improved outcomes.

Of note, *Recommendation 16: Increase the efficacy of Australia's mental health workforce,* raised actions that included measures to increase the number of psychiatrists through a national plan with a priority focus on those practising outside of major cities (Action 16.2). Other actions aimed to promote mental health as a career option (Action 16.7).

These recommendations and other insights from the inquiry informed the development of the PWP, which was announced as part of the 2021–22 federal budget.

3.1.1 Budget announcements

As part of the 2021–22 federal budget, the Australian Government invested $2.3 billion into the National Mental Health and Suicide Prevention Plan [3]. The National Mental Health and Suicide Prevention Plan was the first phase of the government's response to findings from the Productivity Commission's Inquiry into Mental Health [4]. The plan was based on five key pillars, one focused on workforce and governance. Within this pillar, there was a commitment of

> *$11 million to boost the psychiatrist workforce by making available 30 additional training posts by 2023, supporting regional and remote training pathways, and promoting psychiatry as a career pathway.*

and:

> *$15.9 million to support GPs and other medical practitioners to provide primary mental healthcare. This includes [among other initiatives] developing a nationally recognised Diploma of Psychiatry for medical practitioners [3].*

This formed the basis of the PWP.

3 PWP CONTEXT

In June 2023, the Australian Government committed an additional $27.5 million to extend the PWP for a further three years (to 2026) and bring the total funding to $39.5 million since its commencement in February 2022 [5].

3.2 POLICY DRIVERS

The Australian Government has launched a number of policy initiatives over the years to address the challenges faced by rural and remote areas due to limited access to quality healthcare services. The sections below provide more detailed descriptions of these initiatives, along with RANZCP's Rural Psychiatry Roadmap, which was developed in response to the maldistribution of the psychiatric workforce.

3.2.1 Rural and remote workforce strategy

About one-third of Australia's population lives in regional, rural, and remote areas. These Australians have limited access to quality healthcare services and are more likely to experience poor health outcomes compared to their metropolitan counterparts. This is partly due to the maldistribution of healthcare professionals in Australia.

Research indicates a strong correlation between health professional education conducted in rural environments and increased retention of healthcare providers in these areas. Introducing undergraduate students and trainees to rural community experiences during the early stages of their careers has a significant impact on their interest in pursuing careers in rural healthcare. The deliberate inclusion of students and trainees with rural backgrounds in educational programs has proven effective in encouraging graduates to practise in rural settings. Avenues for ongoing education and professional development significantly contribute to healthcare professionals' likelihood of living and working in rural regions.

The **Stronger Rural Health Strategy** aims to build a sustainable, high-quality health workforce distributed across the country according to community needs, particularly in rural and remote communities. It focuses on strategies along the workforce development continuum from education and training to recruitment to build a sustainable rural health workforce.

3.2.2 Rural and remote medical workforce training

Over the last two decades, the Australian Government has significantly invested in rural medical training and other workforce initiatives to increase the supply and distribution of doctors working in rural, remote, and regional areas. The broader medical workforce (e.g. GPs and emergency medicine specialists) also provides mental healthcare to patients. The shortage of psychiatrists in rural and remote locations means access to mental healthcare via the broader medical workforce is critical to patient care.

The **National Rural Generalist Pathway** is a dedicated medical training pathway to attract, retain and support rural generalist doctors who can provide primary care services and emergency medicine and have training in additional skills such as obstetrics, anaesthetics or mental health services. Rural generalists give these communities a broader range of specialist medical services.

3.2.3 Rural Psychiatry Roadmap

In response to the Productivity Commission's recommendation to develop a national plan to increase the number of generalist psychiatrists practising outside major cities, and the focus of the Australian National Medical Workforce Strategy (released in 2021) on restructuring and reforming medical training pathways to address the undersupply of trainees in rural and remote areas, RANZCP developed the Rural Psychiatry Roadmap 2021–31 [1] (the Roadmap) to build a dedicated RPTP. The RPTP to fellowship focuses on expanding opportunities for aspiring psychiatrists to live, train and practise

3 PWP CONTEXT

rurally. The pathway also aims to optimise the support available for those who take up these opportunities [1].

The Roadmap outlined a 10-year strategy addressing 45 deliverables across five key areas of governance, education programs, selection and onboarding, clinical rotations, and support. RANZCP approved the implementation plan for the Roadmap, and the Australian Government allocated funding to facilitate the progression of its key deliverables. The primary funding for this initiative was provided through the PWP, with additional support from the Flexible Approach to Training in Expanded Settings (FATES) and a brief allocation from the STP. Deliverables of the Roadmap funded under the PWP are detailed in section 3.4.2.

3.3 PSYCHIATRY TRAINING FUNDING

PWP funding for training posts comprises salary contributions, rural loadings, and a Private Infrastructure and Clinical Supervision (PICS) allowance. The point of difference between PWP and other specialist training programs, including STP, is the provision of supervisor funding. PWP funds 0.33 FTE supervisor funding for every one FTE psychiatry trainee.

Training posts funded through the Integrated Rural Training Pipeline (IRTP) differ from the STP and the PWP in that the funding 'follows' the trainee through multiple rotations at one health service, thereby enabling the trainee to complete a large portion of their training in one health service if it is in a rural/remote area. Psychiatry trainees in positions funded by STP and PWP can move freely between regions and jurisdictions to fulfil their training requirements. However, the funding remains with the host employer to continue funding that rotation.

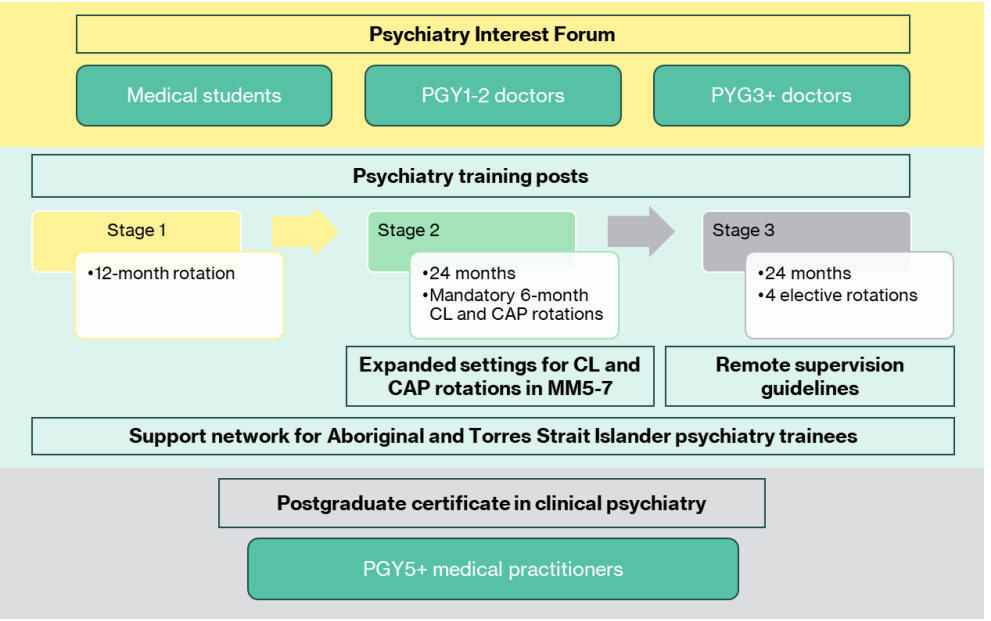
Training posts (trainee salaries) in public hospitals funded through state/territory governments are in addition to those funded through RANZCP.

0 outlines the number of training posts available through each training stream, the salary contribution, and the availability of other supports such as rural loading or supervision funding.

3.4 ELEMENTS OF THE PWP

The PWP funds four key activities: the PIF, the RPTP and network, funding and allocation of psychiatry training posts, and the Postgraduate Certificate in Clinical Psychiatry. Figure 3.1 presents the cohorts targeted by PWP activities.

Figure 3.1: Cohorts targeted by PWP activities



The following sections outline the objectives and activities of each element.

3 PWP CONTEXT

3.4.1 PIF

The PIF was initiated by RANZCP (in 2013) to foster and cultivate interest in psychiatry among medical students and prevocational doctors from the onset of their academic journey. Medical students and doctors registered with the Australian Health Practitioner Regulation Agency (who are not RANZCP fellows or trainees) are eligible to apply to the PIF. The PIF coordinates with internal RANZCP faculties and branches to identify opportunities (e.g. conferences or workshops) for PIF members to attend (usually via sponsorship). In addition, the PIF sponsors events held by the Australian Medical Students Association (AMSA), and the Australian Indigenous Doctors' Association (AIDA). The PIF distributes biannual surveys to members and former members, as well as post-activity surveys. The biannual surveys aim to understand the motivation for membership, value derived and future career intentions. Post-activity surveys aim to assess participants' understanding of psychiatry as a specialty and career pathway.

The PIF collaborates with universities to support the implementation of psychiatry-related programs and activities through student societies. The PIF also actively participates in university career expos and partners with Local Health Districts (LHDs) to promote psychiatry. Furthermore, the PIF works closely with the jurisdictional branches of RANZCP to support local activities and assist PIF members in attending them.

The PIF provides online information and runs a range of free online events, seminars, competitions, and classes for members to learn about a career in psychiatry. PIF offers scholarships to psychiatry conferences, including the RANZCP Congress, the International Medicine in Addiction conference, Faculty, Section, and Branch conferences, as well as seminars.

Examples of activities facilitated by PIF include:

- online essay competition – the winner's work is published in a scientific journal, offering early career recognition opportunities
- Introduction to psychiatry short courses – aim to provide foundational knowledge and insight into psychiatry
- Psychiatry Fellowship Program webinar – details the various state-based psychiatry training programs, giving participants a comprehensive overview of their options
- RANZCP annual Congress – a scientific conference where psychiatrists share research and professional developments in their sub-specialty. The PIF supports several members in attending by providing grants to cover travel and conference fees.

0 presents a more detailed list of activities conducted by the PIF.

3.4.2 Rural Psychiatry Training Roadmap

The Roadmap (detailed in section 3.2.3) delineates 45 deliverables necessary for establishing the RPTP. Among these, PWP funded two key projects that aimed to expand opportunities for supporting training in regional, rural, and remote locations as described below.

Remote supervision

> *Deliverable 30: develop regulations for remote supervision, including remote case review and online clinical team meetings [1]*

A Remote Supervision project was undertaken to develop a model that enables supervisors to train rural doctors remotely. The project scope was to develop remote supervision guidelines outlining the requirements for sites, supervisors and trainees. Additionally, resources and education were developed for sites, supervisors, and trainees to adequately prepare them.

Stage 2 mandatory rotation settings

> *Deliverable 31: broaden settings and regulations in which consultation liaison and Child and Adolescent Psychiatry can be*

provided, recognising cumulative rotations and competencies across a range of settings [1]

RANZCP completed a project to scope alternative settings to undertake the stage 2 mandatory rotations (Child and Adolescent Psychiatry (CAP), and Consultant Liaison (CL)). It is anticipated that the expansion of settings to undertake these rotations may alleviate bottlenecks in the fellowship training pathway. The expanded settings are limited to psychiatry trainees in rural and remote areas.

3.4.3 Psychiatry training posts

The PWP funds new training posts that have not been previously funded and that meet one or more of the following criteria:

- one FTE PWP-funded trainee to be located in MM2–7 locations
- provide services to Aboriginal and Torres Strait Islander communities
- CL (stage 2 mandatory rotation)
- CAP (stage 2 mandatory rotation).

The program also funds a 0.33 FTE supervisor allowance per PWP trainee post. PWP posts are only open to current RANZCP trainees and Specialist International Medical Graduates on the pathway to RANZCP fellowship.

The PWP performance indicators (per the Funding Agreement Schedule with the Department) stipulate 95 per cent of funded training posts and supervisor positions to be filled. Half the training posts must also be in MM2–7 areas.

Stage 2 mandatory rotations

The RANZCP Fellowship Training Program mandates rotations in CAP and CL during stage 2. The limited positions in these sub-specialties and restrictions to hospital settings mean potential bottlenecks in the fellowship training pathway.

The PWP aimed to alleviate these bottlenecks by funding CAP and CL posts in health services. Note, CL and CAP posts are typically based in metropolitan areas. Hence, the RANZCP project was undertaken to scope alternative settings for stage 2 mandatory rotations (see section 3.5.2).

3.4.4 Postgraduate Certificate in Clinical Psychiatry

RANZCP developed a nationally recognised Postgraduate Certificate in Clinical Psychiatry (the Certificate) for medical practitioners. A formal policy and program offering were developed in conjunction with the curriculum. The policy outlines the requirements for the Certificate, including governance, eligibility and enrolment, supervision, learning activities and assessments, and other administrative processes. The program offering outlines course particulars for prospective participants in the Certificate.

RANZCP fellows provide the supervisor, reviewer, and peer facilitator roles for all RANZCP Certificate participants.

The number of participants in the RANZCP Certificate is contingent on the capacity of RANZCP fellows to undertake supervisor, reviewer, and peer facilitator roles. If the number of applicants exceeds RANZCP fellow capacity, priority will be given to medical professionals who:

- work in rural areas
- identify as Aboriginal and/or Torres Strait Islander
- work with Aboriginal and/or Torres Strait Islander populations
- have no previous experience and/or training in mental health.

GPs and emergency medicine physicians are the primary target audience. However, any medical practitioner with general or specialist registration as a medical practitioner in Australia who can satisfy the following is eligible:

1. undertaking their fifth or subsequent postgraduate year
2. working in Australia with patients who require assessment and/or care and support about their mental health

3 PWP CONTEXT

ACRRM and RACGP trainees completing their AST in mental health, or their Rural Generalist Fellowship, can complete the Certificate concurrently with their respective training programs.

Medical practitioners must also meet professional conduct standards associated with registration as a medical practitioner in Australia.

The RANZCP Certificate distinguishes itself from other available programs in practical application. The focus is on practical, real-world skills applicable to diverse clinical scenarios, with a primary emphasis on skills rather than specific diagnoses, age groups, or clinical settings. The practical component is complemented by learning in the following areas through the formal education component:

- assessment of a new mental health presentation
- assessment and management of risk
- use of biological interventions
- use of psychological and social interventions

Enrolled participants of the Certificate are also eligible to apply for **recognition of prior learning** (RPL). To be eligible for RPL, the participant must have been a registered medical practitioner at the time the prior learning was undertaken. Any prior learning and assessment must have been completed in a formal education or training context, with any work experience supervised by a psychiatrist (if relevant). Any prior learning and assessment must have been completed within the previous five years.

The **minimum time requirement for participants completing the Certificate is 12 calendar months or four three-month terms**. Participants will be deemed unsuccessful if they have not completed the core and elective components within 48 calendar months from the commencement.

Note that the recognition of the CPD for GPs (and other specialists), and subsequent access to resources to enable currency of skills and knowledge, have not been addressed by RANZCP.

3.5 SPECIALIST TRAINING FUNDING

The Australian Government plays a significant role in funding specialist training posts through medical colleges. Funding targets areas with identified workforce shortages. These shortages typically encompass rural and remote regions and specialties such as psychiatry. **STP is a Commonwealth-funded initiative** that aims to expand vocational training for specialist registrars (trainees) in settings outside traditional metropolitan teaching hospitals, including regional, rural, remote, and private facilities.

Psychiatry training in jurisdictions is funded by both the state/territory and the federal government. The key priorities and pressure points of jurisdictions are outlined below:

- **New South Wales** priorities are centred on community-based mental health and crisis care for young people experiencing mental distress. These areas lend themselves to CAP training roles and rotations in settings outside of hospitals; both are targeted positions in PWP and STP.
- **Victoria** previously allocated $7.5 million in funding to directly support 43 psychiatry registrars undertaking stage 2 mandatory rotations. However, Victoria plans to advocate for greater flexibility in undertaking stage 2 rotations as a longer-term solution.
- **Queensland**-funded initiatives specific to psychiatry are centred on the acute setting and support infrastructure. To this end, Queensland seeks additional support from the Commonwealth for rural training pathways.
- **South Australia's** (SA) psychiatry training program faces a capacity bottleneck as demand for the program significantly outpaces available training positions. SA Health acknowledges the deficit in the psychiatry workforce and training, particularly in regional and rural areas. A 10-year SA Mental Health Workforce Strategy and SA Psychiatry Workforce Plan were under development at the time of reporting.
- **Western Australia** (WA) relies heavily on Commonwealth funding to expand psychiatry training opportunities in rural and remote areas. Like

3 PWP CONTEXT

SA, WA is facing a training capacity bottleneck, with demand significantly outpacing available psychiatry training positions.

- **Tasmania** relies heavily on multiple funding streams and programs to provide services and training for registrars due to challenges with maintaining RANZCP training accreditation.
- The **Northern Territory's** (NT) unique geography and many remote areas mean psychiatrists are difficult to attract and retain in the NT. As such, the RANCZP NT Branch advocates for better collaboration between the NT government and the Commonwealth to invest in attracting, training, and retaining psychiatrists in the NT. NT also advocated for greater flexibility in stage 2 rotations (expanded settings).
- Private and community-based training positions in the **Australian Capital Territory** (ACT) appear to be solely supported by Commonwealth funding. ACT Health recently funded additional community-based mental health programs and child and adolescent mental health programs. ACT also advocated for greater flexibility in stage 2 rotations.

3.6 ADVANCED MENTAL HEALTH TRAINING

GPs and other medical practitioners (e.g. physicians or emergency medicine practitioners) can complete postgraduate mental health or psychiatry training. A GP can also undertake mental health training through the GP colleges to become a rural generalist with advanced mental health skills. The medical practitioner training pathways and the psychiatry and mental health training opportunities are presented in 0 Figure 10.2.

Advanced training in mental health for medical practitioners focuses on two streams: clinical skillset expansion and academic.

The expansion of mental health capability among GPs is largely achieved through rural generalist GP training pathways offered by the RACGP and ACRRM. Workforce Incentive Practice payments are available for GPs practising advanced skills in MM3–7 areas. Additional training for GPs to develop mental health treatment plans and carry out psychological therapies is available from accredited course providers. These courses enable access to MBS items.

NSW Health Education and Training Institute (HETI) offers a course to specialise in psychiatry for both GPs and RANZCP trainees. All PGY5+ medical practitioners who practise mental healthcare in some form are eligible to undertake the RANZCP Certificate. The proposed corresponding MBS item is a point of difference for the RANZCP Certificate.

The RANZCP Certificate, RACGP, and ACRRM advanced training in mental health are all workplace-based training programs that require an element of supervision. While RACGP and ACRRM advanced training in mental health is focused on the rural setting, the RANZCP Certificate and HETI Master of Psychiatry (specialisation) are not dependent on remoteness.

Academic programs, such as the Master of Psychiatry from the University of Melbourne and the Master of Mental Health – Psychiatry from Monash University, offer theoretical and research-based learning, a departure from the RANZCP's practical, real-world skills applicable to diverse clinical scenarios. These master's programs cater to a broader audience (including international medical professionals) and emphasise academic advancement rather than clinical practice.

From a cost perspective, the RANZCP Certificate represents comparative value for money with flexibility in delivery mode for postgraduate medical practitioners. However, GP registrars can complete advanced training in mental health as part of Commonwealth-funded vocational training pathways.

Appendix D, Table 10.12 presents a summary of the advanced mental health training course elements for medical practitioners.

PART B FINDINGS AND RECOMMENDATIONS

4 IMPLEMENTATION

This chapter presents insights into the PWP's intended implementation. It focuses on *KEA 1 Implementation: understand whether the PWP has been implemented successfully as planned.*

The evaluation sub-questions to be addressed under KEA 1 were as follows:

1. To what extent has the PWP been implemented as intended?
2. To what extent has the PWP reached the target population?
3. How has policy shaped the implementation of the PWP?
4. How is success measured for Aboriginal and Torres Strait Islander graduates?

4.1 PSYCHIATRY TRAINING POSTS

The PWP performance indicators (per the Funding Agreement Schedule with the Department) stipulate that 95% of funded training posts and supervisor positions must be filled, and half of the training posts must be in MM2–7 areas. In addition, at least one trainee must identify as Aboriginal or Torres Strait Islander, or at least one post must provide services to Aboriginal and Torres Strait Islander communities.

Analysis of PWP program data (from RANZCP) showed that 102 eligible applications were received for the initial expression of interest to establish the program, demonstrating strong demand for the program. From this, 20 posts were funded from rotation 1 in 2022, and 10 more were funded from rotation 1 in 2023. A further expression of interest was undertaken at the end of 2023 to create a reserve list; 53 applications were received. Twelve posts were added to the reserve list, and one post successfully gained funding in 2024 when another post was defunded due to a lack of supervisor availability.

The profile of training posts spanning rotations 1 (January to June) and 2 (July to December) from January 2022 to July 2025 showed that the PWP met and exceeded its performance indicator targets, as follows:

- the occupancy rate of trainees in funded training posts varied from 80% to 97%
- the occupancy rate of supervisors in funded training posts varied from 93% to 100%
- approximately 70% of training posts were located in MM2–7
- thirty-three out of 68 (49%) post campuses/facilities were located in MM4–7
- over half of training posts encompassed more than one campus/facility (two to eight), with most of these being in MM2–7
- training posts were either all located in MM1 or in MM2–7
- training posts with a stage 2 mandatory rotation ranged from 33% to 40%; other psychiatry sub-specialties included:
  - Aboriginal and Torres Strait Islander health/mental health
  - adult psychiatry
  - addiction
  - psychotherapy
  - forensic psychiatry
- at least 90% of training posts provided some level of services to Aboriginal and Torres Strait Islander communities (except for rotation 1 in 2022, which had only 70% providing these services)
- four to five training posts provided services wholly focused on Aboriginal and Torres Strait Islander communities

Table 4.1 presents PWP training posts by jurisdiction and the total number of health service sites serviced by training posts by MM setting as of rotation 1

4 IMPLEMENTATION

in 2025. Nearly 60% of sites included in the training posts were in MM1, 3, or 6.

Table 4.1: PWP training posts by jurisdiction and MM setting

STATE / TERRITORY	NO. TRAINING POSTS	HEALTH SERVICE SITES SERVICED BY TRAINING POSTS							TOTAL SITES
		MM1	MM2	MM3	MM4	MM5	MM6	MM7	
ACT	1	0	0	0	0	1*	0	0	1
NSW	6	5	0	7	0	0	2	0	14
NT	4	0	4	0	0	0	5	6	15
QLD	5	4	1	1	5	4	1	1	17
SA	2	1	0	1	0	0	0	0	2
TA	1	0	1	0	0	0	0	0	1
VIC	5	3	0	4	0	1	0	0	8
WA	6	2	0	1	1	1	3	2	10
Total	30	15	6	14	6	7	11	9	68
%		22%	9%	21%	9%	10%	16%	13%	100%

Source: PWP program data (Rotation 1 in 2025) from RANZCP. Total number of training posts exceeds 30 due to some posts servicing multiple health services.

*The ACT post is physically located in NSW in an MM5 location close to the ACT-NSW border. Due to the close proximity to the ACT, the training post is part of the ACT training program, and full responsibility (including supervision and providing a trainee) sits with the RANZCP ACT Branch Training Committee.

Table 4.2 presents the training sites by jurisdiction and facility type as of rotation 1 in 2025. Public hospitals represented the most common training site facility type, followed by private and public clinics.

Table 4.2: PWP training posts by jurisdiction and facility type

STATE / TERRITORY	NO. TRAINING SITES	ABORIGINAL MEDICAL SERVICES	PUBLIC CLINIC	PUBLIC HOSPITAL	PRIVATE CLINIC	PRIVATE HOSPITAL
ACT	1	0	0	0	1	0
NSW	6	1	0	10	3	0
NT	4	1	6	8	0	0
QLD	5	1	0	10	6	0
SA	2	0	0	2	0	0
TA	1	0	0	1	0	0
VIC	5	1	0	7	0	0
WA	6	0	0	9	0	1
Total	30	4	6	47	10	1

Source: PWP program data (Rotation 1 in 2025) from RANZCP. Total number of training posts exceeds 30 due to some posts servicing multiple health services.

Note: Public and private clinics are community-based

The PWP trainee occupancy rate varied due to planned and unplanned personal leave. As of rotation 1 in 2023, all rotations were filled, except for an Aboriginal Medical Service in Canberra (this post was subsequently reallocated).

Most health services consulted reported no issues attracting trainees as they believed their location offered a comprehensive training experience. This is reflected in the fact that only one post has been reallocated since 2022. Health services in more remote settings expressed ongoing challenges with attracting trainees; however, this was not unique to PWP.

> *The rural arrangement, isolation, etc. makes it a tough experience for trainees. It is hardcore Indigenous mental health here, a bit crude, vast distances, Indigenous culture. It is hard to attract trainees – rural health service*

4 IMPLEMENTATION

Difficulties in attracting and retaining supervisors/consultants were reported in some regional, rural, and remote areas, particularly in child and adolescent services and consultant liaison roles.

Psychiatry trainees reported that opportunities to train in rural health and private settings (e.g. addiction medicine, where private clinics are more likely to offer specialist services, such as inpatient rehabilitation) provided a comprehensive experience. Some thought a blend of regional and metropolitan settings was important for a comprehensive training experience.

FINDING 1 There was more than sufficient demand from eligible health services, and all PWP training posts were allocated in accordance with the funding criteria, exceeding performance indicators. A broad cross-section of posts was funded, spanning public, private, and remote settings (particularly MM2–7), stage 2 mandatory rotations, and posts focused on First Nations communities.

FINDING 2 Any issues reported in the attraction and retention of psychiatry trainees and supervisors in PWP-funded rotations were in the minority and not inherent to PWP but rather broader systemic issues.

4.2 PSYCHIATRY INTEREST FORUM (PIF)

Membership and transition to the RANZCP fellowship pathway have steadily increased since 2016 (discussed in more detail in section 5.2.4). However, RANZCP estimated that a portion of its membership was *passive* – PGY3+ members interested in psychiatry but unlikely to transition to the RANZCP fellowship.

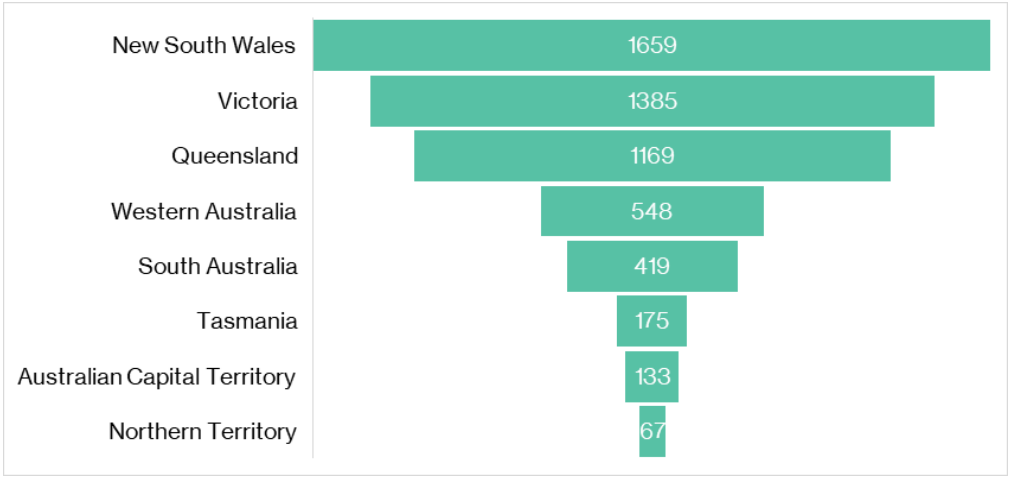
Analysis of RANZCP PIF data revealed that as of July 2025, PIF membership comprised approximately 5,552 individuals, with the majority being medical students (51%) and those in postgraduate years 3 and above (PGY3+) (40%). *Active* PIF members include medical students and PGY1–2 doctors (who are more likely to transition to a psychiatry fellowship). Membership growth ranged between 16% and 19% per annum since 2021. Indigenous members represented 3% of the PIF membership base.

Analysis of the February to June 2025 RANZCP survey of current PIF members (183 respondents) revealed that they ranked *interest in better understanding psychiatry as a career* as the highest motivation for membership, followed by *mental health and treating mental illness*. The latter is not unexpected, given the large proportion of members who are PGY3+.

The PIF received funding under PWP to continue growing its membership base, particularly among those of rural origin. Rural origin and background status were not routinely collected during the PIF application process until December 2024. The 2025 RANZCP survey of current PIF members reported that 83 (45%) respondents had a home address in MM2–7 for at least 5 years consecutively or a cumulative period of 10 years or more. Most members were located in New South Wales, Victoria or Queensland.

Figure 4.1 presents the current number of PIF members by jurisdiction.

Figure 4.1: Number of PIF members by state and territory



4 IMPLEMENTATION

Source: PIF membership data July 2025

PIF delivered a total of 129 activities from mid-2022 to June 2025. In-person events accounted for 91% (n=117) of activities, with PIF providing support through sponsorship (see 0 PIF activities). Sponsored university medical society events accounted for 31% (n=41) of the activities. Half of the activities were led internally by RANZCP with support from the PIF; these were largely faculty and branch events (conferences, networking events, etc). PIF hosted seven events, including the PIF retreat, PIF at Congress, and the PIF essay competition.

Between January 2022 and June 2025, a total of 341 PIF members were sponsored to attend events. This equated to 5% (64) of 2022 membership (medical students and PGY1-2), 5% (121) of the 2023 membership, 4% (137) of the 2024, and 1% (19) of the membership in 2025 (noting 2025 was only six months of data). Approximately 21% (72) of the members sponsored in 2022 to 2024 were based in MM2–7, and 10% (34) identified as Aboriginal and/or Torres Strait Islander. There was no formal process to prioritise or weight sponsorship applications from those in MM2–7.

Between 2023 and June 2024, 860 members attended RANZCP-led events supported by PIF (attendance figures for 2022 were not reported). A total attendance of 11,635 was reported for externally led events sponsored by PIF. Note that several events included large conferences that extended beyond the field of psychiatry.

FINDING 3 The PIF primarily supported (through sponsorship) a range of internal and external activities aimed at increasing knowledge of psychiatry as a career and connecting members to RANZCP events and resources. The PIF membership base has experienced annual growth, which is likely attributed to the PIF's increased efforts to broaden its external connections, primarily through sponsorships of university medical societies and AMSA events.

FINDING 4 The PIF sponsored approximately 5% of active PIF members (medical students and PGY1–2 doctors) to attend sponsored events each year. While around 20% of those sponsored were based in MM2–7, there was no formal process to prioritise or weight sponsorship applications from those in MM2–7 locations. Similarly, around 10% of sponsored members identified as Aboriginal and/or Torres Strait Islander.

FINDING 5 A large proportion of PIF members are passive (PGY3+ are unlikely to transition to RANZCP fellowship training), which suggests that the PIF is also a mechanism for doctors to access information on mental health issues and treatments.

4.3 RURAL PSYCHIATRY TRAINING PATHWAY ROADMAP

Completion of deliverables 30 (remote supervision) and 31 (stage 2 mandatory rotation settings) were discrete activities completed with PWP funding to progress the Roadmap. The completion of these activities provided a basis for advancing remote supervision and expanding stage 2 mandatory settings in rural and remote areas. No unintended outcomes occurred. RANZCP successfully executed these projects. Further details are provided in the following sections.

4.3.1 Remote supervision

RANZCP developed remote supervision guidelines in May 2024, and these guidelines have now been transitioned to the Education and Training Team for implementation.

The RANZCP consulted with psychiatry trainees and supervisors (RANZCP fellows) in the development of the remote supervision model. During RANZCP's consultation process, current psychiatry trainees reported interest in the remote supervision model, perceiving it as a favourable concept. Some

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trainees thought living and training in metropolitan areas was financially onerous compared to regional, rural, and remote areas.

The model developed includes a requirement for health services to employ the remote supervisors at 0.3 FTE capacity. An additional 0.2 FTE is designated for an on-site supervisor to provide holistic professional support and guidance to ensure adequate support for psychiatry trainees. The on-site supervisor does not have to be a fellow of RANZCP.

Remote supervision has now been piloted in several locations, including Western Australia and South Australia. The training positions were existing training posts. Several workshops were convened for trainees and supervisors to understand the requirements and concept of remote supervision in preparation.

4.3.2 Stage 2 mandatory rotation settings

RANZCP completed a project to scope alternative settings for the stage 2 mandatory rotations (CAP and CL). It was anticipated that expanding the number of settings for these rotations would relieve bottlenecks in the fellowship training pathway.

The project scope was limited to rural and remote fellowship training pathways to provide flexibility in the settings where mandatory rotations could occur. The focus was on gaining a breadth of experience and exposure to various parts of the sub-specialty rather than merely fulfilling a set number of hours. The outcomes of these rotations are to be assessed through written reflections and work-based assessments under the supervision of a consultant psychiatrist. Trainees will also have the option to extend the standard six-month timeline if they encounter difficulties in completing the rotation.

The expanded settings for CL and CAP rotations in rural and remote areas have both been endorsed by RANZCP's Education Committee. Expanded CL rotations have been endorsed for integration into rural and remote training pathways, whereas expanded CAP rotations must be trialled first before being expanded to business as usual.

FINDING 6 RANZCP successfully actioned deliverables 30 and 31 under the RPTP Roadmap as planned. Remote supervision guidelines were developed and endorsed by RANZCP. These have been piloted in Western Australia and South Australia and integrated into the psychiatry fellowship training model. Similarly, expanded settings for stage 2 CL/CAP mandatory rotations in rural and remote areas have been developed and endorsed for use; however, CAP must be trialled before a full rollout.

4.4 POSTGRADUATE CERTIFICATE IN CLINICAL PSYCHIATRY

RANZCP successfully developed a vocational Postgraduate Certificate in Clinical Psychiatry (the Certificate) for medical practitioners. An expert advisory group was convened to guide the development of the Certificate. The group comprised representatives from the Royal Australian College of General Practitioners (RACGP), the Australian College of Rural and Remote Medicine (ACRRM), the Australasian College for Emergency Medicine, the Department, and the university sector.

Despite its involvement in the expert advisory group, ACRRM felt that the resulting Certificate deviated from the original intent and overlapped with ACRRM/RACGP advanced skills training.

The RANZCP Board endorsed the Certificate curriculum, policy, and program offering in May 2024, following initial delays in development. Approximately 200 medical practitioners, primarily GPs, expressed interest in undertaking the Certificate.

Applications for the Certificate opened in June 2024, with the first intake scheduled for September 2024 and a second intake for March 2025,

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resulting in a total of 28 participants enrolled (note, a third intake opened in September 2025).

As outlined in section 3.4.4 the number of participants in the RANZCP Certificate is contingent on the capacity of RANZCP fellows to undertake supervisor, reviewer, and peer facilitator roles.

RANZCP has not yet sought recognition of the Certificate as CPD for GPs (and other specialists) by the relevant colleges. However, RANZCP Committees acknowledge the importance of participants maintaining and further developing their knowledge and skills in providing mental health care, as well as offering learning opportunities through the RANZCP. Participants who complete the Certificate will be eligible for the membership category of *Certificant*. This enables access to RANZCP online CPD learning activities.

FINDING 7 The Postgraduate Certificate in Clinical Psychiatry was developed, endorsed and launched by RANZCP in the second half of 2024 within budget. Two scheduled intakes per year have generated sufficient demand and uptake among medical practitioners in a range of settings.

FINDING 8 RANZCP has not addressed the recognition of the Certificate as CPD by other relevant colleges for participants. This is a critical gap for RANZCP to consider and address.

4.5 ABORIGINAL AND TORRES STRAIT ISLANDER PSYCHIATRY TRAINEES

One of the PWP aims was to increase the number of Aboriginal and Torres Strait Islander psychiatry trainees. However, the PWP was not funded to undertake an activity specifically for this purpose; there were no initiatives specific to the PWP that aimed to encourage or prioritise Aboriginal and Torres Strait Islander trainees in PWP posts. Despite this, RANZCP reported on several activities it undertook to achieve this objective in the Activity Work Plans. For example, the PIF activities in the Activity Work Plan included a focus on sponsoring AIDA activities and Aboriginal Torres Strait Islander members. The intention was to increase the number of Aboriginal and Torres Strait Islander members who potentially choose to apply for the RANZCP psychiatry fellowship training.

Similarly, RANZCP developed a college-wide Indigenous trainee support network, funded through the STP. The network aimed to support all Indigenous psychiatry trainees completing their fellowship in any psychiatry training program, including PWP. The network facilitated two forums at the time of this report (one in-person and one online). Participants renamed the network to the 'yarning network'. Initial engagement with the network was reported to be approximately a dozen trainees. At the time of reporting, engagement was reported to have dropped by half, which was suggested to be a result of individual trainee preferences and priorities, and the availability of the AIDA specialist trainee support program for all trainees of all medical specialties.

RANZCP and other specialist medical colleges have adopted a whole-of-organisation approach to engage and support Aboriginal and Torres Strait Islander psychiatry trainees. Support for Aboriginal and Torres Strait Islander trainees identified during consultation is discussed further in the sections below.

4.5.1 Supporting Indigenous trainees

Specialist medical colleges recognise the importance of supporting Aboriginal and Torres Strait Islander trainees to enhance their fellowship training experience and ensure a culturally safe environment. There was a strong consensus on the value of cultural safety workshops, webinars, and ongoing training as effective methods for increasing cultural competency among trainees and consultants/supervisors.

Stakeholders recognised the necessity to accommodate the unique needs and circumstances of Indigenous trainees. This extended to flexible work

4 IMPLEMENTATION

arrangements, access to culturally appropriate support services, and recognition of cultural responsibilities.

RANZCP

RANZCP offers Back to Country Grants for Indigenous psychiatry trainees. These grants offer financial support of up to $3,000 to Aboriginal and/or Torres Strait Islander trainees, aiming to assist them in visiting their country to fulfil cultural responsibilities and reconnect with family or community. The grants can be used for travel, accommodation, and meal expenses and are intended to help avoid burnout, improve wellbeing, and celebrate Aboriginal culture. The grants are available to current RANZCP psychiatry trainees who identify as Indigenous and are limited to one per applicant per annum.

Additionally, Aboriginal and/or Torres Strait Islander trainees gain access to scholarships, such as the Gamadji Nanggit scholarship, as well as individual mentoring. The PIF sponsored AIDA conferences in 2022 and 2024 and sponsored several Aboriginal and /or Torres Strait Islander PIF members to attend.

Specialist medical colleges

The STP allocates a component of its funding to create and manage support programs. During consultation, the **colleges felt that STP funding enabled cultural safety in healthcare**. Several colleges have also incorporated cultural safety training as a core component of their fellowships (for trainees and fellows).

Colleges noted that private practices (in general) may not have the same level of policies, governance, and education on cultural safety as larger health services. Colleges and Indigenous advisory groups are reportedly working to develop recommendations for private practices regarding culturally safe practices.

Stakeholders noted that Indigenous support networks for trainees and members serve as a valuable platform for sharing ideas and learnings, as well as promoting cultural safety within the broader training community. For example, General Practice Registrars Australia supports the Indigenous General Practice Trainee Network, which provides professional and cultural support to Indigenous GP trainees. The AIDA supports Aboriginal and Torres Strait Islander non-GP specialists through their AIDA specialist trainee support program.

AIDA also offers the Aboriginal and Torres Strait Islander Health in Clinical Practice (ATSIHiCP) training program. This clinically focused program is designed to help medical practitioners integrate cultural safety into their practices, thereby improving healthcare for Aboriginal and Torres Strait Islander patients. Several colleges partner with AIDA to deliver this cultural safety training program to their trainees and fellows. The ATSIHiCP is accredited for CPD with these colleges.

FINDING 9 The PWP did not fund an activity aimed at increasing Aboriginal and Torres Strait Islander trainees, nor are there any initiatives specific to the PWP that target Aboriginal and Torres Strait Islander trainees. The RANZCP developed a support network for all Aboriginal and Torres Strait Islander psychiatry trainees, funded by the STP. In addition, the PIF (funded via PWP) supported Aboriginal and Torres Strait Islander psychiatry trainees with scholarships to attend (mostly) Indigenous events.

FINDING 10 RANZCP and specialist colleges more broadly recognise the importance of supporting Indigenous trainees (and specialists) in colleges and health settings. Continuing to work with AIDA to enable cultural safety in healthcare is a priority.

4.6 POLICY DRIVERS

Section 3.2 discussed the challenges faced by rural and remote areas in Australia due to limited access to quality healthcare services, which results in poorer health outcomes compared to metropolitan regions. It highlighted the

4 IMPLEMENTATION

importance of rural health professional education and the positive impact of early career exposure to rural communities on retention rates.

The activities funded by PWP aimed to address workforce maldistribution, foster a sustainable psychiatry workforce pipeline, and provide access to mental healthcare as follows:

- **Training posts**: boost health service capacity to train and expand service delivery to communities
- **PIF**: promote psychiatry as a career pathway
- **Remote supervision guidelines and expanded settings for CL and CAP**: boost opportunities for training in rural and remote areas
- **Postgraduate Certificate in Clinical Psychiatry**: boost mental health skills in medical practitioners and strengthen opportunities for shared care

FINDING 11 The PWP has progressed work to expand psychiatric training and service delivery in rural and remote areas through additional training posts, training levers (remote supervision and expanded settings for CL and CAP), and strengthening the mental health skills of medical practitioners.

5 APPROPRIATENESS OF THE PWP

This chapter presents insights into the PWP's appropriateness to address the needs of psychiatry trainees and rural communities. It focuses on *KEA2 Appropriateness: relevance of the PWP to the needs of rural communities and psychiatry trainees.*

The evaluation sub-questions to be addressed under KEA 2 were as follows:

1. To what extent does the PWP address the need for psychiatry services in regional, rural and remote communities?
2. What are the needs of psychiatry trainees to support them through training in rural areas?
3. How does the PWP support trainees completing rotations in region/rural/remote?
4. How does the PWP complement and build upon existing training programs (STP, IRTP, Military and Veteran Psychiatry Training Program, and state/territory-funded programs) and support psychiatry training posts?
5. How will the Postgraduate Certificate in Clinical Psychiatry complement training provided through mental health Advanced Specialist Training (AST) and other mental health postgraduate programs undertaken by GPs or emergency medicine specialists?

5.1 ADDRESSING THE NEEDS OF RURAL AND REMOTE COMMUNITIES

The PWP criteria included training posts in MM2–7 locations. Consultations with the jurisdictions, PWP training sites, and psychiatrists discussed how the PWP helped address the need for psychiatry services in regional, rural, and remote communities.

Jurisdictions acknowledged the PWP to be somewhat effective in addressing the need for psychiatric services in rural and remote areas in the short to medium-term. Various factors, including personal circumstances and preferences, professional support, and access to ongoing professional development, contributed to the psychiatry workforce shortage and maldistribution. Conversely, PWP training sites cited PWP as an important program to address gaps in training and community needs.

> *PWP has enabled telepsychiatry and fly-in-fly-out services in MM6–7 areas – health service*

> *We would like to expand this model [in other regional areas] with other consultants – health service*

WA found that the PWP was more successful at supporting rural training pathways than the STP program. However, securing ongoing funding to continue psychiatry services seeded through the PWP was reportedly challenging for WA.

> *PWP has been an outstanding model, an enabler of RPTP – jurisdictional health unit*

All jurisdictions consulted agreed that rural-based fellowship training is an effective strategy to help build a sustainable workforce in rural areas. Rural-based training beginning at university was also suggested to be potentially more effective.

> *If [you] want to take lessons from rural generalists, then [you] need to grow the workforce locally – jurisdictional health unit*

5 APPROPRIATENESS OF THE PWP

FINDING 12 The PWP offers opportunities to enhance psychiatric services in rural and remote areas, addressing community needs. However, most stakeholders conceded that the benefits are limited to the funding period of the PWP and are subject to other external stressors in more remote areas.

5.2 ALIGNMENT OF PWP TO OTHER FUNDED PROGRAMS

The PWP is one of several initiatives along the medical training pathway that aim to increase the medical workforce in regional, rural, and remote areas. Postgraduate training for medical practitioners also aims to improve access to mental healthcare in these areas. As described in section 3.5 other programs include STP and IRTP (funded by the Commonwealth) and state/territory government funding of training posts.

Most health services consulted during the evaluation reported that the PWP complements other Commonwealth-funded psychiatry training programs, including the STP and the IRTP. Several health services reported providing end-to-end training using all three funding sources.

> *PWP means we can provide an attractive, well-rounded experience – all five years can be done here. We rely on external funding for a lot of positions – health service*

> *Our goal was to provide Stage 3 advanced training, and PWP has been instrumental in achieving this. PWP has significantly enhanced our training programs by ensuring that Stage 2 rotations are met with targeted funding – health service*

> *First-year trainees are recruited into an IRTP position, then rotate into an STP position and PWP – health service*

FINDING 13 The PWP training posts directly target bottlenecks in training (stage 2 mandatory rotations), anecdotally believed to be beneficial for health service delivery and trainees, not targeted by other training programs. Additionally, the flexibility in the funding criteria allowed it to be used in conjunction with other Commonwealth-funded training programs, enabling end-to-end training in health services/local health networks.

5.2.1 PWP-funded rotations

PWP funding comprises salary contributions, rural loadings, and a PICS allowance. The point of difference between PWP and other specialist training programs is the provision of supervisor funding. PWP funds 0.33 FTE supervisor funding for every 1 FTE psychiatry trainee.

The sections below outline the key differences between PWP-funded rotations and postgraduate training in clinical psychiatry.

Stage 2 mandatory rotations

The RANZCP Fellowship Training Program mandates rotations in CAP and CL during stage 2. The limited positions in these sub-specialties (traditionally based at metropolitan hospitals) and restrictions to hospital settings mean potential bottlenecks in the fellowship training pathway.

The PWP aims to alleviate these bottlenecks by funding CAP and CL posts in health services in extended settings, i.e. rural areas, and private hospitals. Training sites consulted highlighted the PWP as an essential source of funding for CAP and CL training positions.

> *Health service [executive] do not understand the need for psychiatry registrars – PWP funding has allowed us to expand from four to five registrars – health service (consultant)*

5 APPROPRIATENESS OF THE PWP

An extra consultant liaison position is good, as we have not had enough of these positions and have lost trainees. It has cleared our bottleneck – health service

While the small number of psychiatry trainees consulted reported no issue securing a stage 2 rotation, they knew colleagues who had experienced challenges.

Most stakeholders acknowledged that the provision for stage 2 rotation training positions in the PWP helped address these bottlenecks in fellowship training. However, there was some opinion in the jurisdictional chief psychiatrists group that a more innovative approach to undertaking or recognising alternative settings for stage 2 rotations was needed (discussed further in section 5.2.1). This will likely be enabled through deliverable 31 under the Rural Psychiatry Training Roadmap, which identified expanded settings for these rotations in rural and remote areas (completed under PWP funding).

Supervisor funding

Funding to contribute to the cost of supervision from consultant psychiatrists was generally viewed as value-adding and a point of difference from other fellowship training programs funded by the Commonwealth. Tasmania and the NT expressed a preference for using the supervisor funding to support health service delivery and training more broadly. For example, the funding could be used to bolster the resources of Rural DoTs in the jurisdiction to oversee workforce growth and development more effectively.

With ongoing difficulties attracting and retaining consultant psychiatrists in rural and remote areas, salaries may be higher than those in metropolitan areas (to attract candidates). The PWP funding contribution to supervisor salaries is the same amount for all jurisdictions and remoteness settings. While there is a PWP rural and remote salary contribution loading (less than $20,000 per post annually), this was still deemed insufficient for remote areas such as those in remote Western Australia.

There was a consensus among stakeholders that more efforts are needed to incentivise consultant psychiatrists to take up supervisory roles. Chief psychiatrists highlighted that supervision can be burdensome, and the increasing administrative burden (driven by governance requirements and the shift towards assessment-based training) has placed additional strain on supervisors, potentially discouraging their involvement. It was suggested that funding supervisors within their existing roles might not be effective, and other models should be explored. For example, funding consultants outside of their regular work to undertake supervision roles may be a more successful approach. This alternative approach may attract private and part-time psychiatrists to supervisory roles.

Most health services consulted used the supervisor funding element of PWP to expand their supervision capacity. Supervisor funding was reportedly used to fund a range of supervisor elements, including the psychotherapy case component of psychiatry fellowship training, expanding existing consultant capacity, and creating new consultant roles.

A specialty psychotherapy case is needed for advanced training and is expensive, so we use the [PWP] funding for supervision for that – health service

Very helpful – used it to build capacity to get the second consultant liaison doctor who supervises Stage 2 – health service

Used the funding to create consultant roles for supervision and [thus] a bigger pool of supervisors to reduce burnout – health service

For health services that were fully staffed with consultant supervisors, the PWP funding was not used to expand existing consultant capacity or create a new consultant role. The supervisor funding component was reported to contribute to the salaries of consultants and/or trainees**.**

5 APPROPRIATENESS OF THE PWP

FINDING 14 Funding for supervision was viewed as value-adding and a point of difference from other fellowship training programs funded by the Commonwealth. Inadvertently, the funding allows different types of supervision to be funded (everyday oversight or psychotherapy case), based on the clinical service delivery and employment model of the health service. However, since some health services did not use it for supervision purposes, the distribution mechanism for this element requires further consideration.

5.2.2 Postgraduate Certificate in Clinical Psychiatry

As discussed earlier in section 3.4.4 the RANZCP Certificate distinguishes itself from other available programs in practical application. The focus is on practical, real-world skills applicable to diverse clinical scenarios, with a primary emphasis on skills rather than specific diagnoses, age groups, or clinical settings. Additionally, it is workplace-based and open to all geographic settings and PGY5+ medical practitioners who have a vested interest in upskilling in mental health.

A comparative summary of the RANZCP Certificate and other postgraduate psychiatry and mental health training programs for medical professionals was undertaken (section 3.6**Error! Reference source not found.**).

The analysis showed that the RACGP and ACRRM advanced training in mental health is focused on practising mental health in rural settings, whereas the RANZCP Certificate is focused on learning clinical skills applicable to diverse clinical scenarios. Despite this, ACRRM believed the Certificate was duplicative of their program.

Academic-focused mental health training offered by universities provides theoretical and research-based learning. This represents a departure from the RANZCP's practical skills, which apply to diverse clinical scenarios.

Additionally, workforce Incentive Practice payments are available for GPs practising advanced skills (including mental health) in MM3–7 areas.

Additional training for GPs to develop mental health treatment plans and carry out psychological therapies is available from accredited course providers. These courses enable access to Medicare Benefits Schedule (MBS) items. RANZCP is strongly advocating for an MBS item that is accessible to doctors who have completed the RANZCP Certificate. This would mean that doctors can practise mental health and access specific MBS items in a greater range of clinical settings.

FINDING 15 The RANZCP Postgraduate Certificate in Clinical Psychiatry addresses a gap in the mental health skills training landscape. It targets medical practitioners who require skills-based training and is agnostic to health settings or remoteness.

5.3 SUPPORT FOR RURAL AND REMOTE PSYCHIATRY TRAINEES

PWP is not a professional support program but a funding program that includes salary contributions for psychiatry trainees and supervisors. Professional support for rural and remote trainees is the primary responsibility of the local training network and/or the accredited health service responsible for the trainee's employment and training. RANZCP sets the training standards, runs the fellowship training program, provides educational resources, and professional representation. Additionally, RANZCP offers a confidential member advice line for all RANZCP members to discuss professional matters, fellowship, or training in confidence.

Each state and territory has its own employment agreements (EBAs) for medical practitioners, which include provisions for specialist registrars. As EBAs are determined at the state and territory level by the relevant health departments and employer bodies, there are differences in specific training pathways, allowances, and conditions.

5 APPROPRIATENESS OF THE PWP

The consultation process highlighted several areas that need strong consideration to support specialist trainees in rural and remote areas. These included peer connections and support, accommodation and financial assistance, and access to education and training, including clinical exposure to ensure a comprehensive training experience. These are discussed in more detail below.

5.3.1 Peer connections and support

During consultation, colleges highlighted the risk of registrars (regardless of specialty) feeling isolated in rural and remote areas and emphasised the importance of peer support from fellow registrars. Colleges aim to provide a range of supports to ensure access to training opportunities, and professional and peer support for trainees in rural areas that includes:

- access to online tutorials and learning modules for rural trainees to overcome challenges in attending face-to-face learning and training sessions
- trainee travel to larger training hubs to access educational and training support from their peers
- orientation to the community
- scholarships to attend congress events, conferences, etc.

5.3.2 Financial assistance and accommodation

Colleges acknowledged the extra financial burden that comes with rural training positions. Financial assistance (such as the rural loading from the STP) to support relocation, accommodation, family support, and conference attendance was highlighted as important. Like the STP, the PWP also offers a rural annual loading of $17,763 to $30,452 (ex. GST) per annum, pro rata for PWP posts with a minimum of 50 per cent of training conducted in MM2–7 locations. The loading, managed by RANZCP, assists with additional costs associated with having a PWP training position in regional and remote settings.

Accommodation and/or relocation assistance were reported to be available in some instances for psychiatry trainees. Financial support for accommodation and relocation was noted as valuable by psychiatry trainees, particularly those undertaking only a single rotation in a regional/rural area and needing to continue paying for their primary residence. However, financial support from health services was noted to vary between jurisdictions based on different EBAs.

5.3.3 Education and training

Health services and psychiatry trainees reported improved accessibility to curriculum activities through online training and education. The ‘STP Tasmanian Project’ was highlighted as a key support system for Tasmanian-based psychiatry trainees, which brings in education and clinical mentorship online. Health services noted that online training contributed to the ability of psychiatry trainees to complete end-to-end training in a regional/rural area. However, fewer registrars in a region equate to increased on-call duties, which can impact the time spent on studying and assessments.

Psychiatry trainees in more remote areas suggested that support to undertake short-term placements in other settings (e.g. aged care, large tertiary hospital) would be beneficial and enable a comprehensive training experience. Rural DoTs supported this sentiment; the importance of adequate exposure to sub-specialties, along with exam support, was highlighted as critical.

> *A variety of rotations is important; it would be great to be supported to experience/learn about things that aren’t here, e.g. aged care, go somewhere for a month or so like an exchange – PWP trainee*

5 APPROPRIATENESS OF THE PWP

Several Rural DoTs described the importance of peer connections and exam support for trainees. For example, the Victorian Rural Director of Training facilitates online exam tutorials that encompass trainees from multiple health services. These were also reported to facilitate peer connections.

> *We are running rural exam support and tutorials – are online – and have been instrumental in connecting the rural services – Victorian Rural Director of Training*

There was a consensus among stakeholders that trainees from rural origins or backgrounds were more likely to continue their vocational training and/or professional careers in rural areas. However, some stakeholders believed that positive training experiences were more likely to influence trainees' decisions to live and work rurally. College representatives noted that trainees are also more likely to have better experiences in more established towns with better amenities and infrastructure. However, reported challenges such as the availability of supervisors and housing issues in rural regions continue to be barriers to attracting trainees to rural areas.

> *[We have] flipped the [training] model – have integrated training programs in rural areas where at least one rotation is done in metro – Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG)*

5.3.4 Doctors providing services to Aboriginal and Torres Strait Islander communities

The need to provide additional cultural training and clinical governance for psychiatry trainees was cited as important by a regional post that provides services directly to Aboriginal and Torres Strait Islander communities. Observation and more structured supervision (including from Aboriginal and Torres Strait Islander health workers), along with reflective practices, were highlighted as key components of implicit learning to understand and respect cultural care.

> *There is a lot of discretion around cultural governance and appropriateness in how clinical contact is delivered [to First Nation people] – New South Wales health service*

FINDING 16 All psychiatry trainees (broadly all specialist trainees) require additional support in rural and remote areas. Access to training and education for curriculum activities is critical and also enables peer connections. Additional costs will likely be incurred associated with relocating; however, housing availability is also an issue in rural and remote areas. Additionally, governance of clinical practices to be culturally aware and appropriate is important to deliver care to Aboriginal and Torres Strait Islander communities.

6 PROGRAM EFFECTIVENESS

This chapter presents insights into the extent to which the PWP achieved its intended short-term outcomes, and progress towards medium-term outcomes, where possible. It focuses on *KEA* 3 *Effectiveness – Effectiveness of the PWP in achieving intended outcomes*.

The evaluation sub-questions to be addressed under KEA 3 were as follows:

1. How effective is the PWP in achieving desired program outcomes in the short and medium-term? What are the key contributing factors to achieving the outcomes?
2. What is the awareness of, and support for, the PWP? Is there sufficient understanding about its intended outcomes?
3. To what extent has early engagement of medical graduates resulted in increased interest and recruitment in psychiatry as a career through the expansion of the RANZCP PIF?
4. Has the PWP successfully attracted First Nations medical students or graduates to enter psychiatry training? How can this be improved?

6.1 AWARENESS AND SUPPORT FOR PWP

The awareness of PWP as a discrete funded program was contained to psychiatrists, funded posts (health services), psychiatry workforce units within state/territory health departments, and psychiatry Rural DoTs. PIF members and psychiatry trainees who completed a PWP-funded rotation were unaware of the funding sources for psychiatry fellowship training. The awareness of GP/specialist medical colleges was largely limited to those who participated in the expert advisory group convened to guide the development of the Postgraduate Certificate in Clinical Psychiatry only.

6.2 EFFECTIVENESS IN ACHIEVING INTENDED SHORT-TERM OUTCOMES

The effectiveness of PWP to achieve the intended short-term outcomes is presented, along with the enablers and barriers to doing so efficiently.

6.2.1 Sustained capacity of the health sector to train psychiatry trainees

PWP training sites and other stakeholders consulted cited PWP as an important program to address gaps in psychiatry training and community needs. However, some considered the benefits to be short-term, limited to the funding period of the PWP post. Despite this, the demand for PWP posts was high, with eligible applications for PWP-funded rotations exceeding the number of funded training positions (30) more than threefold.

All stakeholders consulted generally perceived stage 2 mandatory rotations (CAP and CL) to be a rate-limiting step in psychiatry fellowship training. They acknowledged that the provision for **stage 2 rotation training positions in the PWP helped address these bottlenecks in fellowship training**. However, some members of the chief psychiatry group held the opinion that a more innovative approach to undertaking and/or recognising stage 2 rotations was needed. Suggestions to broaden opportunities to undertake stage 2 rotations included:

- offering training rotations in alternative settings such as community-based services and Aboriginal Medical Services

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- flexibility when stage 2 mandatory rotations can be undertaken (e.g. Stage 3, years 4 to 5)

  ... be more flexible about what year the child and adolescent or consultant liaison rotations are, rather than the setting – ACT Health

- expanding the scope of the mandatory positions. For example, a rotation in aged care psychiatry could potentially provide sufficient comparable experience compared to a CL rotation. Similarly, a dedicated rotation in intellectual disability may be comparable to a CAP rotation.

FINDING 17 There was a high demand from the health sector to train psychiatry trainees. However, this was reported to be contingent on Commonwealth funding, including PWP, alongside state/territory-funded registrar positions. Expanded settings to undertake stage 2 rotations were suggested to create additional training opportunities.

6.2.2 Sustained capacity to supervise psychiatry trainees

While stakeholders acknowledged the value added by funding supervision, they also highlighted various challenges that could limit the effectiveness in attracting existing and/or new consultant psychiatrists to provide supervision, including:

- the migration of senior psychiatrists to the private sector
- an increase in telemedicine among psychiatrists
- the attractive nature of locum work.

While supervisor funding was agreed to be highly valuable, a remote health service noted that it did not necessarily equate to sustained workforce presence. For rural areas with no psychiatrists on site, the PWP supervisor funding was noted to be insufficient to adequately contribute to the salary of a fly-in-fly-out supervisor.

Several Rural DoTs consulted felt that opportunities for sub-specialty training (stage 2 rotations) in rural and remote areas helped to sustain attraction and retention of both consultants and trainees.

Several posts reportedly expanded their consultant FTE to the region for supervision of the post. Mount Gambier (South Australia), Hunter New England (New South Wales), and Southwest Healthcare Warrnambool (Victoria) contracted additional consultant FTE for supervision. Several posts in Victoria and ACT reported using the supervisor funding to increase FTE internally for supervision.

FINDING 18 The provision of funding for supervision under PWP enabled some health services to expand their supervision capacity. Additionally, funding sub-specialty training was thought to increase the likelihood of attracting and retaining consultants.

6.2.3 Increased access to psychiatric care

As discussed in section 5.1, expanding rural-based psychiatry training to increase access to psychiatry care in rural and remote areas was broadly supported by all stakeholders consulted. PWP posts aimed at stage 2 mandatory rotations or services that provide care specifically to Indigenous populations may also be located in MM1 areas.

While PWP was credited with helping to provide better services in rural and remote areas, outer metropolitan areas were also reported to need more psychiatric services. This was attributed to rapid corridor growth over the last few years. Training posts in MM1 included much-needed services for Aboriginal and Torres Strait Islander communities, including child and adolescent services. However, the PWP criteria for non-metropolitan locations limited further support for outer metropolitan areas.

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Health organisations that provide services to Aboriginal and Torres Strait Islander people also credited PWP with bolstering service provision.

The number of PWP training positions funded (30) was noted to be comparatively small when considering the overall number of psychiatry fellowship training positions. Thus, the impact of the PWP was perceived by some as limited in terms of access to psychiatry for rural communities. However, health services used PWP posts in combination with STP and IRTP funding (which resulted in an ability to provide end-to-end psychiatry training in one rural location), thereby demonstrating the synergistic effect of the PWP. Additionally, support from the PWP to add a consultant psychiatry position was seen by some stakeholders as a positive for rural areas.

Several PWP posts created additional services, including posts in Queensland and New South Wales that reported additional outreach services resulting from increased FTE. A Queensland Rural DoT described the reduced need for locums in northern Queensland due to Commonwealth-funded specialist training, including the PWP posts.

FINDING 19 While PWP training posts were limited to 30 positions across Australia, additional FTE enabled rural and remote health services to bolster their services to better meet community demand. This view was not limited to rural and remote services; metropolitan and large rural posts also reported an increase in service delivery capability.

6.2.4 Convert PIF members to psychiatry trainees

The PIF was established in 2013 to generate interest in psychiatry as a career choice for medical students and prevocational doctors. The psychiatry headcount in 2013 was 1,047 (13 FTE per 100,000 population), with a projected future shortfall of 125 fellows by 2030 [6]. This increased to a headcount of 4,272 (14.4 FTE per 100,000 population) in 2023 [7]. Despite the increase, a projected gap in psychiatry FTE to meet future demand remained [8]. However, some stakeholders believed that there was not a shortage of the psychiatric workforce, but rather a maldistribution of the workforce. The maldistribution of psychiatrists between rural and remote areas compared with metropolitan areas was highlighted in the 2025 Psychiatry Supply and Demand Compendium Report. In 2023, the FTE psychiatrists per 100,000 population in metropolitan areas (MM1) was 17.0, compared to only 2.2 in medium rural towns (MM4) and 1.1 in small rural towns (MM5) [8].

Psychiatry was ranked sixth as the first preference of specialty for future practice by Australian medical student respondents to the 2025 Medical School of Dean's Medical School Outcomes Survey [9]. Similarly, psychiatry was ranked seventh by interns' reported specialty of interest in the 2024 Ahpra Medical Training Survey [10].

While the PIF links members to information on RANZCP's rural psychiatry via activities such as the rural readiness workshops, the PIF did not have a formal strategy to engage and prioritise rural and remote members.

The PIF undertakes routine post-activity surveys to evaluate any increase in knowledge of psychiatry and the likelihood of pursuing a career in psychiatry as a result of attending the event. Note, most PIF members are sponsored to attend events and, therefore, have a higher likelihood of bias in responses. These results have not been included for this reason.

A large proportion of doctors joining the RANZCP Fellowship Training Program over the last few years were PIF members. The proportion of RANZCP trainees who were PIF members increased from 41–73% five to 10 years ago to 70–86% over the last few years. Figure 6.1 presents the proportion of doctors who were PIF members entering RANZCP fellowship training each year.

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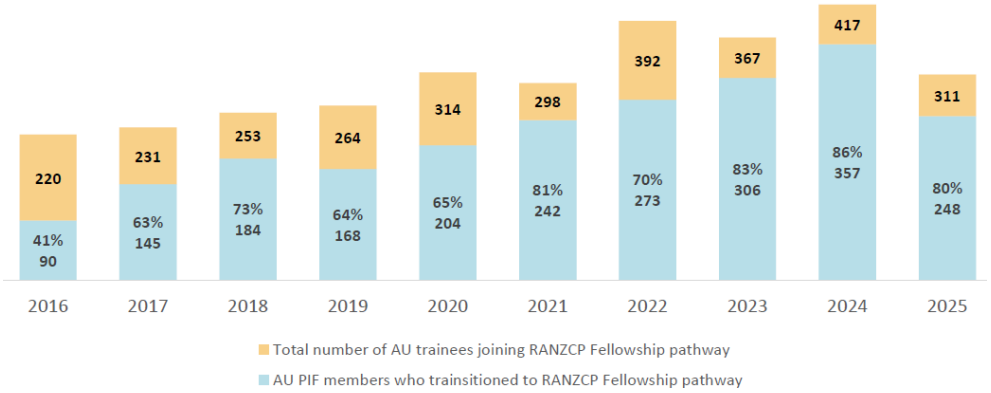
Figure 6.1: Proportion of RANZCP trainees who were PIF members



Source: RANZCP PIF membership profile analysis July 2025

This increase was likely due to the PIF's contribution to boosting the profile of psychiatry as a career and providing opportunities for PIF members to connect with RANZCP members and attend events. However, other factors were also reported to influence the medical career pathway, which are discussed further in the sections below.

Influence of PIF on career choice

Based on the analysis of February to June 2025 RANZCP PIF survey results (183 respondents in total, 20% being a medical student or PGY1–2), 62% (n=96) of PIF members indicated an increased likelihood of choosing psychiatry as a specialty after participating in PIF activities. However, the RANZCP PIF survey has a poor response rate (3% of all members), and caution is required when interpreting these results. PIF members who have transitioned to fellowship are also surveyed biannually. However, the results are excluded due to poor response rates (24 respondents in 2024, 10 in 2025).

To further understand the various sources of influence on medical career pathways, consultations were conducted with PIF members and psychiatry trainees, including an examination of the extent to which PIF influenced their interest in pursuing a career in psychiatry. Psychiatry trainees reported that their interest in pursuing a career in psychiatry stemmed from their **prevocational experiences and other factors**. The PIF was reported to be a **strong driver in building interest in pursuing a career in psychiatry** among PIF members. The PIF members consulted highlighted the following online events as the most insightful regarding a career choice:

- the psychiatry fellowship application process webinar
- sub-specialty lectures
- interactive sessions with psychiatrists to understand what being a psychiatrist entails

PIF members reported that **online activities** were valuable because they mitigated the need to travel and/or pay for travel and were more accessible as they could be accessed after the fact.

> *Often I cannot attend at the time they are occurring – I find online sessions and recordings very helpful – PIF member*

One of the PIF activities reported was **sponsorship of universities**, often through medical student psychiatry societies. PIF members consulted noted this as a point of difference compared to other specialist colleges, which were reported to be less accessible for early insights into specialist medical career opportunities and pathways.

Other sources of influence

While the PIF was a valuable source of information, psychiatry trainees also reported **social media** to be insightful. Prevocational doctors and registrars have shared their experiences in psychiatry on platforms including Reddit and YouTube. Medi-Nav is an online resource for medical students and prevocational doctors to understand workforce and training requirements for medical specialties in Queensland.

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PIF members and psychiatry trainees reported several other sources that influenced their preference towards psychiatry, as follows:

- **Lifestyle and work-life balance** were common factors contributing to PIF members' preference for psychiatry. Psychiatry training can be completed in one local area or region and is attractive to people with families and other personal commitments.
- **Psychiatry was thought to be easier to get into** than other specialist streams, such as anaesthesia and surgery. PIF members and psychiatry trainees did not want to spend years in unaccredited registrar positions to get into more competitive specialist streams. The supply and demand for psychiatry positions were also more favourable than those of other specialist streams, which may also be limited to metropolitan areas.
- **Personal experience with mental health**, both lived and through previous carer experiences. The personal connection to, and impact of, mental health reportedly highlighted the need for more psychiatry services and prevalence.

The **humanities side of psychiatry** was noted to be appealing, along with the **more personal connection with patients** rather than a transactional one.

> *The health system lacks personal connection – which influenced me to move into a different field [psychiatry] – PIF member*

Clinical placements in psychiatry were considered valuable opportunities to observe, discuss, and understand what being a psychiatrist entails, as well as the various sub-specialties.

PIF members suggested that **more exposure to private or non-hospital settings would help them understand** psychiatry practice more broadly. **Smaller, local or regional PIF events** were also suggested to enhance accessibility for all members and provide opportunities to interact with local psychiatry consultants and registrars. Several Rural DoTs described coordinating local regional events to bring together medical students and junior doctors to build knowledge and interest in psychiatry as a career pathway.

> *We host movie nights and play 'Who Wants to Be a Psychiatry Trainee' to create sustained interest and a pipeline into the rural training program. We also have trainees and consultants to give insights into what it's like being in psychiatry. – Queensland Rural Director of Training*

FINDING 20 The PIF is a platform for building knowledge and interest among doctors to pursue a career in psychiatry. Up to 80% of psychiatry trainees were reportedly PIF members; however, a range of other factors also influence the career pathways of medical students and junior doctors.

FINDING 21 Regionally hosted events for rural medical students and junior doctors represent a valuable opportunity to foster local relationships and workforce pipelines. Despite an increase in the psychiatric workforce over time, a maldistribution of the workforce still exists. This suggests that efforts may be best focused specifically on rural and remote cohorts, leveraging regional and rural training networks (including Rural DoTs).

6.3 EFFECTIVENESS IN ACHIEVING INTENDED MEDIUM-TERM OUTCOMES

The effectiveness of PWP to achieve desired medium-term outcomes is presented, along with the enablers and barriers to do so efficiently.

6.3.1 Psychiatry workforce training investment in priority areas by state and territories

Psychiatry training in jurisdictions is funded via both the state and the Commonwealth. The extent to which Commonwealth funding of psychiatry training programs complements or influences jurisdictional planning and investment in psychiatry training was explored with stakeholders.

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Stakeholders consistently observed that Commonwealth funding has minimal influence on workforce planning at the jurisdictional level. Jurisdictional planning was reported to be primarily focused on developing clinical service models in response to specific local needs.

Stakeholders highlighted a range of drawbacks associated with the current Commonwealth funding period for PWP and psychiatry training programs in general, including:

- **Commonwealth fellowship training funding is streamed in an ad-hoc approach that does not align with jurisdictional health service planning cycles. For example, Commonwealth funding is typically three years or less, while WA reported their planning cycles to be at least five years**. The importance of longer-term funding certainty for health services was emphasised. WA also noted that consultants were contracted for a minimum of five years, potentially transitioning to future ongoing contracts.
- **The PWP funding period does not align with the five-year psychiatry fellowship training program.**

The PWP funding contributed to the salaries of trainees and supervisors, with the expectation that health organisations would contribute to the gap. This is a standard Commonwealth fellowship training funding arrangement. WA and the NT reported challenges in bridging the funding gap. **Higher salaries were reported to be necessary to attract consultant psychiatrists and trainees to rural and remote locations.**

> *You have to come up with additional funding [for trainee and/or consultant/supervisor] so it creates an increased drain on NT – Chief Psychiatrist NT*

However, psychiatrists highlighted that Commonwealth-funded psychiatry fellowship programs unlocked opportunities for training in rural and remote areas and boosted the overall numbers. The opinion was that historically, state-funded training post allocations have disproportionately favoured metropolitan settings.

State and territory governments fund public health services to deliver health services. Aside from Victoria (funded separately), this includes a workforce encompassing psychiatry registrar positions. Supervision is not a separately funded training element; it is assumed to be within the remit of the consultant psychiatry position. However, accredited public health services can apply directly for Commonwealth psychiatry training funding.

States and territories acknowledged and supported expanding psychiatry training, particularly in more rural settings. However, they also advocated for greater flexibility in training rotation settings and generalist psychiatry training. Several jurisdictions felt state/territory funding for psychiatry training was more focused on metropolitan and regional settings and thus looked to the Commonwealth to fund rural-based training.

FINDING 22 Jurisdictional planning and investment are primarily focused on developing clinical service models in response to specific local needs. Commonwealth funding reportedly had minimal influence on workforce planning at the jurisdictional level and was utilised by individual health services to address funding/training gaps.

6.3.2 Additional training program levers available to expand training opportunities in rural and remote settings

As discussed in section 4.3, RANZCP undertook work to progress two deliverables under the Rural Psychiatry Roadmap, as follows:

- Remote supervision guidelines were developed, endorsed and are subsequently being piloted in various MM5–7 locations across Australia.
- Expanded settings for stage 2 mandatory rotations (CAP and CL) were defined and endorsed for use in rural and remote areas, with the exception that CAP must be trialled before rolling out. It is anticipated that expanding the types of settings for these rotations may relieve bottlenecks in the

fellowship training pathway. Although the number of relevant training sites in rural and remote areas is likely to be small.

6.3.3 Increase in Aboriginal and Torres Strait Islander trainees

As stated earlier in section 4.5, PWP did not directly fund activities specifically for this purpose. The PIF activities funded by PWP included targeting Aboriginal and Torres Strait Islander medical students for recruitment into psychiatry (as per RANZCP Activity Work Plan). However, the process for PGY2+ doctors to apply and be selected for entry into psychiatry fellowship training is a separate, independent process that is not contingent on PIF membership. There were no initiatives specific to the PWP that aimed to encourage or prioritise Aboriginal and Torres Strait Islander trainees in PWP posts. RANZCP adopts a whole-of-organisation approach to supporting Aboriginal and Torres Strait Islander members, including trainees. This includes **establishing a peer support network for Indigenous psychiatry trainees to connect in person and online.**

In addition, in 2024, RANZCP provided $95,000 to support the training pathways of 19 trainees who identify as Aboriginal and/or Torres Strait Islanders (and eight trainees who identify as Māori) and sponsored five Aboriginal doctors to participate in the Australian Medical Association's Emerging Leaders Program.

The number of Indigenous Australians entering and working in the medical profession, including psychiatry, is on the rise. Nearly 40 psychiatry trainees identify as Aboriginal and Torres Strait Islander. This represents a large proportion of the overall RANZCP members[3] who voluntarily identify as Aboriginal or Torres Strait Islander (63). This indicates positive progress towards promoting and attracting Aboriginal and Torres Strait Islander doctors to pursue a career in psychiatry.

FINDING 23 RANZCP has taken a whole-of-organisation approach to encourage and support Indigenous psychiatry trainees, including the development of a peer support network. While this has likely contributed to the substantial increase in Indigenous psychiatry trainees over the last few years, it is not directly attributable to the PWP.

6.3.4 Uptake in the Postgraduate Certificate in Clinical Psychiatry

There was strong interest from medical practitioners to upskill in mental health. Applications for the Certificate opened in June 2024, with the first intake in September 2024, and a second intake in March 2025. At the time of reporting, a total of 28 participants were enrolled in the Certificate, with two applications received (as of July 2025) for the September 2025 intake.

Table 6.1 presents the enrolled participants by intake, jurisdiction and vocation. Most participants were GPs located in Victoria, Western Australia or Queensland.

Table 6.1: Enrolled participants by intake, jurisdiction and vocation

	CAREER MEDICAL OFFICER	GP	PHYSICIAN	RACGP/RACP REGISTRAR/ MEDICAL OFFICER	TOTAL
September 2024 intake	3	8	3	-	14

[3] As reported in RANZCPs 2024 Annual Review https://www.ranzcp.org/college-committees/annual-reports-plans-and-evaluations/annual-reports-and-strategy

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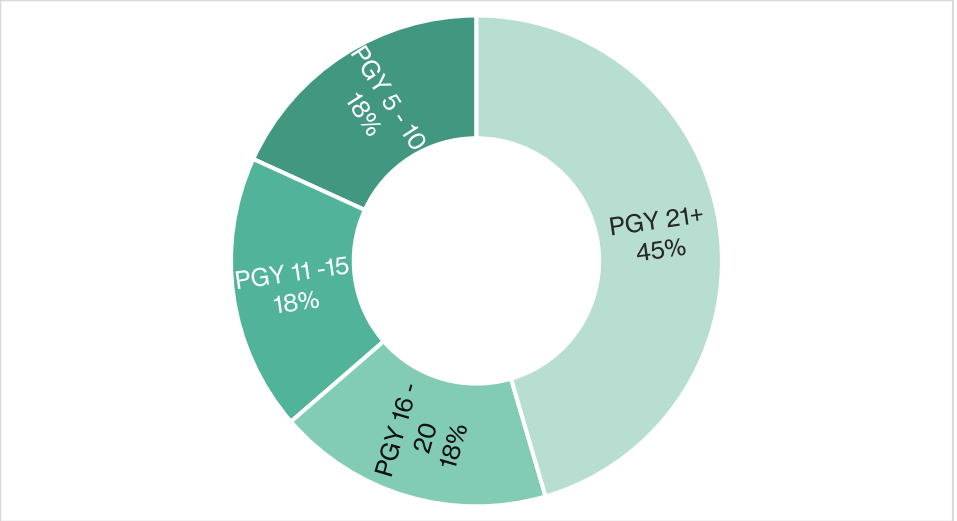
	CAREER MEDICAL OFFICER	GP	PHYSICIAN	RACGP/RACP REGISTRAR/ MEDICAL OFFICER	TOTAL
ACT			1		1
NSW		1			1
NT					
QLD			1		1
SA					
TAS					
VIC	1	4			5
WA	2	3	1		6
March 2025 intake	1	11	-	2	14
NSW		3			3
QLD		4		2	6
SA		2			2
WA	1				1
VIC		2			2
Total	4	19	3	2	28

Source: RANZCP Postgraduate Certificate in Clinical Psychiatry uptake data, March 2025

Nearly half (45%, n=10) of the enrolled participants were PGY 21+, with PGY 5–10, 11–15 and 16–20 representing 18% (n=4) each (Figure 6.2).

Figure 6.2: PGY status of enrolled participants



Source: RANZCP Postgraduate Certificate in Clinical Psychiatry uptake data, March 2025

During consultation, many colleges indicated that uptake of the Certificate among their fellows would depend on individual interests and workplace needs. States and territories felt that GPs and emergency medicine physicians would benefit most from undertaking the Certificate, since they often encounter patients with mental health issues. They noted that improving the mental health training of these frontline medical staff would enable them to effectively manage common disorders such as anxiety and depression, thereby allowing psychiatrists to focus on more complex cases.

> *There is an over-reliance on referrals to specialty services and primary care [stream] have lost a skill set – specialist medical college*

Most stakeholders suggested that the uptake of the Certificate would depend on its perceived relevance and potential return on investment, such

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as the use of an MBS item for GPs who have completed the Certificate. The length of time needed to complete the Certificate, and the cost (approximately $12,000) were suggested as potential barriers to uptake.

Most consulted stakeholders thought the mental health training provided by RANZCP would likely carry more credibility compared to other colleges that offer mental health training, due to the organisation's specialisation in mental health. It was suggested that most medical professionals would prefer to have RANZCP as their CPD home for mental health training.

From a cost perspective, the RANZCP Certificate represents comparative value for money with flexibility in delivery mode for postgraduate medical practitioners. GP registrars can complete advanced training in mental health as part of Commonwealth-funded vocational training pathways (advanced skill training for rural generalists). However, as the Certificate is workplace-based, it is likely a more attractive option than other advanced training that requires moving to an accredited position in another health setting (usually a hospital).

Supervisor role

Certificate enrolment numbers are constrained by the number of RANZCP fellows who can provide participants with supervisor, reviewer, and peer facilitator roles (as discussed earlier in section 3.4.4).

Supervisors of participants receive honorarium payments, i.e. payment is given as a token of appreciation for services, not in exchange for them. The current honorarium per activity is $225 (GST inclusive) for the following activities:

- completion of Structured Feedback Activities for core or elective components
- completion of Progress Review (meeting with the participant and completion of the Progress Review Form)

Certificate Peer Group Facilitators are not eligible to receive an honorarium but may be eligible to claim CPD.

Given that supervision payments are activity-based, if activities are conducted within regular service provision hours, there is no financial incentive for fellows to participate. Salaried consultants may participate during regular service hours, subject to employer agreement; however, those in private billing will incur losses. It may be in the interests of rural health services/networks to support the Certificate with in-kind consultant services to foster a skilled primary care workforce. The RANZCP reported that college members typically undertake roles in the college voluntarily.

The RANZCP has stated its intention to evaluate the Certificate. It is advisable to review the actual hours of input for supervisors and participants to understand any unintended outcomes or inefficiencies.

Anticipated impact

The anticipated impact of the Certificate and its influence on the healthcare delivery of medical practitioners was discussed with stakeholders.

Most colleges did not anticipate a significant influence on clinical practice from completing the Certificate. However, some specialties (such as physicians) and stakeholders representing states and territories believed it would be useful for medical practitioners in more remote areas with limited access to psychiatric services.

Several stakeholders suggested the Certificate could enable GPs to be recognised as mental health specialists, similar to postgraduate vocational training from other colleges, for example, the Rural Generalist Anaesthesia Training Program offered by the Australian and New Zealand College of Anaesthetists (ANZCA), and the Associate (Procedural & Advanced Procedural) training program by RANZCOG. Both of these training programs aim to equip GPs with specialist skills in places where specialist assistance is remote. These programs were suggested as frameworks to inform the development of the RANZCP Certificate in this context. The need for ongoing support was also highlighted as an important element. For example, GPs may find managing conditions such as attention-deficit/hyperactivity disorder and eating disorders to be challenging.

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Add extra skills to help colleagues in areas where a psychiatrist is not available [for generalist specialists] – Royal Australian College of Physicians

Several stakeholders expressed concern that medical professionals may overestimate their capabilities relative to psychiatrists upon completion of the Certificate. There was a perceived risk that the system would replace psychiatrists with GPs and emergency medicine practitioners in regional and rural areas solely on the basis of this certification. However, this opinion was in the minority (two stakeholders).

FINDING 24 The Postgraduate Certificate in Clinical Psychiatry has garnered substantial interest from medical practitioners, especially GPs. While there has been sufficient demand for two intakes per year, the number of intakes to the Certificate is limited by the capacity of RANZCP fellows to support training. Given that supervision payments are activity-based, there is no financial incentive for fellows to participate. Opportunities to leverage rural health services/networks to support the Certificate with in-kind consultant services, thereby fostering a skilled primary care workforce, should be explored. It is advisable to review the actual hours of input for supervisors and participants to understand any unintended outcomes or inefficiencies.

7 PROGRAM EFFICIENCY

This chapter presents insights into the PWP's efficiency in achieving intended outcomes. It focuses on *KEA 4 Efficiency: arrangements in place that allow the PWP to meet intended outcomes through an efficient use of resources.*

The evaluation sub-questions to be addressed under KEA 4 were as follows:

1. What governance arrangements are in place for the PWP?
2. Are monitoring and evaluation mechanisms in place for the PWP, including reporting requirements?
3. Is the PWP accessible to clinicians who are interested in extended mental health training?
4. What are the barriers and enablers to the intended outcomes of the PWP?

7.1 GOVERNANCE AND MONITORING

PWP's governance arrangements and processes, including performance monitoring and reporting, are outlined below.

7.1.1 Governance arrangements

RANZCP has a governance structure in place to oversee and guide training post allocations and activities and is the decision-maker for allocating PWP posts. The Australian Government Training Programs Committee assesses training sites as eligible and scores and weights applications. The priorities of the RANZCP Branch Training Committees in each jurisdiction are also taken into consideration. Proposed training sites are submitted to the Education Committee and Executive Meetings for endorsement, after which applicants are notified of the outcome. Training sites reported they were unaware of the other training sites funded under PWP and that the transparency of Commonwealth-funded programs (including PWP) could be improved.

7.1.2 Performance monitoring and reporting

The Department contracted RANZCP to administer the PWP program. RANZCP collected PWP program data and reported on activities to fulfil grant requirements administered under the Commonwealth Standard Grant Agreement. Grant activity to achieve the PWP's aims were measured against performance indicators, underpinned by an Activity Work Plan that formed the basis for reporting. RANZCP submitted biannual performance reports to the Department.

Each PWP training site submitted a report to RANZCP, briefly detailing the occupancy of the training rotation (trainee and supervisor). Health services reported that the requirements were straightforward and largely binary, with minimal context. RANZCP collated this information to inform their performance reports. The unidimensional measure of occupancy – supervisor and trainee – was used as a performance indicator for training posts. While this monitored the utilisation of training posts, there was a lack of visibility on the potential outcomes or impacts. Outcomes and impacts reported by several health service training posts included increased capacity to deliver services (e.g. clinics, outreach services), and reduced use of locums (see section 6.2).

Similarly, the PIF largely reported on outputs, i.e. activities conducted, and several examples of post-activity member survey responses. However, as noted in section 6.2.4, post-activity surveys conducted by the PIF were completed mainly by members who were sponsored to attend, creating a potential risk of bias in the responses. The primary aim of the PIF is to

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enhance the profile of psychiatry and influence doctors to consider psychiatry as a career, particularly those based in rural and remote areas. The visibility of PIF members of rural origin was low; the collection of rural origin status only commenced in December 2024 for new PIF members.

Activity work plan

A PWP Activity Work Plan was developed at the beginning of the grant agreement period. The Activity Work Plan outlined the four key activities and performance indicators to be completed and reported on biannually. However, not all funded activities extended across the life of the funding term, such as the development of the postgraduate certificate in clinical psychiatry. It is noted in the Activity Work Plan that other activities may be identified and undertaken by the grantee (RANZCP) to achieve the overarching objectives which the key activities support. Having activities planned across the full funding term with completion dates will improve visibility in future.

It is acknowledged that activities funded through other Commonwealth funding streams, such as STP, also contribute to the medium to longer-term outcomes of PWP. Inclusion of the impact of non-PWP-funded activities in the progress reports can provide context and inform synergistic outcomes. For example, activities to progress the development of an RPTP funded under PWP included the development of remote supervision guidelines (completed in 2024). A remote supervision pilot using the guidelines (funded under STP) was included as a measure of success in Performance Report 5 (January-June 2024). Similarly, STP-funded projects that contributed to the aims of the PWP (such as the Aboriginal and Torres Strait Trainee Network and the Aboriginal and Torres Strait Peer Support Program) were reported in PWP progress reports. It is acknowledged that these supports likely contribute to sustaining and/or increasing the number of Aboriginal and Torres Strait Islander trainees, a key aim of the PWP.

While it is important to identify activities that also impact the PWP's outcomes, it would be prudent in the future to clearly delineate between activities funded by the PWP and those not.

Financial reporting

The income and expenditure for each of the four key activities funded by PWP were reported in each biannual performance report. Program expenditure was delineated by income source (grant funding, unexpended funds rolled over, interest earned on funds) and reported as an aggregate amount for each activity. That is, there was no breakdown to determine direct and indirect costs, which would have provided some insight into program efficiency. There is no single program administration ratio standard or figure to guide non-profit organisations on how much they should be spending on resources to maintain and deliver programs. The indirect costs of a program will vary according to the level of complexity and risk in program delivery; for example, some organisations will need to spend more on training and IT to effectively generate outcomes [11]. A recent analysis of nine not-for-profit Australian organisations calculated an average indirect cost of 33% of their total expenses [12]. Table 7.1 presents the aggregate expenditure by calendar year for each key PWP activity.

The costs to deliver PIF activities in 2023, 2024, and January to June 2025 were provided by RANZCP to the evaluation team (Appendix E). The proportion of PIF funding allocated to PIF activities (sponsorship, event costs, staff cost to attend events, etc.) was 31% in 2023 and 29% in 2024 (Table 7.2). Other costs were attributed to staff resources and overheads. Staff resources included one manager, two project officers, one administrative officer, and one marketing and administrative officer, with an average FTE of 3.37 from 2023 to 2025 (see Appendix E for details). Other costs were reported to include overheads for financial services, human resources, IT services and support, IT infrastructure, facilities, and legal and contract management. The 2025 expenditure has not yet been reconciled.

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There was a significant underspend (approximately 45%) in 2022. The underspend was rolled over to 2023. However, there was no clear plan for how the rolled-over funds were to be spent. This resulted in limited visibility of the expenditure of the funds rolled over from 2022.

The program's cost per active PIF member (medical students and PGY1–2) was estimated to range between $296 and $377 from 2022 to 2024.

The average cost per PIF member transitioned in 2023 and 2024 was $2,378. This is a broad indicator only; a PIF member may remain a member of the PIF for more than 12 months.

Additionally, the average cost per training post was calculated for full calendar years 2023 and 2024 (Table 7.3). The average cost per training post was assumed to include administration costs, salary contributions of trainees and supervisors, and rural loadings. The average cost ranged from $163,333 in 2023 to $195,780 in 2024.

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Table 7.1: PWP reported expenditure

PWP ACTIVITY	2022 EXPENDITURE	2023 EXPENDITURE	2024 EXPENDITURE	JANUARY 2025 TO JUNE 2026 BUDGET	TOTAL	%
Training posts	$2,039,259	$4,899,997	$5,873,409	$16,098,140	$28,910,805	78%
PIF	$408,328	$738,953	$837,924	$1,623,795	$3,609,000	10%
Supporting the Development of Rural and Remote Psychiatry Training Pathway (RPTP) and Network	$239,784	$403,795	$360,695	$1,432,726	$2,437,000	7%
Postgraduate certificate in clinical psychiatry	$238,352	$700,338	$932,844	$46,598	$1,918,131	5%
Governance and administration for PWP			$222,600	$163,613	$386,213	1%
Totals	$2,925,722	$6,743,083	$8,227,472	$19,364,872	$37,261,149	100%

Table 7.2: PIF expenditure overview

	2022	2023	2024	2025 (JAN TO JUN)	JANUARY 2025 TO JUNE 2026 BUDGET	TOTAL
Total PIF program expenditure (as reported by RANZCP in financial reports to the Department)	$408,328	$738,953	$837,924	not reported yet	$1,623,795	$1,985,205
Costs to deliver PIF activities	not reported	$226,464	$241,875	$161,439		$629,777
Other PIF costs	n/a	$512,490	$596,049			
Other PIF costs %		69%	71%			
Number of active PIF members	1,229	1,958	2,833			
Cost per PIF member (active)	$332	$377	$296			

Note: Costs to deliver PIF activities and other PIF costs are reported directly from RANZCP to the evaluation team (HMA). Active PIF members include medical students and PGY1–2 doctors; cost per active PIF member is total PIF program cost divided by the number of active PIF members

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Table 7.3: Training posts expenditure breakdown

EXPENDITURE	2023 (30 POSTS)	2024 (30 POSTS)
Total training posts expenditure (as reported by RANZCP in financial reports to the Department)	$4,899,997	$5,873,409
Average annual cost per training post (Total expenditure divided by total number of posts)	$163,333	$195,780

Note: Average cost per training post assumes program administration cost, salary contributions to trainees and supervisors, and rural loadings.

FINDING 25 Oversight and administration of the PWP was integrated into RANZCP's existing governance and reporting structures. This included processes to score, prioritise, and allocate training posts, as well as endorse Rural Psychiatry Roadmap deliverables (remote supervision and expanded settings for CL and CAP).

FINDING 26 Adequate performance monitoring and reporting mechanisms were in place to reconcile contracted obligations and performance indicators for PWP training posts via biannual performance reporting. However, consideration of outcome measures at the health service level may aid in a better understanding of the program's impact on the workforce and community.

FINDING 27 The inclusion of activities and success measures not funded by PWP in biannual performance reports potentially distorted the magnitude of the program's success. In future, it will be essential to acknowledge and clearly distinguish between activities funded by the PWP and those that are not.

FINDING 28 Given some key activities were completed before the end of the funded period (2022 to 2026), planning activities across the full funding term with completion dates will improve visibility in future.

FINDING 29 The level of financial budget and expenditure reported was minimal. The rollover of unspent funds was not directly linked to rolled-over activities or new planned activities in the performance reports. Additionally, expenditure for activities that generate a variable outcome, such as the PIF (interest in psychiatry, transition to RANZCP fellowship training), did not differentiate between direct and indirect costs, thereby limiting a broad understanding of the program's efficiency. The administration costs of the PIF were estimated at 70%, demonstrating poor efficiency given the low complexity and risk of PIF activities and the benefits realised.

7.2 ACCESSIBILITY OF MENTAL HEALTH TRAINING

The Postgraduate Certificate in Clinical Psychiatry is workplace-based, i.e. the enrolled participants' workplace. This likely makes it a more accessible and attractive option when compared to other vocational mental health training pathways, such as advanced skills training for GPs and rural generalists. Advanced skills training usually requires moving to an accredited position in another health setting (usually a hospital).

Compared to the advanced skills training offered by RACGP and ACRRM, the RANZCP Certificate is more expensive. However, medical practitioners – those able to bill MBS – can continue to generate private practice revenue

7 PROGRAM EFFICIENCY

while completing the RANZCP Certificate. GPs and GP registrars can complete advanced mental health training as part of Commonwealth-funded vocational training pathways (advanced skills training for rural generalists), usually in a salaried registrar-level position. The federal government will support 200 places in the RANZCP Certificate in future as part of the 2025 pre-election commitment [13].

FINDING 30 The individual workplace-based format and practical nature of the Postgraduate Certificate in Clinical Psychiatry are likely to positively influence uptake.

7.3 BARRIERS AND ENABLERS TO PWP

7.3.1 PWP posts

Program stakeholders reported that supervisor funding, other federally funded specialist training programs, and stage 2 mandatory rotations were critical enablers of trainees' quality of experience and fellowship training.

Supervisor funding was cited as key to increasing health service capacity to host a trainee by uplifting consultant FTE, contributing to trainee salaries (not intended for this purpose), or contracting in external supervision for psychotherapy cases. The inclusion of stage 2 mandatory rotations offered exposure to sub-specialties not otherwise available in some rural and remote areas. Combined with other federally funded training program positions, some health services (e.g. Goulburn Valley Health, Victoria) were able to offer end-to-end training locally. The theory of end-to-end training is that trainees will continue to practise in the location after completing their fellowship – a longer-term outcome of the PWP. **Additionally, offering sub-specialties was reported to be likely to increase the attraction and retention of psychiatrist consultants in rural and remote areas.**

There were minimal reported or observed barriers to the PWP achieving its intended outcomes. While several program stakeholders reported challenges in attracting and retaining consultants (to supervise) in rural and remote areas, this was not specific to PWP but rather stemmed from broader workforce challenges. Similarly, the PWP generally aligns with the priorities of health services for service delivery.

7.3.2 Postgraduate Certificate

The RANZCP Postgraduate Certificate in Clinical Psychiatry was successfully launched in 2024. However, the rate-limiting factor to the number of enrolled participants is the capacity of supervisors (RANZCP fellows). Supervisors of participants receive an honorarium payment (not commensurate with consultant EBA salaries or private billing). Thus, the participation of supervisors is more likely to be altruistic in nature. Additionally, as the Certificate is still in its infancy, RANZCP has not had the program recognised or endorsed by other CPD homes (specialist colleges). Participants can apply to their individual colleges to have the program considered for CPD. This may deter some potential participants.

8 VALUE FOR MONEY

This chapter presents the analysis of *KEA 5 Value for money: is the PWP value for money?*

The program efficiency chapter looks at the resources and processes used to deliver the program outputs, i.e. governance and monitoring, and the barriers and enablers to doing so efficiently.

The value-for-money approach by Julian King was selected as the economic evaluation approach for PWP. Value for money is a distinct concept from program efficiency that brings together the different types of outcomes – or benefits expected to be realised – to understand how well resources are used to deliver the level of outputs and outcomes, and **if the end result is justified**. It is more than a cost-effectiveness analysis.

8.1 VALUE FOR MONEY APPROACH

After consideration of various economic evaluation approaches, the **value-for-money** approach designed by Julian King[4] was selected for the PWP. This value-for-money analysis is a broader construct than efficiency. It is an evaluative question about how well resources are used and whether a particular use of resources is justified.

8.1.1 Standards and criteria

A mixed-methods approach (qualitative, quantitative, and economic) to judge value for money was based on a transparent set of **standards rubric**. Table 8.1 presents the criteria and corresponding definitions for PWP. The criteria were developed with input from subject matter experts and the Department.

Table 8.1: Standards rubric criteria

CRITERIA	DEFINITION
Efficiency	Level of outputs produced (relative to contractual requirements set out in the grant agreement)
Effectiveness (Outcomes/impact)	Outcomes achieved relative to activity maturity
Environment	Level of engagement with external programs and the value derived from this, or the value and additional benefits resulting from the activities over and above other external programs, e.g.: • Intersection with other training programs and networks • Collaboration with universities, training networks, and medical training groups • Intersection with other colleges
Equity	Extent to which the activity addresses inequities for rural and/or Aboriginal and Torres Strait Islander trainees or communities, e.g.:

[4] Julian King Economic Evaluation and Value for Money Available at https://www.julianking.co.nz/vfi/econ/

8 VALUE FOR MONEY

CRITERIA	DEFINITION
	• Accessibility to PIF events by regional and rural members • Increased access to services for rural and remote or Aboriginal and Torres Strait Islander communities from posts for psychiatry trainees in a range of settings (rural and remote, Indigenous health services and communities, expanded settings for stage 2 rotations)
Cost-effectiveness	Examples include: • Cost per unit of delivery, e.g.: — sub-program cost (inc. administrative costs) per PIF member • Activities delivered within budget • Training post allocation and funding utilisation as a proportion of the budget • Cost per unit of delivery for the PIF (including and excluding administration costs): — per PIF member — per PIF member converted to a psychiatry trainee • Indirect cost benefits, e.g.: — training posts reduced the use of locums and fly-in-fly-out (FIFO) consultants — psychiatry trainees travel or relocation costs to complete rotations in other health services/areas — reduced cost burden on regional and rural PIF members to attend PIF events

The PWP program's activities, outputs and outcomes were then assessed against the defined criteria using a scale ranging from poor to excellent. See the value-for-money rubrics and definitions for what poor, adequate, good and excellent mean in the value-for-money rubrics for each activity in Appendix C. The criteria for the standards rubric were developed for each funded PWP activity by:

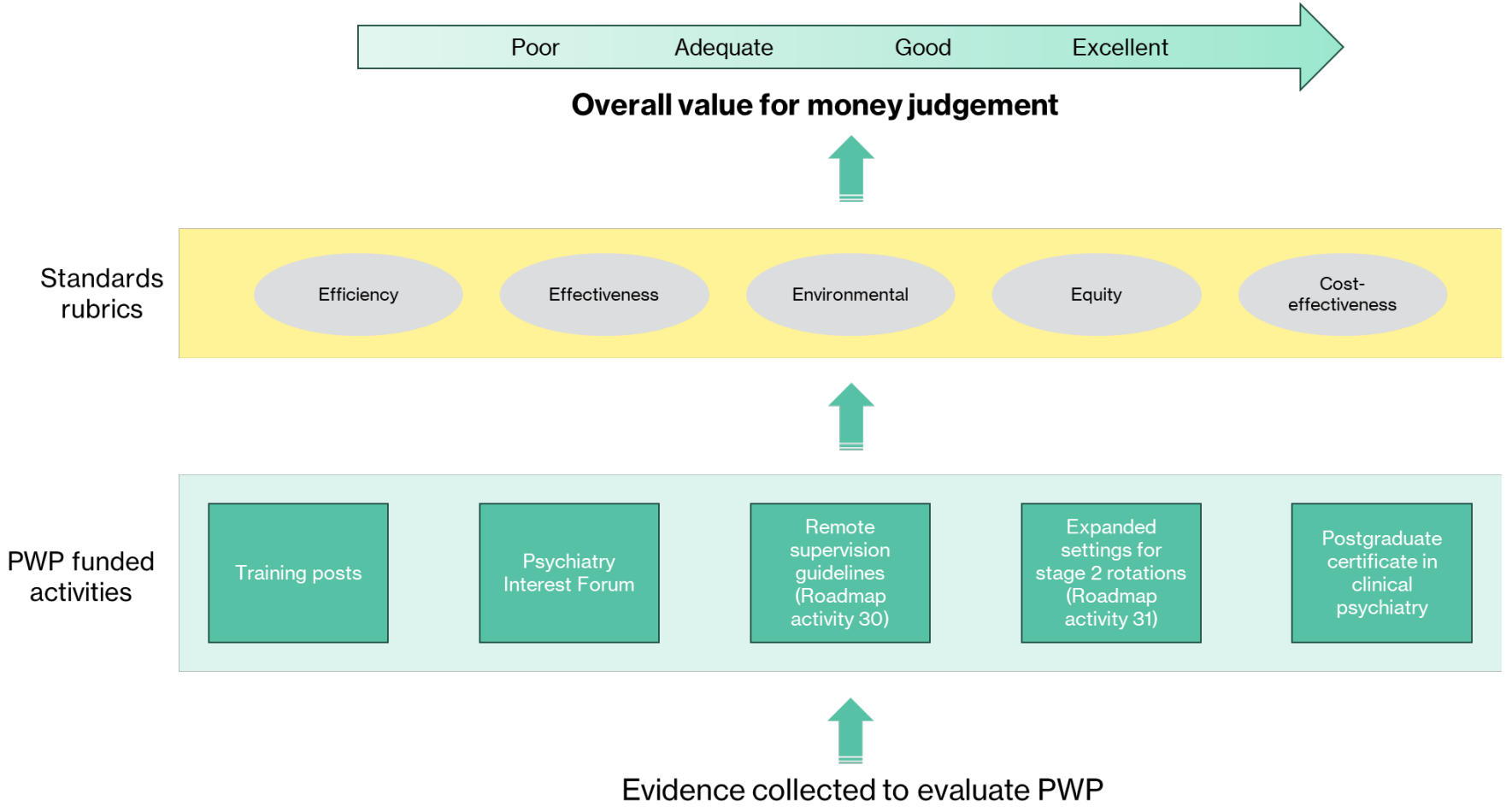
- mapping the elements of the PWP (e.g. funding, output, outcomes/benefits) to each of the value-for-money criteria components (effectiveness, environment, equity and cost-effectiveness)
- mapping the PWP outputs/evidence of each value-for-money criterion to each value-for-money level (poor, adequate, good, excellent)

Figure 8.1 presents the overall concept of the value-for-money analysis for the PWP.

8 VALUE FOR MONEY

Figure 8.1: Value-for-money concept

Value-for-money framework for the Psychiatry Workforce Program (PWP). Evidence collected from funded activities is assessed against five criteria – efficiency, effectiveness, environmental considerations, equity and cost-effectiveness – to inform an overall value-for-money judgement ranging from poor to excellent.



8 VALUE FOR MONEY

8.2 VALUE PROPOSITION MAPPING

An exercise was undertaken to map and understand the value proposition of the PWP. First, the value proposition identified:

- who invested resources, and what type of resources (Table 8.2)
- for whom is the investment valuable and in what way (Table 8.3)

State/territory health departments provided indirect investment in the PWP through Rural DoTs. State/territory health departments contributed funds to Rural DoTs, which support psychiatry training in MM2–7 locations.

Table 8.2: Resource investments into PWP

RESOURCE INVESTOR	RESOURCE TYPE
Commonwealth	• Funding for PWP training posts — Trainee salary (1 FTE x 30 posts) — Supervisor salary (0.33 FTE x 30 posts) • Funding for PIF to increase membership and activities • Funding to execute deliverables 30 and 31 under the Rural Psychiatry Training Roadmap • Funding to develop the Postgraduate Certificate in Clinical Psychiatry
RANZCP	• Administration of PWP program activities: — PWP training posts allocation and funding — PIF — Execution of deliverables 30 and 31 under the Rural Psychiatry Training Roadmap — Development and launch of the Postgraduate Certificate in Clinical Psychiatry
Health services	• Funding for PWP training posts — Salary contribution to PWP trainees — Salary contribution for supervision • In-kind organisational support (IT, office infrastructure, WorkCover, etc.)
Supervisors	• Fulfil minimum supervision requirements for PWP psychiatry trainees
Trainees	• Completion of the PWP-funded training rotation

Table 8.3: Benefit realisation

WHOM	HOW BENEFIT IS REALISED
RANZCP	• Increased awareness and destigmatisation of psychiatry as a career • Increase in psychiatry trainees (and subsequently RANZCP members and fellow psychiatrists)
State/territory health departments	• Increased psychiatry workforce overall and in rural and remote areas
Health services	• Increased psychiatry workforce and service delivery capacity • Increased revenue opportunities • Increased opportunities to retain psychiatry trainees with end-to-end training pathways
Supervisors	• Quarantined time for supervision
Trainees	• Increased training opportunities in rural and remote areas and stage 2 mandatory rotations • Potentially reduced time to complete fellowship • Increase in end-to-end training pathways in rural and remote areas
Aboriginal and Torres Strait Islander trainees	• Access to Indigenous peer support and mentorship
Local regions/community	• Increased access to mental health expertise, reduced waiting times
First Nations people	• Increased access to mental health expertise
PGY5+ medical practitioners enrolled/completed the	• Practical learning and application of mental health skills available in the workplace

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WHOM	HOW BENEFIT IS REALISED
Postgraduate Certificate in Clinical Psychiatry	

Theories of change

Second, the value proposition determined how the investment created value, i.e.:

How are the resources used to create something more valuable?

The section below provides *theories of change* for each PWP activity undertaken (as per the logic model), which articulate the expected value to be generated:

- **PIF**
  - Increased early engagement of medical students/junior doctors into the PIF will boost awareness and result in an increased number of psychiatry trainees
  - Funding and delivery of networking events, resources and university psychiatry societies will promote ongoing interest and reduce stigma in psychiatry
- **Training posts**
  - Additional training posts in rural and remote areas will contribute to improving the geographical maldistribution of the psychiatry workforce
  - Additional training posts in organisations providing services to First Nations people will improve access to mental health services for First Nations people
  - Additional training posts for stage 2 mandatory rotations (child and adolescent or clinical liaison) will reduce bottlenecks to achieving fellowship, which will aid in reducing the time to complete a fellowship
  - Funding for supervisors will assist health services (public or private) to quarantine time for supervision (or contract supervision), which will increase the ability of health services to offer posts, which will increase the availability of posts, which will increase the psychiatry workforce
  - Funding for supervisors and trainees will encourage state/territory health departments to contribute to additional psychiatry FTE in public settings
  - Additional posts will increase the clinical capacity of health services, which will increase the volume of patients seen, which may increase health service revenue (e.g. MBS or other) and decrease waiting lists, which will improve access to mental health services
- **Postgraduate certificate in clinical psychiatry**
  - Postgraduate certificate in mental health creates access to mental health training for PGY5+ medical practitioners, which increases the capability of these health professionals to address mental health issues, reducing the need for unnecessary referrals/consultant liaison, and increasing referrals for early and appropriate treatment. This improves access to appropriate mental health treatment in rural and remote areas and reduces waiting times.
- **Training program levers to enhance training opportunities in rural and remote settings**
  - Remote supervision increases the capability of health services to be accredited for training posts, which enables more training posts to be accredited in MM5–7, contributing to improving the geographical maldistribution of the workforce
  - Expanded settings are available in which to undertake stage 2 mandatory rotations (child and adolescent, consultant liaison)
- **Aboriginal and Torres Strait Islander peer support network**
  - A peer support network for Aboriginal and Torres Strait Islander trainees provides access to appropriate support and mentorship, which increases the number of Aboriginal and Torres Strait Islander trainees who complete their fellowship training

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Factors of influence

Last, the value proposition identified factors that influence whether the program can create a lot of value or a little. The section below identifies the influencing factors for each PWP activity:

- **Training posts**
  - Integration and alignment with other training programs, e.g. STP, IRTP, state/territory-funded programs
  - Availability of supervisors for training posts
  - Ability of the health service to become accredited for the post
  - Quality of the training posts for trainees – clinical opportunities, cultural safety, pastoral supports
  - Interest of junior doctors in the psychiatry training pathway
  - Barriers to rural and remote training for trainees, e.g. family commitments (spouse, kids, school, etc.)
  - Salary contribution to PWP trainees and/or supervisors by health services
  - In-kind organisation support by health services for PWP trainees and/or supervisors (IT, desk, WorkCover, etc.)
  - Rural DoTs support quality psychiatry training in MM2–7 (inclusive of PWP trainees)

    State/territory health departments contribute funds to Rural DoT positions
- **PIF**
  - Other sources of influence direct medical students/junior doctors to other specialist medical career pathways
  - Other sources of information are used to understand psychiatry as a career pathway (YouTube, social media, QLD Health registrar platform)
- **Postgraduate certificate in clinical psychiatry**
  - Enrolment places in the Certificate are limited to the capacity of RANZCP fellows (fewer than 50 places a year currently)
  - Recognition of the Certificate as CPD by the medical practitioners' colleges
  - MBS billing item not linked to completion of the Certificate
- **Training program levers to enhance training opportunities in rural and remote settings**
  - Remote supervision and expansion of settings for stage 2 mandatory rotations

    Psychiatry trainee posts in rural and remote areas are limited by the funding available

    Psychiatry trainee posts in rural and remote areas are limited by on-site clinician capacity
- **Aboriginal and Torres Strait Islander peer support network**
  - Psychiatry trainees do not wish to identify as Aboriginal and Torres Strait Islander voluntarily

8.3 VALUE-FOR-MONEY JUDGEMENT

The qualitative and quantitative findings generated from the PWP evaluation were used to judge the level of value for money. The value-for-money judgement was undertaken by the evaluation team as independent evaluators. The overall value-for-money judgement for each key PWP activity ranges from adequate to good, as detailed below.

Good value for money: the training posts and Rural Psychiatry Roadmap activities were deemed to be good value for money.

- The training posts demonstrated good outcomes, extending beyond the program's performance indicators, and increased service capacity and delivery in priority settings. Additionally, a range of indirect cost benefits is reportedly being realised by health services.

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- The development of the remote supervision guidelines and expanded settings for CL and CAP in rural and remote areas were discrete, time-limited activities. They were completed within budget and endorsed by RANZCP for integration into the psychiatry fellowship training model.

Adequate value for money: the PIF and the Postgraduate Certificate in Clinical Psychiatry are deemed to represent adequate value for money.

- Although the PIF conducted the planned activities and up to 80% of psychiatry trainees were former members, the cost-effectiveness of the PIF was poor due to high administration costs. Given that a range of factors influence career pathway decisions and that psychiatry is reported to be among the top 10 specialties considered by junior doctors, the return on investment for the PIF does not represent good value for money.
- The Postgraduate Certificate in Clinical Psychiatry was developed and launched within budget. However, it is still in the early stages of implementation and there are few short-term outcomes to assess (other than enrolment figures). The outcomes of the Certificate need to be monitored as it matures, although it is anticipated that course fees will cover ongoing course delivery and administration costs.

A standards rubric was developed for the support network for Aboriginal and Torres Strait Islander psychiatry trainees, as one of the key objectives of PWP was to increase the number of Aboriginal and Torres Strait Islander psychiatry trainees (see Appendix C). However, since PWP did not fund the development of this support network, a value-for-money judgement has not been conducted.

Table 8.4 to Table 8.8 present the value-for-money assessment for each PWP activity.

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Table 8.4: Value-for-money judgement for psychiatry training posts

CRITERIA	JUDGEMENT	EVIDENCE
Efficiency (outputs)	Excellent	Psychiatry training posts have met and exceeded their contractual agreement: • 20 posts were funded and allocated from rotation 1 in 2022, and 10 more from rotation 1 in 2023 (30 in total to June 2026) • 100% of posts were allocated with an occupancy rate of 80% to 97% for trainees and 93% to 100% for supervisors • Approximately 70% of training posts were located in MM2–7 • At least 40% of posts are stage 2 rotations • At least 90% of training posts provided some level of services to Aboriginal and Torres Strait Islander communities • Four to five training posts provided services wholly focused on Aboriginal and Torres Strait Islander communities • 10 private clinics hosted rotations
Effectiveness (outcomes and impact)	Good	PWP training posts have met their objective to increase mandatory stage 2 rotations, increase rotations in MM2–7 locations and rotations servicing Aboriginal and Torres Strait Islander people. • **Increase in stage 2 training positions**. Each year 33% to 40% of posts were stage 2 mandatory training rotations, rotation 1 in 2025 includes five CL and five CAP rotations. Three posts reported several sub-specialties, including CL and/or CAP with adult, Aboriginal and Torres Strait Islander, and/or addiction medicine. All stakeholders consulted perceived stage 2 mandatory rotations (CAP and CL) to be a rate-limiting step in psychiatry fellowship training and acknowledged that the PWP posts helped address these bottlenecks. However, some stakeholders felt that further innovation in mandatory rotation settings could be explored, including AMS and community-based settings. • **Increased capacity of health services to supervise trainees** – health services consulted reported increased supervisor FTE internally or externally – some health services reported contracting in external supervision for the psychotherapy case – increased access to psychiatry care, particularly in MM2–7 and First Nation communities • **Increased psychiatry service delivery capacity to MM2-7 communities** – at minimum, 21 additional FTE psychiatry added to MM2–7 areas through the trainee positions – this was further enhanced in posts that recruited a new psychiatrist position to the region for supervision of the post. Several posts in Mount Gambier (South Australia), Hunter New England (New South Wales), and Southwest Healthcare Warrnambool (Victoria) contracted additional consultant FTE for supervision. – several posts in Victoria and ACT reported using the supervisor funding to increase FTE internally for supervision – several PWP posts created additional services, including posts in Queensland and New South Wales, which reported additional outreach services as a result of increased FTE – Queensland Rural DoT described the reduced need for locums in northern Queensland due to Commonwealth-funded specialist training, including the PWP posts

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CRITERIA	JUDGEMENT	EVIDENCE
Environment	Good	Stakeholders credited PWP with helping to provide better services in rural and remote areas. However, outer metropolitan areas were also reported to need more psychiatric services due to population growth in these areas. PWP training posts in MM1 included services for Aboriginal and Torres Strait Islander communities, including child and adolescent services. PWP posts actively leverage other funding mechanisms to amplify the impact of funding and create rural training networks for psychiatry. • Health services used PWP posts in combination with STP and IRTP funding. This increased their ability to provide end-to-end psychiatry training in one rural location, thereby demonstrating the synergistic effect of the PWP with other federal government funding sources. • Support from the PWP to add a consultant psychiatry position was seen by some stakeholders as a positive for rural areas • Several Rural DoTs described the importance of peer connections and exam support for trainees. For example, the Victorian Rural DoT facilitates online exam tutorials that encompass trainees from multiple health services. These were also reported to facilitate peer connections. • Remote supervision guidelines and expanded settings for stage 2 mandatory rotations guidelines have been endorsed for use in rural and remote areas. Health services and Rural DoTs were generally supportive of remote supervision in appropriate contexts with adequate support for trainees. These additional training levers are not specifically funded and would need to be used in current funded training positions or additional funding sought. However, PWP (and other federal government funding) does not align with jurisdictional workforce and health service planning, nor does it account for length of employment contracts or salary variations between jurisdictions and rural locations.
Equity	Excellent	• Increased capacity of MM2–7 health services to facilitate psychiatry training (inferred from supervisor funding and posts in MM2–7), including capacity of services in MM4–7 (33 out of 68 post campuses/services are MM4–7) • Increased opportunities for registrars to train in rural and remote areas and provide services to First Nations communities
Cost-effectiveness	Good	• 30 posts funded biannually according to PWP program guidelines • Health services are reportedly realising a range of indirect cost benefits, examples include: — reduction in registrar or locum costs to deliver complementary clinical services — recruitment of additional consultants as supervisors, hence an increase in service delivery as well as supervision capacity — reduced use of locums and FIFO consultants — improved continuity of care for patients
Overall value-for-money assessment: psychiatry training posts	Good	The posts have met and exceeded contractual obligations, with many posts in regional or rural locations and/or servicing Aboriginal and Torres Strait Islander communities. Reportedly, the additional posts enable additional outreach clinics or increased service capacity, and the supervision funding has been reported to contribute to increased capacity for mandatory rotations by some health services. The PWP posts are early in their implementation but appear to be on track to generate expected outcomes in the future. However, it is noted that many health services felt the PWP is valuable in addition to STP/ITRP funding. Any changes to the STP program based on the 2025 redesign process will potentially impact the PWP training posts in future.

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FINDING 31 The PWP posts were assessed as value for money, rating good or excellent on all criteria. The posts were implemented efficiently and reportedly yielded good outcomes for rural and remote locations, as well as Aboriginal and Torres Strait Islander communities. Health services reported even greater benefits when PWP posts were used in conjunction with other federal government funding streams, such as STP and IRTP. The PWP should monitor any future changes to the STP program and assess the impact that these changes will have on PWP delivery.

8.3.1 PIF

Table 8.5: Value-for-money judgement for PIF

CRITERIA	JUDGEMENT	EVIDENCE
Efficiency (outputs)	Adequate	The PIF has met its contractual agreements. • 16 to 18% annual increase in PIF membership since 2022 – rural origin[5] status collection of new members commenced Dec 2024, identified 123 of 550 (22%) new members (to June 2025) had a rural origin • The range of PIF activities conducted included: – webinars – short course – PIF retreat and PIF@Congress – branch networking events • The PIF sponsors AMSA events, career expos, and university medical societies • The PIF sponsors PIF members (medical students and junior doctors) to attend in-person events, most of which are conducted in metropolitan (MM1) areas. Between 2023 and June 2025, 277 members were sponsored to attend events. This equates to 5% (121) of PIF members (medical students and PGY1–2) in 2023 and 4% (137%) in 2024. • PIF delivered a total of 129 activities from January 2022 to June 2025. In-person events accounted for 91% (n=117) of activities, with PIF providing support through sponsorship. Sponsored university medical society events accounted for 31% (n=41) of the activities. Half of the activities were led internally by RANZCP with support from the PIF; these were largely faculty and branch events (conferences, networking events, etc). PIF hosted seven events, including the PIF retreat, PIF at Congress, and the PIF essay competition. • 860 members attended RANZCP-led events supported/sponsored/hosted by PIF between 2023 and June 2025 (attendance not reported for 2022). A total attendance of 11,635 was reported for externally led events sponsored by PIF. Note that several events included large conferences that extended beyond psychiatry.

[5] Home address classified as MM2–7 for a minimum cumulative period of 10 years and/or minimum of five consecutive years

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CRITERIA	JUDGEMENT	EVIDENCE
Effectiveness (outcomes and impact)	Good	The PIF has realised its objective to increase the number of psychiatry trainees: • since 2016 there has been an increase in the annual number of psychiatry trainees joining the fellowship program (from 231 new trainees in 2016 to 311 new trainees in 2025) • of the 311 new trainees in 2025, 80% (n=248) were PIF members, a proportion that has been steadily increasing since 2016 (41%, n=90). The observed increase in psychiatry trainees since 2016 suggests that there is a greater awareness of and interest in psychiatry as a specialty among medical students and junior doctors. This is supported by the fact that psychiatry was ranked sixth as the first preference of specialty for future practice by Australian medical student respondents to the 2025 Medical School of Dean's Medical Schools Outcomes Survey [9] and seventh by interns' reported specialty of interest in the 2024 Ahpra Medical Training Survey [10]. The correlation between the increased interest in psychiatry and the commencement of the PIF since 2013 suggests that the increase is, at least in part, attributable to the role of the PIF. However, the outcome cannot be fully attributed to the PIF (see environmental discussion). The impact of the PIF on rural students/doctors was not measurable during this evaluation since the collection of rural origin status among PIF members only commenced in December 2024 (22% of new PIF members were of rural origin as of June 2025). Continued monitoring of the impact of PIF on rural members will be an essential metric for RANZCP to monitor in future. Many trainees and fellows remain PIF members (40% of the PIF membership is PGY3+ doctors). However, the level of engagement of this cohort is not measured by RANZCP. It is possible that some of these members do not actively engage in PIF activities. Having membership levels that identify active and passive members would assist RANZCP in assessing the value of the PIF for psychiatrists and registrars in the long run. The PIF now has online resources for members to access and sponsors a range of activities to raise the profile of psychiatry as a career choice, including university medical societies and AMSA. • PIF focus groups highlighted the online events as the most insightful to psychiatry as a career choice • While the PIF was noted to be a vehicle for building knowledge and interest for doctors to pursue a career in psychiatry, the preference towards psychiatry as a career was reportedly influenced by a range of other factors (see environment discussion).
Environment	Adequate	While the PIF was acknowledged as a valuable source of information by PIF members during focus group consultations, they also reported other sources of awareness and information on psychiatry training, including social media platforms such as Reddit and YouTube. Medi-Nav was also mentioned as a useful online resource for medical students and prevocational doctors (regarding workforce and training requirements in Queensland). Other factors influencing the choice of specialty medical training acknowledged by PIF members were perceptions of lifestyle and work-life balance, ability to undertake training in one location, relative ease of being accepted to the training pathway (compared with other specialties), personal experience with mental health (either lived experience or previous carer experience), and the humanities side of psychiatry, i.e. opportunities for a more personal connection with patients (compared to other specialties).

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CRITERIA	JUDGEMENT	EVIDENCE
Equity	Adequate	Sponsored university medical society events accounted for 35% (n=41) of the funded PIF activities. The PIF also provided support (largely through sponsorship) to external activities, including career expos and medical student conferences. Although the PIF recognises other awareness channels, it has not collaborated with them to design joint campaigns or activities. The 2024 PIF member survey also indicated that 48% of members (from 24 responses) were ambivalent towards the influence of PIF in selecting psychiatry as a specialty. However, the PIF member survey responses are low in number, and the results need to be interpreted with caution. As of June 2025, 22% of new PIF members were of rural origin, suggesting that the PIF has significant engagement in rural areas. Five per cent (64) of active PIF members (medical students and PGY1–2) in 2022, 5% (121) in 2023, and 4% (137) in 2024 were sponsored to attend an event supported by the PIF. 21% (72) of the members sponsored in 2022 to 2024 were based in MM2–7, and 10% (34) identified as Aboriginal and/or Torres Strait Islander. Several in-person events were convened in regional areas, including the introduction to psychiatry short course in Darwin (NT) and Orange (NSW), and faculty/branch events in Darwin and Tasmania. However, PIF scholarships were reported by RANZCP to be merit-based on the individual's application; there was no prioritisation or weighting towards members based in MM2–7. Analysis of psychiatry workforce data showed an 11.6% increase in FTE psychiatrists from 2019 (n=3417.8 FE) to 2023 (n=3812.6 FE). The increase in FTE per 1,000 population was higher in non-metropolitan areas (MM2–7) at 22.6% compared to 4.3% in metropolitan areas (with MM2 (23.6% growth), MM5 (22.2% growth) and MM6–7 (20.6% growth) showing the highest growth). This analysis demonstrates that efforts to increase the rural psychiatry workforce are working. The PIF is likely to contribute to the overall workforce increase, including those working in rural areas. However, the data is insufficient to determine a cause-and-effect relationship of the PIF on the psychiatry workforce at this point in time. Data sourced from the Australian Government Psychiatry Supply Profile website.
Cost-effectiveness	Poor	PIF activities are conducted within budget as per the grant agreement. However, the cost of delivering the PIF per active member or per transitioning member was deemed not to **be value for money** by the evaluation analysis. • The PIF provided the costs to deliver activities in 2023, 2024 and January to June 2025 to the evaluation team (Appendix E). • The proportion of PIF funding allocated to PIF activities (sponsorship, event costs, staff cost to attend events, etc.) was 30% in 2023 and 28% in 2024 (Table 7.2). The expenditure for 2025 has not yet been reconciled. • The program's cost per active PIF member (medical students and PGY1–2) was estimated to range between $296 (n=2,833 active members) and $377 (n=1,958 active members) from 2022 to 2024. • The average cost per PIF member transitioned in 2023 and 2024 was $2,375 (n=332 average number of PIF members that transitioned). This is a broad indicator only; a PIF member may participate in the PIF for more than 12 months, thus attributable costs may be cumulative. • There was a significant underspend (approximately 45%) in 2022.

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CRITERIA	JUDGEMENT	EVIDENCE
Overall value-for-money assessment: PIF	Adequate	Overall, the value for money of the PIF was rated as adequate. The PIF helps to promote and raise awareness of psychiatry as a specialty among medical students and junior doctors, and it appears to serve as a valuable resource for members already thinking of transitioning into psychiatry. However, the current positive trend in psychiatry trainees and the workforce cannot solely be attributed to the PIF. The PIF does not leverage external programs adequately to increase impact. The lack of engagement of members in biannual surveys suggests a large cohort is passive. Combined with the high administrative costs, it diminishes the value for money offered by the PIF. The PIF has achieved its goal to increase awareness and interest in psychiatry. However, the improved psychiatry workforce suggests that this should no longer be an area of focus for the federal government but rather be incorporated into business as usual for RANZCP. Although there has been an increase in rural psychiatrists during this time, improving the distribution of the medical workforce remains an area of interest to the federal government. The federal government could consider funding travel scholarships to support rural origin students/trainees attend metropolitan conference through the Rural DoTs.

FINDING 32 Although the PIF helps to promote awareness of psychiatry as a medical specialty, it is not delivered in a cost-efficient manner. Efforts to streamline administrative processes may improve their cost efficiency. However, the evaluation found that the PIF lacks a dedicated focus on areas of interest to the federal government (i.e., rural and remote workforce) and therefore should no longer be a federal funding priority.

8.3.2 Progress the Rural Psychiatry Roadmap, Activity 30 (remote supervision guidelines)

Table 8.6: Value-for-money judgement for Rural Psychiatry Roadmap Activity 30 (remote supervision guidelines)

CRITERIA	JUDGEMENT	EVIDENCE
Efficiency (outputs)	Excellent	Activity 30 of the Progress the Rural Psychiatry Roadmap (remote supervision guidelines) activity of the PWP met and exceeded the contractual commitments. • Regulations for remote supervision, including remote case review and online clinical team meetings, were developed, endorsed by RANZCP and used in pilots in Western Australia and South Australia • The college is now seeking to expand the regulations to business as usual • The updated RANZCP Supervisor Handbook – Fellowship Program (April 2025) now includes a definition of how remote supervision is defined [14]
Effectiveness (outcomes and impact)	Adequate/Good	Additional training program levers are now available to expand training opportunities in rural and remote settings • Remote supervision guidelines have been reportedly endorsed for use in business as usual • Rural training workshops have been conducted to educate and prepare supervisors and trainees

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CRITERIA	JUDGEMENT	EVIDENCE
		Time to expand the pilot to more locations is required. In future, an evaluation of the perceived level of support received through remote supervision by trainees should be undertaken to ensure it is acceptable to the trainees and of equivalent quality as face-to-face supervision models.
Environment	Adequate	Potential increase in psychiatry services to rural and remote communities • Remote supervision pilots have been conducted in existing funded training positions in MM5–7 The model now needs to be adopted by health services and used to establish new accredited training posts that would not be otherwise possible.
Equity	Good	Psychiatry trainees will have increased opportunities to train in rural and remote health services, which will provide more services to rural and remote communities (including Aboriginal and Torres Strait Islander communities in these locations). Note this is contingent on the appetite and capacity of health services and supervisors to use remote supervision.
Cost-effectiveness	Adequate	Activity 30 completed on budget and within specified timelines
Overall value-for-money assessment: Rural Psychiatry Roadmap Activity 30 (remote supervision guidelines)	Good	The development of remote supervision guidelines was a discrete time-limited project that is now complete and in the process of being integrated into the psychiatry fellowship training model. Any future funding for next-step activities, such as the rural readiness workshops, should be considered as separate time-limited grants and assessed on their own merits.

FINDING 33 The time-limited activity to develop a remote supervision model has been completed and piloted. RANZCP should monitor the uptake and impact of the remote supervision model as it rolls out, to ensure equivalent quality to face-to-face supervision and acceptability to health services, trainees, and supervisors.

8.3.3 Progress the Rural Psychiatry Roadmap, Activity 31 (expanded CL and CAP settings for rural and remote trainees)

Table 8.7: Value-for-money judgement for Rural Psychiatry Roadmap Activity 31 (expanded settings for CL and CAP rotations)

CRITERIA	JUDGEMENT	EVIDENCE
Efficiency (outputs)	Good/excellent	Activity 31 of the Progress the Rural Psychiatry Roadmap (expanded CL and CAP settings for rural and remote trainees), activity of the PWP met and exceeded the contractual commitments • Expanded setting for CL and CAP explored and regulations developed • CL and CAP expanded settings in rural areas endorsed by RANZCP • Expanded settings for CL are being rolled out, and listed on the RANZCP fellowship program website – Stage 2, Rural pathway opportunity for CL rotation (available here) (excellent) • Expanded settings for CAP are earmarked for piloting (good)

8 VALUE FOR MONEY

CRITERIA	JUDGEMENT	EVIDENCE
Effectiveness (outcomes and impact)	Good	Additional training program levers are now available to expand CL and CAP training opportunities in rural and remote settings • CL has been endorsed for business-as-usual training • CAP, while endorsed, must be trialled first as there are greater sensitivities around the child and adolescent sub-specialty stream Both CL and CAP expanded settings have the potential to improve training capacity and, consequently, service delivery in rural and remote areas, as well as alleviate the bottleneck of mandatory training rotations. Further time is required to assess the impact of these initiatives on this space.
Environment	Adequate	Potential increase in CL and CAP service delivery capacity to rural and remote communities • While a potential increase in CL and CAP delivery capacity may occur, the number of relevant contexts/sites is reported by RANZCP to be very small at the time of reporting. More time is needed to assess how well these opportunities are taken up when they become available for broader rollout.
Equity	Good	Psychiatry trainees will have increased opportunities to undertake CL and CAP training in rural and remote health services, which will improve service delivery for rural and remote communities, including Aboriginal and Torres Strait Islander communities in these locations. Expanded CL opportunities are available for broad rollout, and CAP opportunities will be piloted in the near future. Note, any new training positions will still be subject to funding availability.
Cost-effectiveness	Adequate	Activities 31 completed on budget and within specified timelines
Overall value-for-money assessment: Rural Psychiatry Roadmap Activity 31 (expanded settings for CL and CAP rotations)	Adequate/Good	The development of expanded settings for CL and CAP rotations in rural and remote areas was a discrete time-limited project that is now complete and in the process of being integrated into the psychiatry fellowship training model. The endorsement of these rotation options demonstrates a positive cultural shift in how training can be innovated and adapted to the environment. Any future funding for next-step activities, such as CAP pilot, should be considered as separate time-limited grants and assessed on their own merits.

FINDING 34 The time-limited activity to develop expanded settings for CL and CAP rotation has been completed, with the expanded setting endorsed. Rural pathway opportunities for CL are now available as business as usual, and CAP rotations will be piloted. RANZCP should monitor the uptake and impact of the expanded settings/pilot, to ensure equivalent quality of training and the impact on mandatory stage 2 rotation bottlenecks.

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8.3.4 Postgraduate Certificate in Clinical Psychiatry

Table 8.8: Value-for-money judgement for the Postgraduate Certificate in Clinical Psychiatry

CRITERIA	JUDGEMENT	EVIDENCE
Efficiency (outputs)	Excellent	Despite initial delays, the activity to develop a Postgraduate Certificate in Clinical Psychology has met and exceeded its contractual agreements • An expert working group was established and consulted • Training content was developed and endorsed by RANZCP Two intakes of course participants per year are planned, with three intakes occurring to date: – September 2024 (14 participants enrolled) – March 2025 (14 participants enrolled) – September 2025 (open) • There appears to be ample demand for the Certificate, with over 200 responses to the expression of interest. The rate-limiting element for the Certificate is the number of supervisors participating, who are paid an honorarium for their time. The Certificate has not been in place long enough for the participant to graduate (the expected time for completion is two years). RANZCP should monitor completion rates and timeframes.
Effectiveness (outcomes and impact)	Adequate	The Certificate has had only two intakes (September 2024 and March 2025), with a third intake scheduled to open at the time of reporting (September 2025). However, there has been good interest in the Certificate from the medical workforce, with over 200 potential participants responding to the initial expression of interest. Current participants are mostly GPs, but also include career medical officers, physicians and RACGP/RACP registrars, with doctors enrolled from across the country (except the NT and Tasmania). Nearly half (45%, n=10) of the enrolled participants are PGY 21+, with PGY 5–10, 11–15 and 16–20 representing 18% (n=4) each. The Certificate has not been in place long enough for the participant to graduate (the expected time for completion is two years). Participants enrolled in the September 2024 intake will complete the Certificate after September 2025 (minimum) to September 2026 (estimated average completion time). RANZCP should monitor completion rates and timeframes.
Environment	Adequate	During the development of the Certificate, RANZCP consulted with the expert working group established, which included representatives from RACGP and ACRRM. However, it should be noted that both ACRRM and RACGP offer advanced training for GPs/GP registrars in mental health as part of the rural generalist training programs. While RACGP and ACRRM advanced training in mental health is focused on the rural setting, the RANZCP Certificate is independent of remoteness.

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CRITERIA	JUDGEMENT	EVIDENCE
		During consultation, ACRRM expressed concern that they were insufficiently consulted during the development of the Certificate and believe the RANZCP Certificate and its proposed MBS item are now duplicative of ACRRM and RACGP training efforts (although ACRRM also believed its training is more targeted to general practice). To date, RANCP has not engaged with ACRRM, RACGP or other medical colleges to seek recognition of the Certificate for CPD in those colleges, which may influence uptake.
Equity	Adequate	All PGY5+ registered medical practitioners can access workplace-based training in clinical psychiatry in all MM settings There are processes in place to prioritise applicants working in rural and remote areas, medical practitioners who identify as Aboriginal and Torres Strait Islander and/or work directly with First Nations communities. However, RANZCP does not go further to market the Certificate specifically to these groups, nor provide any additional financial or other incentives for these doctors to participate.
Cost-effectiveness	Adequate	Developed within the budget
Overall value-for-money assessment: Postgraduate certificate in clinical psychiatry	Adequate	The development of the Postgraduate Certificate in Clinical Psychiatry was a discrete time-limited project that was completed and launched with 28 participants enrolled as of September 2025. Any future funding for next-step activities should be considered as separate time-limited grants and assessed on their own merits – as has been done, e.g. the federal commitment to subsidising 200 participations in the Certificate, which is being established as a separate grant opportunity.

FINDING 35 The time-limited activity to develop the Postgraduate Certificate in Clinical Psychiatry has been completed with 28 enrolled participants in September 2025. RANZCP should monitor enrolment uptake and completion rates. RANZCP may wish to consider attaining RACGP and ACRRM CPD points for the Certificate in future, noting the majority of participants are GPs. RANZCP should also monitor the number of supervisors participating, which is a rate-limiting factor. Should supervisor participation drop off or become a barrier in future, RANZCP may wish to consider alternative payment structures for supervision of participants.

9 RECOMMENDATIONS

This chapter presents recommendations to inform future iterations of the PWP.

9.1 FINDINGS AND RECOMMENDATIONS

The findings of evaluation activities completed and analysed at the time of this report have been synthesised against the key evaluation areas of the M&E framework.

Recommendations for the Department's consideration are presented to address the relevance of the PWP and opportunities for improvement.

It is essential to note that the recommendations have been formulated with consideration for the broader environment in which PWP operates. Many issues or challenges highlighted in the evaluation did not all stem from PWP but rather were systemic to the specialist training sector or the broader medical workforce. As such, recommendations have not been made on where the issue should be addressed in overarching organisational policies and standards.

The evaluation is also cognisant of broader medical training and workforce reforms underway, including the redesign of STP and actions to address recommendations from the 2023 Independent review of health practitioner regulatory settings. The impacts of these activities' outcomes will also need to be considered in relation to their impact on PWP.

Overall, the evaluation supports the continuation of PWP training posts targeting rural and remote areas, mandatory stage 2 rotations, and health services that provide mental health care to First Nations people.

As such, the objectives of PWP should be limited to the training post activity:

> *increase the psychiatrist workforce and consumer access to psychiatric care by increasing the number of training places, including in rural and remote areas across Australia*

The evaluation found that completed time-limited activities (e.g., development of remote supervision and expanded setting guidelines, and development of the Postgraduate Certificate in Clinical Psychiatry) should cease. Any future funding for such activities should be assessed on its own merits. Additionally, the evaluation found that the PIF activity should be streamlined and funded by the college in future.

RANZCP takes a whole-of-organisation approach to supporting Aboriginal and/or Torres Strait Islander trainees, thus any initiatives should not be contained to any one training program.

Table 9.1 presents preliminary recommendations, rationale and associated findings for each PWP activity.

9 RECOMMENDATIONS

Table 9.1: Findings and recommendations

RECOMMENDATIONS	RATIONALE	ASSOCIATED FINDINGS
PWP training posts		
1. PWP should continue to fund training posts based on existing criteria and focus on increasing the psychiatrist workforce and consumer access to psychiatric care by increasing the number of training places 2. Consideration should be given to adding additional weighting towards training sites in rural and remote areas that can offer end-to-end training with PWP funding 3. Consideration should be given to adding additional weighting towards training sites that demonstrate that additional psychiatry services will be delivered with PWP funding 4. Supervisor funding should be a separate funding element from the trainee salary contribution and subject to the following criteria: • Supervisor funding will be used to contract additional consultant FTE for direct supervision • Supervisor funding will be used to contract additional consultant FTE for psychotherapy case supervision • Supervisor funding will be used to quarantine consultant FTE for supervision in private settings	There is more than sufficient demand and demonstrated benefits realised from funding training sites based on the current criteria. The flexibility in the criteria complements other Commonwealth-funded training programs and adapts to the clinical service delivery models of health services. Expanded settings for CL and CAP training rotations are currently limited to trialling in rural and remote areas. This is also a point of tension in regional and metropolitan areas. CL and CAP rotations should continue to include MM1–7.	Finding 1. There was more than sufficient demand from eligible health services, and all PWP training posts were allocated in accordance with the funding criteria, exceeding performance indicators. A broad cross-section of posts was funded, spanning public, private, and remote settings (particularly MM2–7), stage 2 mandatory rotations, and posts focused on First Nations communities. Finding 2. Any issues reported in the attraction and retention of psychiatry trainees and supervisors in PWP-funded rotations were in the minority and not inherent to PWP but rather to broader systemic issues. Finding 13. The PWP training posts directly target bottlenecks in training (stage 2 mandatory rotations), anecdotally believed to be beneficial for health service delivery and trainees, not targeted by other training programs. Additionally, the flexibility in the funding criteria allowed it to be used in conjunction with other Commonwealth-funded training programs, enabling end-to-end training in health services/local health networks. Finding 14. Funding for supervision was viewed as a value-adding and a distinct point of difference from other fellowship training programs funded by the Commonwealth. Inadvertently, the funding allows different types of supervision to be funded (everyday oversight or psychotherapy case), based on the clinical service delivery and employment model of the health service. However, since some health services did not use it for supervision purposes, the distribution mechanism for this element requires further consideration. Finding 17. There was a high demand from the health sector to train psychiatry trainees. However, this was reported to be contingent on Commonwealth funding, including PWP, alongside state/territory-funded registrar positions. Expanded settings to undertake stage 2 rotations were suggested to create additional training opportunities.

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RECOMMENDATIONS	RATIONALE	ASSOCIATED FINDINGS
		Finding 18. The provision of funding for supervision under PWP enabled some health services to expand their capacity for supervision. Additionally, funding sub-specialty training was thought to increase the likelihood of attracting and retaining consultants. Finding 19. While PWP training posts were limited to 30 positions across Australia, additional FTE enabled rural and remote health services to bolster their services to better meet community demand. This view was not limited to rural and remote services; metropolitan and large rural posts also reported an increase in service delivery capability. Finding 22. Jurisdictional planning and investment are primarily focused on developing clinical service models in response to specific local needs. Commonwealth funding reportedly had minimal influence on workforce planning at the jurisdictional level and is utilised by individual health services to address funding/training gaps. Finding 31. The PWP posts were assessed as value for money, rating good or excellent on all criteria. The posts were implemented efficiently and reportedly yielded good outcomes for rural and remote locations, as well as Aboriginal and Torres Strait Islander communities. Health services reported even greater benefits when PWP posts were used in conjunction with other federal government funding streams, such as STP and IRTP. The PWP should monitor any future changes to the STP program and assess the impact that these changes will have on PWP delivery.
Progressing the Rural Psychiatry Training Pathway		
5. Consideration should be given to funding additional posts – not previously funded and that would have been unable to host psychiatry training – using remote supervision, and expanded settings for CL rotations in PWP in rural and remote areas 6. Consider a one-off, time-limited funding grant to support a CAP pilot	Further work is required to advance psychiatry training in rural and remote areas to realise the strategic vision of rural and remote workforce strategies to build a sustainable pipeline of psychiatrists. Support for psychiatry trainees in rural and remote areas extends beyond the remit of PWP. It should be incorporated into training site accreditation	Finding 6. RANZCP successfully actioned deliverables 30 and 31 under the RPTP Roadmap as planned. Remote supervision guidelines were developed and endorsed by RANZCP. These have been piloted in Western Australia and South Australia and integrated into the psychiatry fellowship training model. Similarly, expanded settings for stage 2 CL/CAP mandatory rotations in rural and remote areas have been developed and endorsed for use; however, CAP must be trialled before a full rollout. Finding 11. The PWP has progressed work to expand psychiatric training and service delivery in rural and remote areas through additional training posts, training levers (remote supervision and expanded settings for CL and CAP), and strengthening the mental health skills of medical practitioners.

9 RECOMMENDATIONS

RECOMMENDATIONS	RATIONALE	ASSOCIATED FINDINGS
	standards and professional support mechanisms more broadly in the colleges.	Finding 33. The time-limited activity to develop a remote supervision model has been completed and piloted. RANZCP should monitor the uptake and impact of the remote supervision model as it rolls out, to ensure equivalent quality to face-to-face supervision and acceptability to health services, trainees, and supervisors. Finding 34. The time-limited activity to develop expanded settings for CL and CAP rotation has been completed, with the expanded setting endorsed. Rural pathway opportunities for CL are now available as business as usual, and CAP rotations will be piloted. RANZCP should monitor the uptake and impact of the expanded settings/pilot, to ensure equivalent quality of training and the impact on mandatory stage 2 rotation bottlenecks.
PIF		
7. The PIF should develop a targeted strategy to promote and recruit regional, rural and remote medical students and doctors to the PIF and increase access to in-person events. This may include strategies such as weighting or prioritising scholarship applicants based in MM2–7. 8. RANZCP should self-fund PIF and review the PIF operational processes to streamline and use resources efficiently to continue the promotion of psychiatry as a specialty and career.	PIF is a useful mechanism to generate interest in psychiatry among prevocational doctors. However, there is currently no targeted strategy to promote and recruit regional, rural, and remote medical students and doctors (PGY2+) to the PIF. This would provide further clarity on the PIF approach and how it can complement or intersect with other sources of influence on career pathways, thereby improving the rural psychiatry pipeline. Given the increased interest in psychiatry as a career path since the PIF was established, it is feasible to suggest that RANZCP self-fund the PIF. The PIF operational activities (biannual member surveys, post-event evaluation surveys, etc.) and extensive sponsorship of external bodies and	Finding 3. The PIF primarily supported (through sponsorship) a range of internal and external activities aimed at increasing knowledge of psychiatry as a career and connecting members to RANZCP events and resources. The PIF membership base has experienced annual growth, which is likely attributed to the PIF's increased efforts to broaden its external connections, primarily through sponsorships of university medical societies and AMSA events. Finding 4. The PIF sponsored approximately 5% of active PIF members (medical students and PGY1–2 doctors) to attend sponsored events each year. While around 20% of those sponsored were based in MM2–7, there was no formal process to prioritise or weight sponsorship applications from those in MM2–7. Similarly, around 10% of sponsored members identified as Aboriginal and/or Torres Strait Islander. Finding 5. A large proportion of PIF members are passive (PGY3+ are unlikely to transition to RANZCP fellowship training), which suggests that the PIF also serves as a mechanism for doctors to access information on mental health issues and treatments. Finding 20. The PIF is a platform for building knowledge and interest among doctors to pursue a career in psychiatry. Up to 80% of psychiatry trainees were reportedly PIF members; however, a range of other factors also influence the career pathways of medical students and junior doctors.

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RECOMMENDATIONS	RATIONALE	ASSOCIATED FINDINGS
	events warrant further review to understand the return on investment, as the current administration and staff costs appear to represent approximately 70% of PIF expenditure. Note: a complete review of the PIF expenditure is still underway and is yet to be confirmed. In addition, further work is required to understand the funding and resources attributed to the passive membership of the PIF, and what is reasonable compared to the benefits realised (for passive members and psychiatry more broadly).	Finding 21. Regionally hosted events for rural medical students and junior doctors represent a valuable opportunity to foster local relationships and workforce pipelines. Despite an increase in the psychiatric workforce over time, a maldistribution of the workforce still exists. This suggests that efforts may be best focused specifically on rural and remote cohorts, leveraging regional and rural training networks (including Rural DoTs). Finding 32. Although the PIF helps to promote awareness of psychiatry as a medical specialty, it is not delivered in a cost-efficient manner. Efforts to streamline administrative processes may improve their cost efficiency. However, the evaluation found that the PIF lacks a dedicated focus on areas of interest to the federal government (i.e. rural and remote workforce) and therefore should no longer be a federal funding priority.
Support for psychiatry trainees		
9. RANZCP should continue to work with AIDA to strengthen links with psychiatry trainees who identify as Aboriginal and/or Torres Strait Islander. 10. RANZCP should continue to use a whole-of-organisation approach to supporting Aboriginal and/or Torres Strait Islander trainees	Support for Indigenous psychiatry trainees is not specific to individual fellowship training programs but rather provided in a whole-of-organisation approach. Providing agency to Indigenous psychiatry trainees to define what is important to them and how to connect and support their peers is important. This should extend to the support network for Aboriginal and Torres Strait Islander trainees.	Finding 9. The PWP did not fund an activity aimed at increasing Aboriginal and Torres Strait Islander trainees, nor are there any initiatives specific to the PWP that target Aboriginal and Torres Strait Islander trainees. The RANZCP developed a support network for all Aboriginal and Torres Strait Islander psychiatry trainees, funded by the STP. The PIF supported Aboriginal and Torres Strait Islander psychiatry trainees with scholarships to attend (mostly) Indigenous events. Finding 10. RANZCP and specialist colleges more broadly recognise the importance of supporting Indigenous trainees (and specialists) in colleges and health settings. Continuing to work with AIDA to enable cultural safety in healthcare is a priority. Finding 23. RANZCP has taken a whole-of-organisation approach to encourage and support Indigenous psychiatry trainees, including the development of a peer support network. While this has likely contributed to the substantial increase in Indigenous psychiatry trainees over the last few years, it is not directly attributable to the PWP.

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RECOMMENDATIONS	RATIONALE	ASSOCIATED FINDINGS
11. RANZCP should work with potential sites designated as suitable for remote supervision or an expanded setting for CL and CAP to develop health service guidelines for hosting these types of training rotations. 12. RANZCP should continue to support the Rural DoTs to support the training (including exam preparation) and peer support networking of rural and remote trainees.	It is important for health services hosting trainees using remote supervision to be aware of their additional responsibilities in supporting and providing trainees with a safe clinical experience. RANZCP notes that the development and resourcing of these sites is the responsibility of the employing health service. However, the joint development of on-site guidelines and processes that align with RANZCP's remote supervision guidelines (and expanded settings for stage 2 mandatory rotations) will set and align expectations to foster good training outcomes. It will also aid towards a standardised approach for health services.	Finding 12. The PWP offers opportunities to enhance psychiatric services in rural and remote areas, addressing community needs. However, most stakeholders conceded that the benefits are limited to the funding period of the PWP and are subject to other external stressors in more remote areas. Finding 16. All psychiatry trainees (broadly all specialist trainees) require additional support in rural and remote areas. Access to training and education for curriculum activities is critical and also enables peer connections. Additional costs will likely be incurred associated with relocating; however, housing availability is also an issue in rural and remote areas. Additionally, governance of clinical practices to be culturally aware and appropriate is important to deliver care to Aboriginal and Torres Strait Islander communities.
Postgraduate Certificate in Clinical Psychiatry		
13. RANZCP should take steps to achieve recognition of the Postgraduate Certificate in Clinical Psychiatry as CPD for medical practitioners by their respective colleges, including RACGP and ACRRM 14. RANZCP should explore opportunities with rural health services/networks to support the Certificate with in-kind consultant services to provide supervision to participants, to foster adoption and a skilled local primary care workforce	The launch of the Postgraduate Certificate in Clinical Psychiatry was delayed from 2023 to 2024. While the evaluation can assess the implementation and uptake of the Certificate, the impact cannot be assessed as no participants have yet completed it. The estimated felt need and impact of the Certificate for medical practitioners have been drawn from the sector as a proxy indicator. A pulse survey of enrolled participants to gain insight into the motivation and	Finding 7. The Postgraduate Certificate in Clinical Psychiatry was developed, endorsed and launched by RANZCP in the second half of 2024 within budget. Two scheduled intakes per year have generated sufficient demand and uptake among medical practitioners in a range of settings. Finding 8. RANZCP has not addressed the recognition of the Certificate as CPD by other relevant colleges for participants. This is a critical gap for RANZCP to consider and address. Finding 15. The RANZCP Postgraduate Certificate in Clinical Psychiatry addresses a gap in the mental health skills training landscape. It targets medical practitioners who require skills-based training and is agnostic to health settings or remoteness. Finding 24. The Postgraduate Certificate in Clinical Psychiatry has garnered substantial interest from medical practitioners, especially GPs. While there has been

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RECOMMENDATIONS	RATIONALE	ASSOCIATED FINDINGS
	expected impact/application of the Certificate may be of added value to follow up on in future. While the 2025 pre-election commitment to mental health promised funding support for 200 participants in the Certificate, the capacity of RANZCP fellows as supervisors is a rate-limiting step to the number of participants.	sufficient demand for two intakes per year, the number of intakes to the Certificate is limited by the capacity of RANZCP fellows to support training. Given that supervision payments are activity-based, there is no financial incentive for fellows to participate. Opportunities to leverage rural health services/networks to support the Certificate with in-kind consultant services, thereby fostering a skilled primary care workforce, should be explored. It is advisable to review the actual hours of input for supervisors and participants to understand any unintended outcomes or inefficiencies. Finding 30. The individual workplace-based format and practical nature of the Postgraduate Certificate in Clinical Psychiatry are likely to positively influence uptake. Finding 35. The time-limited activity to develop the Postgraduate Certificate in Clinical Psychiatry has been completed with 28 enrolled participants in September 2025. RANZCP should monitor enrolment uptake and completion rates. RANZCP may wish to consider attaining RACGP and ACRRM CPD points for the Certificate in future, noting the majority of participants are GPs. RANZCP should also monitor the number of supervisors participating, which is a rate-limiting factor. Should supervisor participation drop off or become a barrier in future, RANZCP may wish to consider alternative payment structures for supervision of participants.
Program governance		
15. Future grant agreements for administering the PWP should require an overarching Activity Work Plan. This plan must schedule all funded activities across the full funding term with defined completion dates. Any additional activities that influence program outcomes but are not directly funded should be clearly identified and highlighted to ensure transparency. 16. Collection and reporting of outcome measures at the health service level, such as additional service activity, should be considered to better understand the impact on the community		Finding 25. Oversight and administration of the PWP have been integrated into RANZCP's existing governance and reporting structures. This includes processes to score, prioritise, and allocate training posts, as well as endorse Rural Psychiatry Roadmap deliverables (remote supervision and expanded settings for CL and CAP). Finding 26. Adequate performance monitoring and reporting mechanisms are in place to reconcile contracted obligations and performance indicators for PWP via biannual performance reporting. However, consideration of outcome measures at the health service level may aid in a better understanding of the program's impact on the workforce and community. Finding 27. The inclusion of activities and success measures not funded by PWP in biannual performance reports potentially distorted the magnitude of the program's

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RECOMMENDATIONS	RATIONALE	ASSOCIATED FINDINGS
		success. In future, it will be essential to acknowledge and clearly distinguish between activities funded by the PWP and those that are not. Finding 28. Given some key activities were completed before the end of the funded period (2022 to 2026), planning activities across the full funding term with completion dates will improve visibility in future. Finding 29. The level of financial budget and expenditure reported was minimal. The rollover of unspent funds was not directly linked to rolled-over activities or new planned activities in the performance reports. Additionally, expenditure for activities that generate a variable outcome, such as the PIF (interest in psychiatry, transition to RANZCP fellowship training), did not differentiate between direct and indirect costs, thereby limiting a broad understanding of the program's efficiency. The administration costs of the PIF were estimated at 70%, demonstrating poor efficiency given the low complexity and risk of PIF activities and the benefits realised.

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APPENDIX A LOGIC MODEL AND MONITORING AND EVALUATION FRAMEWORK

Figure 10.1 below presents a high-level logic model for the PWP. Table 10.1 on the following page is the PWP M&E framework used for the evaluation.

Figure 10.1: High-level logic model for PWP

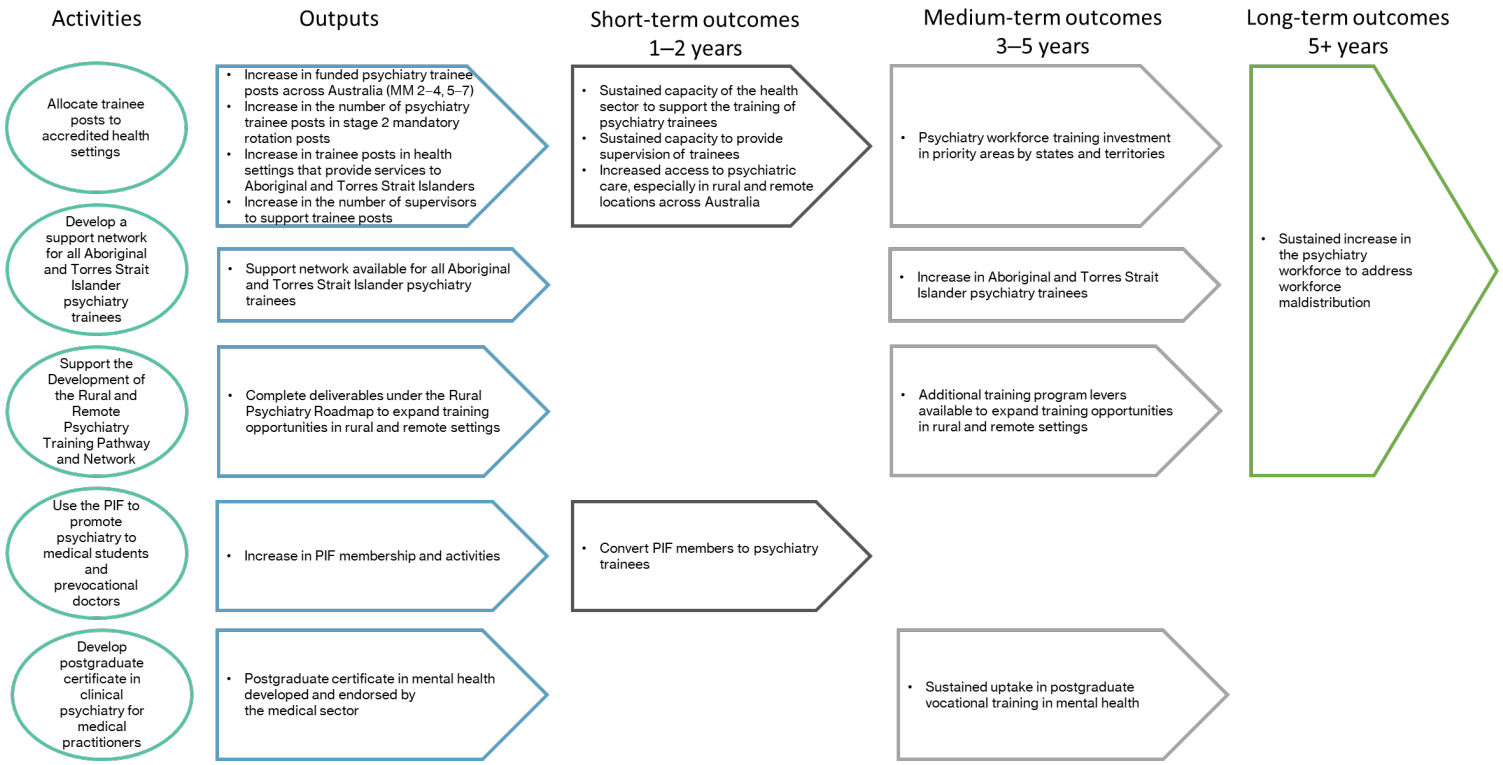

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Table 10.1: Monitoring and evaluation framework for PWP

	KEA AND QUESTIONS	INDICATORS	DATA SOURCE	DATA ANALYSIS
1	**Implementation – Understanding the impact of the PWP**			
1.1	To what extent has the PWP been implemented as intended?	• Proportion of funded PWP posts allocated • Proportion of allocated PWP posts completed • Supervisors recruited – Number of rotations completed by supervisors by post type – Number of additional supervisors recruited by post type • PIF membership – Trend in PIF membership (decrease, same, increase) – Number of activities hosted/facilitated access to over time • Development and [reported] endorsement of the Postgraduate Certificate in Clinical Psychology by the medical sector • Deliverables under the Rural Psychiatry Roadmap to expand training opportunities in rural and remote settings completed – Remote supervision – Review of mandatory Stage 2 rotation settings • Reported barriers and enablers to the intended outputs of the PWP • **Proxy output:** Support network available for all Aboriginal and Torres Strait Islander psychiatry trainees	• Interviews with the Department, RANZCP, PWP supervisors, health setting posts • Program data (allocation of PWP posts and funding) • Program data (postgraduate vocational training in psychiatry enrolment and completion data) • Program data (supervisors)	• Proportion of funded PWP posts allocated • Proportion of allocated PWP posts completed • Reasons for delayed or no completion • Trend in supervisors (change in numbers, Modified Monash (MM) setting, rotation type) • PIF membership number trends and activities • Deliverables under the Rural Psychiatry Roadmap to expand training opportunities in rural and remote settings completed • Support network available for all Aboriginal and Torres Strait Islander psychiatry trainees • Thematic analysis of reported barriers and enablers to the intended outputs of the PWP
1.2	To what extent has the PWP reached the target population?	• Trainees in MM2–4, 5–7 – Trainees who are of rural origin or background • Allocated posts for stage 2 mandatory rotations • Allocated posts for health settings that provide services to Aboriginal and Torres Strait Islanders • PIF membership – Psychiatry trainees who were PIF members • Uptake of the Postgraduate Certificate in Clinical Psychology by medical practitioners • Profile of medical practitioners enrolled in and/or completed Postgraduate Certificate in Clinical Psychology	• Program data (allocation of PWP posts and funding) • Program data (postgraduate vocational training in psychiatry enrolment and completion data) • PIF participant data	• Proportion of trainees who are of rural origin or background • Number/proportion of funded psychiatry posts MM2–4, 5–7 • Number/proportion of stage 2 mandatory posts • Number/proportion of health settings that provide services to Aboriginal and Torres Strait Islanders • Proportion of psychiatry trainees who were PIF members

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	KEA AND QUESTIONS	INDICATORS	DATA SOURCE	DATA ANALYSIS
		compared to target cohort (GPs, emergency medicine specialists) • **Proxy population reach**: Indigenous psychiatry trainees accessing Indigenous support network		• Profile of medical practitioners enrolled in and/or completed Postgraduate Certificate in Clinical Psychology (PGY, MM setting, specialty) • Participation rates in Indigenous support network over time (proxy measure)
1.3	How has policy shaped the implementation of the PWP?	• Identified influences of psychiatry/mental health, specialist workforce and/or rural and remote health workforce policies on PWP (Roadmap, rural health workforce strategies, state/territory strategies, national medical workforce strategy) • Reported opinion by stakeholders on the influence of current and/or forthcoming relevant policies on the implementation of the PWP	• Learnings from environmental scan & literature review • Interviews with the Department, RANZCP, rural workforce agencies and jurisdictional health authorities	• Policies identified to shape PWP • Thematic analysis of the influence of current and/or forthcoming relevant policies on the implementation of the PWP
1.4	How is success measured for Aboriginal and Torres Strait Islander graduates?	• Reported/suggested success measures, definitions, and priorities by psychiatry trainees (that may include Indigenous trainees), e.g. cultural safety measures in place at posts • Suggested success measures, definitions, and priorities by Indigenous peak bodies • Suggested success measures, definitions, and priorities for Aboriginal and Torres Strait Islander trainees gathered by other specialist colleges • Reported efforts by post settings to ensure a culturally safe environment	• RANZCP fellowship exit survey • Focus groups with PWP trainees • Interviews with AIDA, NACCHO (or jurisdictional affiliates) • Interviews with specialist colleges • Interviews with post settings • Interviews with supervisors	• Thematic analysis of reported/suggested measures, definitions, and priorities for Aboriginal and Torres Strait Islander trainees/graduates • Types of supports in place by post settings to ensure a culturally safe environment
	Appropriateness – Relevance of the PWP to the needs of rural communities and psychiatry trainees			
2.1	To what extent does the PWP address the need for psychiatry services in regional, rural and remote communities?	• Perceived impact of the PWP to address the need for psychiatry services in regional, rural and remote communities • Post settings in regional, rural and remote settings undertaking two or more trainee rotations (continuity of care) • Post settings with multiple locations/services in regional, rural and remote communities used effectively • Identified needs and actions required in other reviews/evaluations of other STP/psychiatry programs that align with the objectives of the PWP	• Interviews with specialist colleges (RACGP, Australian College of Emergency Medicine, ACRRM) and psychiatrists • Interviews with supervisors, DoTs and post settings (including health services receiving trainee/supervisor services) • Interviews with rural workforce agencies and jurisdictional Departments of Health • Learnings from the environmental scan & literature review	• Thematic analysis of the reported impact of PWP to address the need for psychiatry services in regional, rural, and remote communities • Proportion of post settings in regional, rural, and remote settings (MM2–4, 5–7) undertaking two or more trainee rotations (continuity of care) • Use of outreach and video/telehealth in post settings with multiple locations/services

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	KEA AND QUESTIONS	INDICATORS	DATA SOURCE	DATA ANALYSIS
2.2	What are the needs of psychiatry trainees to support them through training in rural areas? How does the PWP support trainees completing rotations in regional/rural/remote?	• Reported needs and supports in place for psychiatry trainees to support them in training placement in rural areas by psychiatry trainees (i.e. professional (peer support, mentoring) community, and personal (cultural)) • Reported needs and supports in place for psychiatry trainees to support them in training placement in rural areas by supervisors, DoTs, and health settings (i.e. clinical, cultural, peer and pastoral support) • Reported needs and supports in place for specialist trainees to support them in training placement in rural areas by other specialist colleges (i.e. clinical, cultural, peer and pastoral support)	• Focus groups with PWP trainees – include previous rotations • RANZCP fellowship exit surveys • Ahpra Medical Training Surveys • Interviews with supervisors, DoTs, and health settings • Interviews with RANZCP and other specialist colleges	• Thematic analysis of reported needs and supports in place for psychiatry trainees by stakeholder type
2.3	How does the PWP complement and build upon existing training programs (STP, IRTP, MVPTP, and state/territory-funded programs) and support psychiatry training posts?	• Identified alignment of the PWP to broader psychiatry training programs and initiatives through desktop review, e.g. Back to Country Grants • Reported alignment of the PWP to broader psychiatry training programs and initiatives, e.g. RANZCP state/territory branch activities to attract trainees • Reported impact and benefits of the PWP supervisor funding • Identification of PWP elements determined to be complementary to broader psychiatry training programs, e.g. offers additional placements not offered or in high demand in other psychiatry training programs • Reported alignment of the PWP to broader state/territory training supports (including funding)	• Review of other psychiatry training program documentation • Program data on the uptake of other psychiatry trainee placement programs, including STP (IRTP, Tasmanian Project), and the Military and Veteran Psychiatric Program • Interviews with RANZCP (including Chairs of the RANZCP Branch Training Committees) • Interviews with supervisors, DoTs, and post settings • Interviews with jurisdictional health authorities (medical training/mental health), chief psychiatrists of states/ territories	• Alignment of PWP by intended outputs and outcomes to other psychiatry training programs (by program) • Alignment of PWP activities (PIF) to RANZCP branch activities to attract trainees • Alignment of PWP activities and outputs to state/territory program/supports provided
2.4	How will the Postgraduate Certificate in Clinical Psychology complement training provided through mental health AST and other mental health postgraduate programs undertaken by GPs or emergency medicine specialists?	• Reported alignment of the Postgraduate Certificate in Clinical Psychology with other postgraduate mental health training on offer • Reported awareness and support for the uptake of the Postgraduate Certificate in Clinical Psychology • Reported understanding of the objectives, intended outcomes and alignment of the Postgraduate Certificate in Clinical Psychology to other mental health training programs and certifications	• Learnings from the environmental scan & literature review • Interviews with specialist colleges (RACGP, ACEM, ACRRM) • Interviews with RANZCP (including Expert Advisory Group) and psychiatrists	• Alignment and gaps between the Postgraduate Certificate in Clinical Psychology and other mental health training (objectives, study outcomes, targeted cohort, recognition) • Thematic analysis of reported awareness and support for the Postgraduate Certificate in Clinical Psychology • Thematic analysis of the reported understanding of the objectives and

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	KEA AND QUESTIONS	INDICATORS	DATA SOURCE	DATA ANALYSIS
				perceived alignment of the Postgraduate Certificate in Clinical Psychology to other mental health training
3	**Effectiveness – Effectiveness of the PWP in achieving intended outcomes**			
3.1	How effective is the PWP in achieving desired program outcomes in the short and medium-term? What are the key contributing factors to achieving the outcomes?	• Contributing factors to the PWP achieving its intended outcomes reported by program participants and stakeholders • Reported capacity of post settings to support the training of psychiatry trainees • Reported capacity of supervisors to support the training of psychiatry trainees • Profile of PWP applications versus allocation of posts by criteria type • Uptake in Postgraduate Certificate in Clinical Psychology • Transparency and effectiveness of the training post allocation process	• Interviews with RANZCP (including Expert Advisory Group) and psychiatrists • Interviews with specialist colleges • Interviews with the Department, jurisdictional departments of health, rural workforce agencies • Interviews with post health settings and supervisors • Interviews with enrolled participants in the Postgraduate Certificate in Clinical Psychology • Interviews with regional training hubs and rural clinical schools • Chief psychiatrists of states/ territories • Program data (post applications and allocations)	• Thematic analysis of factors to the PWP achieving its intended outcomes reported by program participants and stakeholders • Description of levels of capacity reported by post settings and supervisors to support the training of psychiatry trainees across setting and rotation types • Description of PWP applications versus allocation of posts by criteria type (MM setting, stage 2 mandatory rotations, health settings that provide services to Aboriginal and Torres Strait Islanders) • Descriptive analysis of uptake and completion of Postgraduate Certificate in Clinical Psychology by participant type (e.g. GP, emergency medicine specialist, PGY) • Descriptive analysis of PWP post allocation criteria and allocation versus demand
3.2	What is the awareness of, and support for, the PWP? Is there sufficient understanding about its intended outcomes?	• Reported awareness and support for the PWP and its intended outcomes by program participants and stakeholders	• Interviews with rural workforce agencies and health authorities across jurisdictions • Interview with PIF advisory group • Interviews with regional training hubs and rural clinical schools	• Thematic analysis of reported levels of awareness and support for PWP and its intended outcomes
3.3	To what extent has early engagement of medical graduates resulted in increased interest and recruitment in psychiatry as a career through the expansion of the RANZCP PIF?	• Sources of influence on PIF members to undertake specialist training pathways (including psychiatry) and drivers to do so • Reported influence of PIF on interest in psychiatry as a career • Career pathway intent reported by PIF members in PIF member surveys	• Focus groups with PIF members, psychiatry trainees • Interview with PIF advisory group • PIF member data • PIF member data – feedback survey outcomes	• Thematic analysis of the reported sources of influence on specialist pathway choices by PIF members (medical students and prevocational doctors) • Thematic analysis of the reported influence of PIF on interest in psychiatry

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	KEA AND QUESTIONS	INDICATORS	DATA SOURCE	DATA ANALYSIS
		• Conversion rate of PIF members to trainees		by PIF members (medical students and prevocational doctors) • Descriptive analysis of reported career pathway intent by PIF members • Descriptive analysis of number/proportion of PIF members who choose the psychiatry fellowship pathway and number/proportion of psychiatry trainees who participated in PIF
3.4	Has the PWP been successful in attracting First Nations medical students or graduates to enter psychiatry training? How can this be improved?	• Psychiatry trainees in PWP who identify as Aboriginal Torres Strait Islander • Psychiatry trainees in PWP who identify as Aboriginal Torres Strait Islander who completed their rotation(s) • Reported enablers, barriers, and challenges to accessing psychiatry training • Reported enablers, barriers, and challenges to completing psychiatry training rotations • Suggested improvements to attract and retain Aboriginal Torres Strait Islander psychiatry trainees	• PWP program data (psychiatry trainees) • Interviews with RANZCP and psychiatrists • Interviews with supervisors, DoTs, and post health settings • Interview with AIDA, other relevant Indigenous groups	• Descriptive analysis of number of Indigenous psychiatry trainees by rotation, rotation type and completion rate over time to 2025 • Thematic analysis of reported enablers, barriers, and challenges to accessing and completing psychiatry training fellowship, rotations for Indigenous trainees • Suggested improvements to attract and retain Indigenous trainees
4	**Efficiency – Arrangements in place that allow the PWP to meet intended outcomes through an efficient use of resources**			
4.1	What governance arrangements are in place for the PWP?	• Identification of governance structures and processes documented by RANZCP • Proportion of PWP funding used for administration purposes and other training program activities • Reported governance issues and considerations for PWP	• Interview with the Department and jurisdictional health authorities • Consultation with DoTs, post health settings and supervisors • Program reporting to the Department (Rotation Progress Reports submitted by health services and private settings)	• Identification of governance structures, processes, and issues across four key governance components[6] and any identified gaps against: – Transparency – Accountability – Stewardship – Integrity • Proportion of PWP funding used for administration purposes and other training program activities • Thematic analysis of reported governance issues and considerations

[6] Governance Institute of Australia, Foundations of good governance Available at https://www.governanceinstitute.com.au/resources/what-is-governance/governance-foundations/

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	KEA AND QUESTIONS	INDICATORS	DATA SOURCE	DATA ANALYSIS
				for PWP in relation to the above four pillars of good governance
4.2	Are monitoring and evaluation mechanisms in place for the PWP, including reporting requirements?	• Review of PWP monitoring and key performance insights in place by RANZCP for each short- and medium-term intended outcome • Felt relevance and transparency of reporting requirements by program stakeholders	• Review of program documentation – RANZCP reporting obligations to the Department – Post setting rotation reports to RANZCP • Interviews with post settings	• Descriptive analysis of performance insights (key performance indicators (KPIs), reporting) to PWP intended short- and medium-term outcomes • Thematic analysis of reported relevance and transparency of PWP reporting requirements by program stakeholders
4.3	Is the PWP accessible to clinicians who are interested in extended mental health training?	• Review of the training cost, time commitment, availability (frequency), mode of delivery and comparison to other mental health training • Reported views of the Postgraduate Certificate in Clinical Psychology accessibility aspects as above by specialist colleges, potential and enrolled medical practitioners	• Review of program documentation (Postgraduate Certificate in Clinical Psychology) • Interviews with RANZCP • Interviews with specialist colleges, potential and enrolled medical practitioners	• Descriptive analysis to compare the Postgraduate Certificate in Clinical Psychology to other training about training cost, time commitment, availability (frequency), mode of delivery • Thematic analysis of reported views on accessibility of the Postgraduate Certificate in Clinical Psychology about training cost, time commitment, availability (frequency), mode of delivery
4.4	What are the barriers and enablers to the intended outcomes of the PWP?	• Barriers and enablers to the intended outcomes of PWP identified in the program documentation • Barriers and enablers to the intended outcomes of PWP reported by stakeholders	• Program documentation and literature scan • Interviews with program stakeholders – Department – RANZCP – Post health settings – Supervisors – Rural DoTs	• Thematic analysis of stakeholder reported barriers and enablers to PWP short- and medium-term outcomes along with those identified in the program documentation and literature scan
5	**Cost-effectiveness – Cost-effectiveness and value of the PWP**			
5.1	What is the social and economic value of the PWP and what are the best measures to demonstrate this?	• Refer to the cost analysis approach	• Funding agreements • Interviews with relevant policy areas of the Department • Interviews with peak bodies • Interviews with post health settings, supervisors, Rural DoTs • Program data (allocation of PWP posts and funding)	• Refer to the cost analysis approach

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	KEA AND QUESTIONS	INDICATORS	DATA SOURCE	DATA ANALYSIS
5.2	Based on the effectiveness of the PWP, what is the overall cost benefit of the program?	• Refer to the cost analysis approach	• Cost benefit analysis outcome	• Refer to the cost analysis approach
5.3	Based on the current delivery of the PWP, is it value for money? Should the program be considered for ongoing funding?	• Refer to the cost analysis approach	• Cost benefit analysis outcomes	• Refer to the cost analysis approach
6	**Sustainability – Factors affecting the future implementation, sustainability, and enhancement of the PWP**			
6.1	Is the PWP tracking in such a way that it will be able to achieve its intended long-term outcomes?	• Monitoring and assessment of identified short-, medium- and long-term outcomes to determine if the intended outcomes were achieved as per KEAs 1 to 4	• Evaluation findings	• N/A
6.2	Are there any changes required to the design, implementation, and funding arrangements of the PWP to enable it to meet its objectives?	• Analysis of the evaluation findings and cost analysis approach will provide insight into the gaps and opportunities to suggest any changes required to enhance the design, implementation, and funding arrangements of PWP to enable it to meet its medium- to long-term objectives	• Evaluation findings	• N/A
6.3	What opportunities exist for improving ongoing delivery of the PWP?	• Suggested changes to improve PWP delivery by program stakeholders • Suggested changes identified in KEA 6.2	• Evaluation findings • Interviews with program stakeholders – Department – RANZCP – Post health settings – Supervisors • Rural DoTs	• N/A

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APPENDIX B STAKEHOLDERS CONSULTED

Table 10.2: Stakeholders consulted in Stage 3B

STAKEHOLDER GROUP	STATUS
Specialist medical colleges	
RACGP	Invited
ACEM	Consulted
ACRRM	Consulted
Royal Australian College of Surgeons (RACS)	Declined
Australian College of Dermatology	Consulted
Royal Australian and New Zealand College of Obstetricians and Gynaecologists	Consulted
Australasian College of Sport and Exercise Physicians	Consulted
Royal Australian and New Zealand College of Radiologists	Consulted
Australian and New Zealand College of Anaesthetists	Consulted
Royal College of Pathologists of Australasia	Invited
College of Intensive Care Medicine	Invited
Royal Australasian College of Medical Administrators	Declined
Royal Australasian College of Physicians	Consulted
Rural Workforce Agencies	
Rural Workforce Agency Network (RWAN)	Invited
Indigenous organisations	
National Aboriginal Community Controlled Health Organisation (NACCHO)	Invited
AIDA	Invited
Peak bodies	
Australian Medical Students' Association (AMSA)	Consulted
State and territory Departments of Health	
NSW Department of Health	Consulted
Vic Department of Health	Invited; same as office of Chief Psychiatrist
Qld Department of Health	Consulted
WA Department of Health	Consulted
SA Department of Health	Invited
Tas Department of Health	Same as office of Chief Psychiatrist
ACT Department of Health	No contact – refer to Chief Psychiatrist
NT Department of Health	Invited; same as office of Chief Psychiatrist
Chief psychiatrists	
Vic Chief Psychiatrist	Consulted
NSW Chief Psychiatrist	Consulted
Qld Chief Psychiatrist	Consulted
ACT Chief Psychiatrist	Consulted
NT Chief Psychiatrist	Consulted
WA Chief Psychiatrist	Consulted
SA Chief Psychiatrist	Consulted
Tas Chief Psychiatrist	Consulted
Psychiatrists	
Mat Coleman	Consulted

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STAKEHOLDER GROUP	STATUS
Nick O'Connor	Consulted

Table 10.3: Health services hosting PWP rotations consulted

HEALTH SERVICE	JURISDICTION
NT Department of Health Top End Palmerston Regional Hospital	NT
Mental Health/Alcohol & Other Drugs – Central Australia Region NT Health	NT
South West Healthcare	VIC
Goulburn Valley Health	VIC
Northern Health	VIC
WA Country Health Service – Great Southern	WA
WA Country Health – Pilbara	WA
Townsville Hospital & Health Service	QLD
Cairns and Hinterland HHS	QLD
Barossa Hills Fleurieu Local Health Network	SA
Hunter New England LHD	NSW
Western NSW Local Health District	NSW
Tasmania Health	TAS
Murrumbateman Specialist Centre	ACT

Table 10.4: Rural Directors of Training and Regional Training Hubs

	REGION	JURISDICTION
Rural DoT	WA Country Health Service	WA
Rural DoT	Department of Health NT	NT
Rural DoT	Central Queensland Hospital and Health Service	QLD
Rural DoT	Cairns and Hinterland Hospital and Health Service	QLD
Rural DoT	Northern NSW Local Health District	NSW
Rural DoT	Barossa Hills Fleurieu Local Health Network	SA
Rural DoT	Albury Wodonga	VIC
RTH	Riverina Regional Training Hub	NSW
RTH	Western NSW Regional Training Hub	NSW
RTH	Gippsland Regional Training Hub	VIC

APPENDIX C VALUE-FOR-MONEY STANDARDS RUBRICS

This section provides the value-for-money assessment rubrics for the individual PWP activities. Each table includes a brief description of what the assessment is based on (description), then the expected result for each value (poor, adequate, good, excellent). Green shading highlights the actual assessment result, as described in detail in Chapter 8 of this report.

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Table 10.5: Psychiatry training posts

RATING	EFFICIENCY (OUTPUTS)	EFFECTIVENESS (OUTCOMES/IMPACTS)	ENVIRONMENT	EQUITY	COST-EFFECTIVENESS
Description	To what extent did the PWP post activity meet contractual arrangements?	To what extent did the PWP post activity achieve its intended objectives?	To what degree does the PWP post activity integrate, rely on or support the broader external environment in which it operates?	Does the PWP post activity focus on improving equity of access to psychiatry services for: • Rural and remote communities • Aboriginal and Torres Strait Islander communities/people (as service users)	What is the total cost of PWP post delivery compared to the outcomes achieved? Is this value for money?
Poor	Does not satisfy contractual requirements • Less than 30 posts available per annum • Less than 95% (20) of posts are filled with a supervisor and trainee • Less than 50% (15) of posts are located in MM2–7 • More than 20% of posts are reallocated • No PWP psychiatry trainees who identify as Aboriginal or Torres Strait Islander • No posts that provide services to Aboriginal and Torres Strait Islander communities	Has not achieved expected outcomes • Challenges with health services attracting trainees in rural and remote areas • Variable capacity of health services to supervise trainees • Limited increase in health service capacity to deliver psychiatry care to MM2–7 communities • No increase in health service capacity to deliver psychiatric care to Aboriginal and Torres Strait Islander communities	Operates in isolation • Posts operate in isolation from other training post funding mechanisms	No specific focus on equity • No increase in training opportunities in services for Aboriginal and Torres Strait Islander people, such as AMSs • No increase in rural and remote training opportunities	Costs are significantly greater than the value of the outcomes • Unspent funds due to reallocation and/or unfilled posts increase program cost per training rotation • Supervisor fees unused or absorbed by the health service

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RATING	EFFICIENCY (OUTPUTS)	EFFECTIVENESS (OUTCOMES/IMPACTS)	ENVIRONMENT	EQUITY	COST-EFFECTIVENESS
Adequate	Has met contractual requirements • 30 posts available per annum • 95% (29) of posts are filled with a supervisor and a trainee • Minimum of 50% (15) of posts located in MM2–7 • Less than 20% (6) of posts are reallocated • At least one trainee who identifies as Aboriginal or Torres Strait Islander OR one post that provides services to Aboriginal and Torres Strait Islander communities	Has achieved some expected outcomes, but not at a level reflective of program maturity • Small increase in stage 2 training positions • Some increased capacity of health services to supervise trainees • Small increase in access to psychiatry care, particularly in MM2–7 and First Nations communities • Some increased psychiatry service delivery capacity to MM2–7 communities	Aware of external programs that may influence outcomes, and adjusts in response to them • PWP positions used to complement STP/IRTP-funded positions • Supervision funding enables increased consultant positions to support the trainee/s	A moderate level of activity has occurred to increase equity • Increased capacity of MM2–7 health services to facilitate psychiatry training, hence improving service delivery to the community	Costs are equal to value of the outcomes • Supervision funds are used: – Internally to support the supervision (increased FTE) component – To enable recruitment of a consultant to the service – Externally to bring in expert supervision for the psychotherapy case • Health service co-contribution increases the capacity of the consultant/registrar to provide services • Registrars enable increased service delivery across multiple disciplines (e.g. aged care and paediatrics)
Good	Achieves above contractual requirements • 30 posts available per annum	Has achieved expected outcomes, reflective of program maturity	Works collaboratively with and/or leverages external programs to create synergistic outcomes	A good amount of activity has occurred to increase equity As above plus	Costs are less than value of the outcomes As above plus

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RATING	EFFICIENCY (OUTPUTS)	EFFECTIVENESS (OUTCOMES/IMPACTS)	ENVIRONMENT	EQUITY	COST-EFFECTIVENESS
	• Minimum 95% (29) of posts are filled with a supervisor and trainee • 50% (15) to 75% (23) posts located in MM2–7 • Less than 10% (3) posts are reallocated • Two to three trainees who identify as Aboriginal or Torres Strait Islander OR at least 30% (10) posts that provide services to Aboriginal and Torres Strait Islander communities • PWP rotations situated in complementary clinical streams, including maternal services, paediatrics, older persons care	As above with greater increased capacity • Significant increase in stage 2 training rotations • Increase in Aboriginal and Torres Strait Islander trainees • Psychiatry trainees experience a more comprehensive training rotation • Increased access to local care for local communities in MM4–7 (e.g. reduction of locums, reduction of fly-in, fly-out models from metropolitan services, increased outreach services from regional centres)	• Rural DoTs are leveraged to support post allocation and accreditation	• Increased opportunities for psychiatry trainees to undertake training rotations servicing First Nations communities	• Reduction in costs incurred by health services due to: – Reduced use of locums – Reduced use of FIFO consultants • Improved continuity of care due to reduced use of locums and FIFO consultants
Excellent	Achieves well above contractual requirements As above plus • 10% (3) posts in private settings • 20% of PWP psychiatry trainees identify as Aboriginal or Torres Strait Islander • At least 50% (15) of posts provide services to Aboriginal	As above, plus downstream impacts have been achieved • Increase in Aboriginal and Torres Strait Islander trainees in posts that provide services to Aboriginal and Torres Strait Islander communities • End-to-end training available at a health service/region	Forms integral alliances with external programs As above plus • Health services work together to form rural training networks enabling trainees to complete the majority of their training in one area/region	Significant activity has occurred to improve equity As above plus • Increased opportunities for doctors in rural and remote areas (MM4–7)	Costs are significantly less than the value of the outcomes As above plus • End-to-end training networks promote consistency and continuity of care • End-to-end training networks enable trainees to complete

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RATING	EFFICIENCY (OUTPUTS)	EFFECTIVENESS (OUTCOMES/IMPACTS)	ENVIRONMENT	EQUITY	COST-EFFECTIVENESS
	and Torres Strait Islander communities	• Increased continuity of care for local communities because psychiatry trainees can complete end-to-end training locally • Reduced reliance on telehealth means more face-to-face clinical care for local communities	• Posts leverage remote supervision models to support trainees in MM5–7 • Posts create innovative models to incorporate extended settings for mandatory stage 2 rotations		their training in one region

Table 10.6: PIF

RATING	EFFICIENCY (OUTPUTS)	EFFECTIVENESS (OUTCOMES/IMPACTS)	ENVIRONMENT	EQUITY	COST-EFFECTIVENESS
Description	To what extent did the PIF activity meet contractual arrangements?	To what extent did the PIF activity achieve its intended objectives?	To what degree does the PIF activity integrate, rely on or support the broader external environment in which it operates?	Does the PIF activity focus on improving equity of access for • Rural and remote students • First Nations students	What is the average cost of PIF delivery per: • Active member* • Member who transitions to fellowship What is the administration ratio of total PIF costs?
Poor	Does not satisfy contractual requirements • No increase in PIF membership	Has not achieved expected outcomes • Less than 50% of PGY2+ members commence a fellowship with RANZCP • No increase in level of awareness of psychiatry as a specialist stream in medicine	Operates in isolation • PIF does not engage with other psychiatry awareness activities	No specific focus on equity • No additional focus or support for rural and remote PIF members, or Aboriginal and Torres Strait Islander PIF members	Costs are significantly greater than the value of the outcomes • PIF activities incur costs over the budget as per the grant agreement • Cost per active PIF member is greater than $165^

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RATING	EFFICIENCY (OUTPUTS)	EFFECTIVENESS (OUTCOMES/IMPACTS)	ENVIRONMENT	EQUITY	COST-EFFECTIVENESS
		• No growth in opportunities for PIF members to attend PIF events			• Average cost per PIF member that transitions to fellowship training is greater than $1,500^ per annum • Ratio of administration costs to activities is more than 35%^
Adequate	Has met contractual requirements • Increase in PIF membership • Increase in PIF membership with members located outside MM1 • PIF activities conducted	Has achieved some expected outcomes, but not at a level reflective of program maturity • 50 to 64% of doctors who commence a fellowship with RANZCP were PIF members • Increased awareness of psychiatry as a specialist stream in medicine • Increased opportunities for PIF members to attend PIF events	Aware of external programs that may influence outcomes, and adjusts in response to them • PIF is aware of several external programs and has used this information to tailor its approach	Awareness of diversity in the cohort • Rural and remote and Aboriginal and Torres Strait Islander PIF members are identified	Costs are equal to the value of the outcomes • PIF activities are conducted within budget as per the grant agreement • Cost per active PIF member is less than or equal to $165 • Average cost per PIF member that transitions to fellowship training is less than $1,500 • Ratio of administration costs to activities is equal to or less than 35%
Good	Achieves above contractual requirements • Over 20% increase in PIF membership annually	Has achieved expected outcomes, reflective of program maturity	Works collaboratively with and/or leverages external programs to create synergistic outcomes	A small number of activities are undertaken to improve equity for the cohort	Costs are less than the value of the outcomes • PIF activities incur costs less than budget as per the grant agreement

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RATING	EFFICIENCY (OUTPUTS)	EFFECTIVENESS (OUTCOMES/IMPACTS)	ENVIRONMENT	EQUITY	COST-EFFECTIVENESS
	• Over 10% increase in PIF members located outside MM1 • Increase in sponsorship of university student groups and events • Formal strategy to target and engage rural and remote PIF members	• 65 to 79% of doctors who commence a fellowship with RANZCP were PIF members • Continued active engagement with the PIF • Rural medical students have more opportunities to explore psychiatry as a specialist stream • Increase in platforms for medicine students to discuss and explore psychiatry as a specialist stream and potential career pathway	• PIF routinely engages with external programs such as AMSA, universities, RANZCP branches and faculties, RTHs, and together they co-design psychiatry awareness programs/campaigns • Collaborative events reduce activity costs through co-contribution and shared resources	• Rural and remote PIF members are prioritised for travel bursaries to attend the Psychiatry Congress in metropolitan locations • Aboriginal and Torres Strait Islander PIF members prioritised for scholarships • Reduced costs incurred for regional and rural members to attend PIF events	• Cost per active PIF member is less than or equal to $150 • Average cost per PIF member that transitions to fellowship training is less than or equal to $1,300 per annum • Ratio of administration costs to activities is equal to or less than 30%
Excellent	Achieves well above contractual requirements • 30% increase in PIF membership • 20% increase in PIF members located outside MM1 • Increase in collaborative events with universities, regional training hubs • Increase in regional and rural PIF events	As above, plus downstream impacts have been achieved • More than 80% of doctors who commence a fellowship with RANZCP were PIF members • Collaborative relationships with universities/rural training hubs to strengthen medical training pathways in rural and remote areas • Increased number of psychiatrists • Increased number of psychiatrists in rural areas	Forms integral alliances with external programs • External programs depend on the PIF to operate effectively	Significant activity has occurred to improve equity • Regional and rural and Aboriginal and Torres Strait Islander PIF members can access face-to-face PIF events locally • Significantly reduced costs incurred for regional and rural members to attend PIF events	Costs are significantly less than the value of the outcomes • PIF activities incur costs less than budget as per the grant agreement • Cost per active PIF member is less than $130 • Average cost per PIF member that transitions to fellowship training is less than $1,000 • Ratio of administration costs to activities is equal to or less than 25%

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*Active member was defined as medical student or junior doctor in PGY 1 or 2
^Benchmark value determined based on an average cost of $250,000 for PIF activities plus $150,00 for RANZCP salaries and 35% administration costs, and an average active membership of 3,300 people or an average annual transition to fellowship of 351 people. Administration costs set at 35% based on estimates of administration for not-for-profit companies.

Table 10.7: Progress the Rural Psychiatry Roadmap, Activity 30 (remote supervision guidelines)

RATING	EFFICIENCY (OUTPUTS)	EFFECTIVENESS (OUTCOMES/IMPACTS)	ENVIRONMENT	EQUITY	COST-EFFECTIVENESS
Description	To what extent did the Roadmap 30 – remote supervision activity meet contractual arrangements?	To what extent did the Roadmap 30 – remote supervision activity achieve its intended objectives?	To what degree did the Roadmap 30 – remote supervision activity integrate, rely on or support the broader external environment in which it operates?	Does the Roadmap 30 – remote supervision activity focus on improving equity of access to psychiatry services for: • Rural and remote communities (including Aboriginal and Torres Strait Islander communities)?	Was the Roadmap 30 – remote supervision activity delivered on time and on budget?
Poor	Does not satisfy contractual requirements • Regulations for remote supervision, including remote case review and online clinical team meetings not developed and/or not endorsed by RANZCP	Has not achieved expected outcomes • Outcome not achieved	Operates in isolation • None realised	No specific focus on equity	Costs are significantly greater than the value of the outcomes • Activity 30 was not completed within the budget and the specified timelines
Adequate	Has met contractual requirements • Developed regulations for remote supervision, including remote case review and online clinical team meetings	Has achieved some expected outcomes • Additional training program levers available to expand training opportunities in rural and remote settings (MM5–7)	Aware of external programs that may influence outcomes, and adjusts in response to them • Makes use of existing approved training posts in MM5–7 areas	A moderate level of activity has occurred to increase equity • Remote supervision model developed	Costs are equal to the value of the outcomes • Activity 30 was completed on budget and within the specified timelines

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RATING	EFFICIENCY (OUTPUTS)	EFFECTIVENESS (OUTCOMES/IMPACTS)	ENVIRONMENT	EQUITY	COST-EFFECTIVENESS
Good	Achieves above contractual requirements • Regulations for remote supervision, including remote case review and online clinical team meetings were used in the pilot	Has achieved many expected outcomes, reflective of program maturity • Ongoing training opportunities in rural and remote areas (MM5–7) identified • Increased continuity of care for rural and remote communities	Works collaboratively with and/or leverages external programs to create synergistic outcomes • Works with hospitals and health services to attract new training post funding/accreditation that would not have been possible without remote supervision	A good level of activity has occurred to increase equity • Remote supervision model approved and piloted	Costs are less than the value of the outcomes • Activity 30 was completed for less than the budget and within the specified timelines
Excellent	Achieves well above contractual requirements • Regulations for remote supervision, including remote case review and online clinical team meetings, continued beyond the pilot	As above, plus downstream impacts have been achieved • Trainees undertaking training opportunities in rural and remote areas using remote supervision • Trainees feel equally supported and have a positive experience • Increased access to psychiatry services for rural and remote communities	Forms integral alliances with external programs As above plus • Forms part of a regional training network that allows trainee rotation to more remote locations	Significant activity has occurred to improve equity • Remote supervision model rolled out broadly	Costs are significantly less than the value of the outcomes As above • Reduction in locum and FIFO use and hence cost • Reduction in travel/relocation costs incurred by trainees as they are able to complete end-to-end training in one region

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Table 10.8: Progress the Rural Psychiatry Roadmap (activity 31)

RATING	EFFICIENCY (OUTPUTS)	EFFECTIVENESS (OUTCOMES/IMPACTS)	ENVIRONMENT	EQUITY	COST-EFFECTIVENESS
Description	To what extent did the Roadmap 31 – CL/CAP activity meet contractual arrangements?	To what extent did the Roadmap 31 – CL/CAP activity achieve its intended objectives?	To what degree did the Roadmap 31 – CL/CAP activity integrate, rely on or support the broader external environment in which it operates?	Does the Roadmap 31 – CL/CAP activity focus on improving equity of access to psychiatry services for: • Rural and remote communities (including Aboriginal and Torres Strait Islander communities)?	Was the Roadmap 31 – CL/CAP activity delivered on time and on budget?
Poor	Does not satisfy contractual requirements • Expanded settings and regulations where CL and CAP can be provided, recognising cumulative rotations and competencies across various settings not developed and/or not endorsed by RANZCP	Has not achieved expected outcomes	Operates in isolation None realised	No specific focus on equity	Costs are significantly greater than the value of the outcomes • Activity 31 was not completed on budget and within the specified timelines
Adequate	Has met contractual requirements • Broadened settings and regulations where CL and CAP can be provided, recognising cumulative rotations and competencies across various settings	Has achieved some expected outcomes, but not at a level reflective of program maturity • Additional training program levers available to expand CL and CAP training opportunities in rural and remote settings	Aware of external programs that may influence outcomes, and adjusts in response to them • Potential increase in CL and CAP service delivery capacity to rural and remote communities	A moderate level of activity has occurred to increase equity • Regulations for extended setting for CL/CAP developed	Costs are equal to the value of the outcomes • Activity 31 completed on budget and within specified timelines

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RATING	EFFICIENCY (OUTPUTS)	EFFECTIVENESS (OUTCOMES/IMPACTS)	ENVIRONMENT	EQUITY	COST-EFFECTIVENESS
Good	Achieves above contractual requirements • CL and CAP expanded settings in rural areas endorsed by RANZCP	Has achieved expected outcomes, reflective of program maturity • Increase in CL and CAP training opportunities in rural and remote areas	Works collaboratively with and/or leverages external programs to create synergistic outcomes • Increased continuity of care for rural and remote communities	A good level of activity has occurred to increase equity • Extended settings for CL/CAP approved and piloted	Costs are less than the value of the outcomes • Activity 31 completed under budget and within specified timelines • Reduction in costs incurred by trainees as able to complete end-to-end fellowship in the region
Excellent	Achieves well above contractual requirements • CL and CAP expanded settings in rural areas piloted	As above, plus downstream impacts have been achieved • Increase in stage 2 training positions in rural and remote areas • Opportunities for expanded CL and CAP training in MM1–4 • Decreased length of fellowship training (reduced impact of bottleneck stages)	Forms integral alliances with external programs • Increased access to CL and CAP services to rural and remote communities	Significant activity has occurred to improve equity Extended settings for CL/CAP rolled out broadly	Costs are significantly less than the value of the outcomes • Reduction in costs incurred by health services to use locums/FIFO consultants to deliver CL and CAP • Reduction in the cost of fellowship training

Table 10.9: Postgraduate Certificate in Clinical Psychiatry

RATING	EFFICIENCY (OUTPUTS)	EFFECTIVENESS (OUTCOMES/IMPACTS)	ENVIRONMENT	EQUITY	COST-EFFECTIVENESS
Description	To what extent did the Certificate activity meet contractual arrangements?	To what extent did the Certificate activity achieve its intended objectives?	To what degree did the Certificate activity integrate, rely on or support the	Does the Certificate activity focus on improving equity	Was the Certificate activity delivered on time and on budget?

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RATING	EFFICIENCY (OUTPUTS)	EFFECTIVENESS (OUTCOMES/IMPACTS)	ENVIRONMENT	EQUITY	COST-EFFECTIVENESS
			broader external environment in which it operates?	of access to psychiatry services for: • Rural and remote communities (including Aboriginal and Torres Strait Islander communities)?	
Poor	Does not satisfy contractual requirements • Insufficient demand and capacity to offer at least one intake per year	Has not achieved expected outcomes • Limited opportunities for medical practitioners to upskill in clinical psychiatry	Operates in isolation • None realised	No specific focus on equity • Does not prioritise applicants who service rural and remote communities or Aboriginal and Torres Strait Islander communities	Costs are significantly greater than the value of the outcomes • Course revenue per participant is less than the unit cost per participant
Adequate	Has met contractual requirements • Expert working group established • Training content developed and endorsed by RANZCP	Has achieved some expected outcomes, but not at a level reflective of program maturity • Expression of interest from the medical workforce to complete the Certificate	Aware of external programs that may influence outcomes, and adjusts in response to them • Other colleges (e.g. ACRRM, RACGP and ACEM) engaged during development	A moderate level of activity has occurred to increase equity • Has processes to prioritise applicants who service rural and remote communities or Aboriginal and Torres Strait Islander communities	Costs are equal to value of the outcomes • Developed within the budget and timeframes
Good	Achieves above contractual requirements • Two intakes of course participants per year	Has achieved expected outcomes, reflective of program maturity	Works collaboratively with and/or leverages external programs to create synergistic outcomes	A good level of activity has occurred to increase equity As above plus	Costs are less than value of the outcomes

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RATING	EFFICIENCY (OUTPUTS)	EFFECTIVENESS (OUTCOMES/IMPACTS)	ENVIRONMENT	EQUITY	COST-EFFECTIVENESS
		• Sustained uptake and completion of the Certificate (at least 80% of participants complete the Certificate) • Medical practitioners have increased access to workplace-based mental health training • Medical practitioners upskilled in mental health across different healthcare settings	• RANZCP fellows are engaged and participate as supervisors • CPD recognised by other relevant specialist colleges	• Active marketing of the Certificate to doctors who service rural and remote communities or Aboriginal and Torres Strait Islander communities	• Delivery of the Certificate is 75% cost-neutral
Excellent	Achieves well above contractual requirements • Sufficient demand and capacity for two course intakes per year	As above, plus downstream impacts have been achieved • 100% of participants complete the Certificate within two years • Sustain pipeline of participants	Forms integral alliances with external programs • Strengthened professional relationships and referral pathways between medical practitioners and psychiatrists	Significant activity has occurred to improve equity As above plus • Additional incentives for doctors who service rural and remote communities or Aboriginal and Torres Strait Islander communities (e.g. discount on fees)	Costs are significantly less than the value of the outcomes • Delivery of the Certificate is cost-neutral (course revenue per participant equals the unit cost per participant)

In addition to the evaluation rubrics for the PWP activities, HMA prepared a rubric for RANZCP's support network for Aboriginal and Torres Strait Islander psychiatry trainees. As this activity is not funded under the PWP, it has not been included in the detailed assessment in Chapter 8, although an indicative rating is provided via the green shading. Similarly, as this activity is not part of the PWP, costing information was not made available. Therefore, cost-effectiveness analysis was not possible.

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Table 10.10: Support network for Aboriginal and Torres Strait Islander psychiatry trainees

RATING	EFFICIENCY (OUTPUTS)	EFFECTIVENESS (OUTCOMES/IMPACTS)	ENVIRONMENT	EQUITY	COST-EFFECTIVENESS
Description	To what extent did the Aboriginal and Torres Strait Islander support network activity meet contractual arrangements?	To what extent did the Aboriginal and Torres Strait Islander support network activity achieve its intended objectives?	To what degree does the Aboriginal and Torres Strait Islander support network activity integrate, rely on or support the broader external environment in which it operates?	Does the Aboriginal and Torres Strait Islander support network activity focus on improving equity for Aboriginal and Torres Strait Islander psychiatry trainees?	Costing information not available – N/A
Poor	Does not satisfy contractual requirements • Network for Aboriginal and Torres Strait Islander psychiatry trainees is still under development	Has not achieved expected outcomes • Limited to no engagement with the Network by Aboriginal and Torres Strait Islander psychiatry trainees	Operates in isolation	No specific focus on equity	
Adequate	Has met contractual requirements • Network is developed and available for Aboriginal and Torres Strait Islander psychiatry trainees	Has achieved some expected outcomes, but not at a level reflective of program maturity • Ongoing engagement with the Network by Aboriginal and Torres Strait Islander psychiatry trainees • Psychiatry trainees who identify as Aboriginal and Torres Strait Islander can connect more readily with each other	Aware of external programs that may influence outcomes, and adjusts in response to them • Aware of AIDA's Specialist Trainee Program	A moderate level of activity has occurred to increase equity • All Aboriginal and Torres Strait Islander psychiatry trainees have access to peer support	

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RATING	EFFICIENCY (OUTPUTS)	EFFECTIVENESS (OUTCOMES/IMPACTS)	ENVIRONMENT	EQUITY	COST-EFFECTIVENESS
Good	Achieves above contractual requirements • At least 50% of Aboriginal and Torres Strait Islander psychiatry trainees access the support network for Aboriginal and Torres Strait Islander psychiatry trainees	Has achieved expected outcomes, reflective of program maturity • Increase in psychiatry trainees who identify as Aboriginal and Torres Strait Islander	Works collaboratively with and/or leverages external programs to create synergistic outcomes • Links with AIDA's Specialist Trainee Program	A good amount of activity has occurred to increase equity • Increased opportunities for Aboriginal and Torres Strait Islander psychiatry trainees to access an Indigenous mentor	
Excellent	Achieves well above contractual requirements • At least 80% of Aboriginal and Torres Strait Islander psychiatry trainees access the support network for Aboriginal and Torres Strait Islander psychiatry trainees	As above, plus downstream impacts have been achieved • Increase in psychiatry trainees who identify as Aboriginal and Torres Strait Islander completing their fellowship	Forms integral alliances with external programs As above plus • Leverages activities from AIDA to ensure non-duplication of efforts while maintaining support for Aboriginal and Torres Strait Islander trainees	Significant activity has occurred to improve equity As above	

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APPENDIX D PWP CONTEXT

The following tables provide additional information on the context in which PWP operated. Table 10.11 compares Commonwealth funding mechanisms for psychiatry training. Table 10.12 compares mental health training programs available to non-psychiatrists.

Table 10.11: Psychiatry training program funding streams

TRAINING PROGRAM	NUMBER OF TRAINING POSTS	FUNDING	ADDITIONAL SUPPORTS
PWP	30	$107,268.16 (ex. goods and services tax (GST)) salary contribution per FTE per year	Rural loading $17,500–$30,000 $90,000 (ex. GST) for 0.33 FTE training supervisor PICS allowance $30,000
STP	≈140 in psychiatry (920 total)	$107,268.16 (ex. GST) salary contribution per FTE per year	Rural loading up to $30,000, PICS allowance up to $30,000 Back to Country grants $3,000
IRTP	≈20 FTE in psychiatry (100 FTE total)	$153,24.23 (ex. GST)*	N/A
MVPTP	10	$106,890 (ex. GST) salary contribution	Rural loading $10,363.24–$25,908.10 Private sector load for infrastructure and clinical supervision $12,954.05–$31,089.72
Tasmanian Project	3 in psychiatry	Indexed annually	Funding for tutorials, subsidised workshops, and advanced training and educational grants

*Salary contribution inclusive of salary support, rural support (education and relocation), minor infrastructure and supervision

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Figure 10.2: Mental health training pathways for medical practitioners

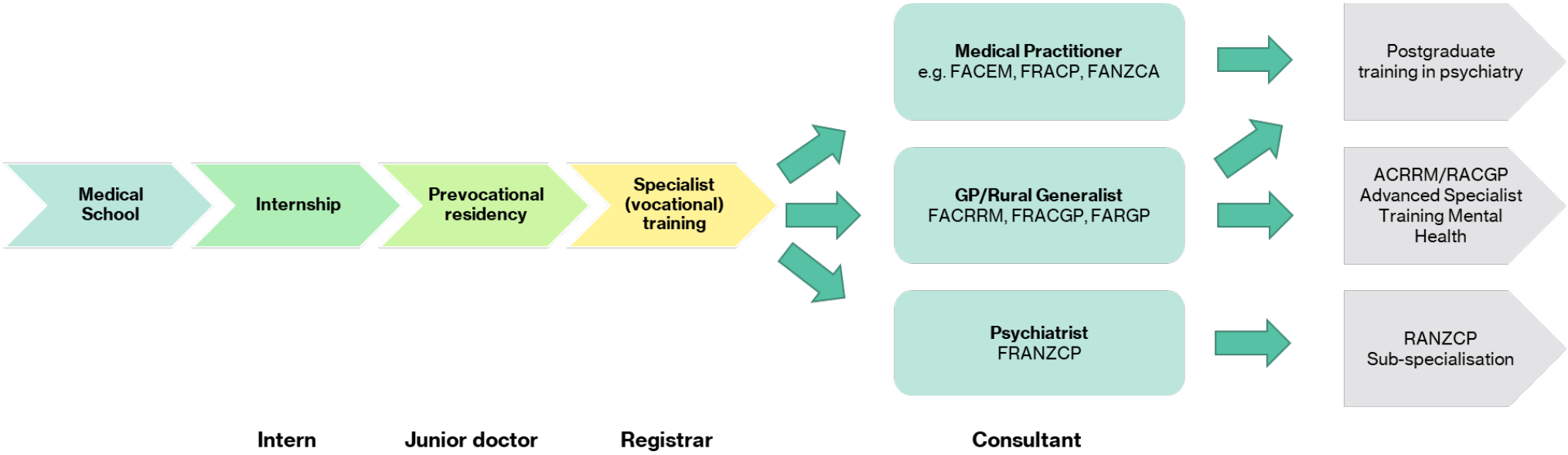

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Table 10.12: Comparison of mental health training programs

	POSTGRADUATE CERTIFICATE IN CLINICAL PSYCHIATRY	ACRRM ADVANCED SPECIALISED TRAINING – MENTAL HEALTH	RACGP ADVANCED RURAL SKILLS TRAINING – MENTAL HEALTH	MENTAL HEALTH SKILLS TRAINING	NSW HETI MASTER OF PSYCHIATRY	UNIVERSITY-LED MASTER OF PSYCHIATRY
Organisation	RANZCP	ACRRM	RACGP	GPMHSC-accredited course providers	NSW HETI	University of Melbourne Monash University
Eligible participants	PGY5+ medical professionals	ACRRM fellowship trainees PGY2+ medical practitioners	RACGP rural generalist fellowship trainees GPs seeking admittance to the FRACGP-RG	GP registrars GPs	RANZCP fellows and trainees RACGP fellows and trainees RANZCP fellows and trainees	Registered and practising medical professionals (PGY1+)
Purpose	Clinical skillset expansion in mental health	Clinical skillset expansion in mental health Advanced mental health skills in rural settings	Clinical skillset expansion in mental health Advanced mental health skills in rural settings	Clinical skillset expansion in mental health	Expansion of mental health knowledge Clinical skillset expansion in mental health	Expansion of mental health knowledge
Duration	12 months minimum (up to 4 years to complete all requirements)	12 months	12 months	6–21 CPD hours	1 to 3 years	1 year full-time/3 years part-time
Mode of delivery	Workplace-based training	Workplace-based training	Workplace-based training	Online and/or face-to-face	Online and/or face-to-face	Online and/or face-to-face
Supervision	Supervised by a fellow of RANZCP (consultant psychiatrist)	Supervised by a specialist psychologist, psychiatrist, or GP with an appropriate skill set	Supervised by a rural GP supervisor/mentor, a medical educator and a clinical psychiatrist who is a fellow of RANZCP	Not applicable	As per fellowship supervision requirements for trainees	Not applicable
Cost	$12,500 for 24 months enrolment	ACRRM fellowship training pathway funded through the Australian General Practitioner Training (AGPT) pathway	RACGP fellowship funded through AGPT Self-funded RACGP fellowship training pathways; fees dependent	$1,200–$1,800	$3,000 for NSW doctors $17,820 for non-NSW doctors ($2,970 per semester)	$28,200–$34,451

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	POSTGRADUATE CERTIFICATE IN CLINICAL PSYCHIATRY	ACRRM ADVANCED SPECIALISED TRAINING – MENTAL HEALTH	RACGP ADVANCED RURAL SKILLS TRAINING – MENTAL HEALTH	MENTAL HEALTH SKILLS TRAINING	NSW HETI MASTER OF PSYCHIATRY	UNIVERSITY-LED MASTER OF PSYCHIATRY
		Self-funded ACRRM fellowship training pathways; fees dependent on supervision and assessments $3,619.50 for PGY2+ medical practitioners (application and administration fee)	on supervision and assessments $2,800 (ex. registration fees)			

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APPENDIX E PIF ACTIVITIES, PROGRAM AND FINANCIAL DATA

Table 10.13 provides information on PIF activities undertaken by RANZCP from 2022 to 2025, including the type of activity/event, the location, number of attendees and number of scholarships provided.

Table 10.13: PIF activities January 2023 to June 2025

YEAR	ACTIVITY TYPE	PIF INVOLVEMENT	INTERNAL OR EXTERNAL	ACTIVITY	MODE	LOCATION	ATTENDANCE	PIF SPONSORSHIP
2022	event	supported	internal	PIF program at Congress	in-person	UNK	UNK	33
2022	event	supported	internal	QLD branch conference	in-person	Queensland	UNK	1
2022	event	supported	internal	WA branch conference	in-person	Western Australia	UNK	1
2022	event	supported	internal	TAS psychiatry conference	in-person	Tasmania	UNK	3
2022	event	supported	internal	VIC branch conference	in-person	Victoria	UNK	3
2022	event	supported	internal	Faculty conference	in-person	New South Wales	UNK	2
2022	event	supported	internal	Faculty conference	in-person	UNK	UNK	5
2022	event	supported	internal	Faculty conference	in-person	Queensland	UNK	5
2022	event	supported	internal	Faculty conference	in-person	UNK	UNK	3
2022	scholarship	supported	external	AMSA rural placement scholarship	in-person	UNK	UNK	3
2022	event	supported	external	AIDA conference	in-person	UNK	UNK	5
2023	event	hosted	internal	PIF retreat	in-person	Melbourne	20	20
2023	webinar	hosted	internal	Introduction to Psychiatry short course	in-person	Darwin	19	19
2023	event	supported	internal	SA branch conference	in-person	Adelaide	1	1
2023	webinar	hosted	internal	RANZCP Training Program webinar	online	N/A	150	0
2023	event	hosted	internal	PIF at Congress	in-person	Perth	34	30
2023	event	supported	internal	Faculty conference	in-person	Sydney	6	6
2023	event	supported	internal	PIF member networking at Uni Adelaide	in-person	Adelaide	6	0
2023	event	supported	internal	PIF member networking at Uni QLD	in-person	Brisbane	12	0

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YEAR	ACTIVITY TYPE	PIF INVOLVEMENT	INTERNAL OR EXTERNAL	ACTIVITY	MODE	LOCATION	ATTENDANCE	PIF SPONSORSHIP
2023	event	supported	internal	QLD branch conference	in-person	QLD	2	2
2023	event	supported	internal	ACT travelling scholar dinner and presentation	in-person	Canberra	2	2
2023	event	supported	internal	Faculty conference	in-person	Hobart	2	0
2023	event	supported	internal	Faculty conference	in-person	Noosa	2	2
2023	event	supported	internal	Faculty conference	in-person	QLD	6	6
2023	event	supported	internal	Faculty conference	in-person	Northern Territory	3	5
2023	event	supported	internal	Tasmanian branch CPD dinner	in-person	Tasmania	4	6
2023	event	supported	internal	Networking event	in-person	Darwin	2	0
2023	event	supported	internal	NT branch event	in-person	Darwin	2	0
2023	event	supported	internal	Online short course	online	N/A	66	0
2023	webinar	supported	internal	Branch conference	in-person	NSW	2	2
2023	event	supported	internal	FPOA conference	in-person	Melbourne	6	6
2023	event	supported	internal	Faculty conference	in-person	Sydney	4	4
2023	competition	supported	internal	Essay competition	N/A	N/A	0	0
2023	event	supported	internal	Branch conference	in-person	VIC	2	2
2023	webinar	hosted	internal	PIF Australian webinar	online	N/A	N/A	N/A
2023	event	supported	external	Adelaide University Psychiatry Society events	in-person	Adelaide	50	0
2023	event	supported	external	Bond University Psychiatry Association events	in-person	Gold Coast	110	0
2023	event	supported	external	Curtin Association of Medical Students events	in-person	Perth	81	0
2023	event	supported	external	Deakin University Medical Students Association events	in-person	Melbourne	35	0
2023	event	supported	external	Deakin University Psychiatry Interest Group events	in-person	Melbourne	35	0
2023	event	supported	external	Flinders University Medical Students Society events	in-person	Adelaide	140	0

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YEAR	ACTIVITY TYPE	PIF INVOLVEMENT	INTERNAL OR EXTERNAL	ACTIVITY	MODE	LOCATION	ATTENDANCE	PIF SPONSORSHIP
2023	event	supported	external	James Cook University Medical Students Association events	in-person	QLD	30	0
2023	event	supported	external	Griffith University Psychiatry Society events	in-person	QLD	20	0
2023	event	supported	external	Monash University Medical Students events	in-person	Melbourne	60	0
2023	event	supported	external	Monash University Psychiatry Society of Monash events	in-person	Melbourne	50	0
2023	event	supported	external	University of Newcastle Medical Society events	in-person	NSW	50	0
2023	event	supported	external	University of New South Wales Psychiatry Society events	in-person	NSW	50	0
2023	event	supported	external	University of Notre Dame MANDUS event	in-person	Sydney	39	0
2023	event	supported	external	University of Queensland Medical Society events	in-person	QLD	27	0
2023	event	supported	external	University of Queensland Medical Society events	in-person	QLD	35	0
2023	event	supported	external	University of Queensland events	in-person	QLD	27	0
2023	event	supported	external	University of Tasmania Medical Students Society events	in-person	Tasmania	100	0
2023	event	supported	external	University of Melbourne Psychiatry Students' Interest Society events	in-person	Melbourne	50	0
2023	event	supported	external	University of Western Australia Medical Students Society	in-person	WA	30	0
2023	event	supported	external	Conference	in-person	Sydney	150	0
2023	event	supported	external	Adelaide Pre-Vocational Psychiatry program	in-person	Adelaide	40	0
2023	event	supported	external	Careers expo	in-person	NT	120	0
2023	event	supported	external	Australian Indigenous Doctors' Association	in-person	N/A	15	0
2023	event	supported	external	MD student conference	in-person	Melbourne	1400	0

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YEAR	ACTIVITY TYPE	PIF INVOLVEMENT	INTERNAL OR EXTERNAL	ACTIVITY	MODE	LOCATION	ATTENDANCE	PIF SPONSORSHIP
2023	event	supported	external	Various Australian Medical Students' Association events	in-person	N/A	N/A	N/A
2023	event	supported	external	Australian Indigenous Doctors' Association Conference	in-person	Hobart	10	4
2023	event	supported	internal	Rural training pathways congress	in-person	VIC	3	4
2024	event	supported	internal	Introduction to Psychiatry short course	in-person	Orange	22	22
2024	event	supported	internal	Branch conference	in-person	SA	6	6
2024	webinar	supported	internal	RANZCP Training Program webinar	online	N/A	120	0
2024	event	supported	internal	PIF Congress program	in-person	Canberra	30	30
2024	event	promoted	internal	Networking event	in-person	ACT	14	0
2024	event	supported	internal	RANZCP conference	in-person	Healesville, Vic	2	2
2024	event	supported	internal	Branch conference	in-person	QLD	2	2
2024	event	supported	internal	Faculty conference	in-person	Sydney	4	4
2024	event	supported	internal	Faculty conference	in-person	Christchurch, NZ	3	3
2024	event	supported	internal	ACT travelling scholar dinner and presentation	in-person	ACT	2	4
2024	event	hosted	internal	PIF retreat	in-person	Brisbane	22	22
2024	event	supported	internal	Branch conference	in-person	WA	3	2
2024	event	hosted	external	PIF networking activity	in-person	WA, Sydney	3	0
2024	event	supported	internal	Presentation	in-person	SA	1	0
2024	event	supported	internal	Faculty conference	in-person	Gold Coast	21	25
2024	webinar	supported	internal	PIF introduction to psychiatry online short course	online	N/A	75	0
2024	event	supported	internal	Neuropsychiatry conference	in-person	Melbourne	4	4
2024	event	supported	internal	Branch conference	in-person	VIC	2	2
2024	event	supported	internal	Faculty conference	in-person	Christchurch, NZ	2	2
2024	competition	hosted	internal	PIF essay competition	N/A	N/A	N/A	N/A
2024	event	supported	internal	Branch conference	in-person	Tasmania	1	2

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YEAR	ACTIVITY TYPE	PIF INVOLVEMENT	INTERNAL OR EXTERNAL	ACTIVITY	MODE	LOCATION	ATTENDANCE	PIF SPONSORSHIP
2024	webinar	supported	internal	PIF pre-recorded webinar	online	Tasmania	N/A	N/A
2024	event	supported	external	Deakin University Psychiatry Interest Group events	in-person	Melbourne	140	0
2024	event	supported	external	Flinders University Medical Students Society events	in-person	Adelaide	50	0
2024	event	supported	external	James Cook Psychiatry Interest Group events	in-person	QLD	40	0
2024	event	supported	external	Macquarie University Medicine Society events	in-person	Sydney	30	0
2024	event	supported	external	Monash University Medical Society events	in-person	Melbourne	250	0
2024	event	supported	external	Monash University Psychiatry Society of Monash events	in-person	Melbourne	80	0
2024	event	supported	external	Adelaide University Psychiatry Society events	in-person	Adelaide	150	0
2024	event	supported	external	University of Melbourne Psychiatry Students' Interest Society events	in-person	Melbourne	550	0
2024	event	supported	external	University of Melbourne Medical Student Society events	in-person	Melbourne	50	0
2024	event	supported	external	University of Melbourne Student Conference	in-person	Melbourne	3000	0
2024	event	supported	external	University of New South Wales Psychiatry Society events	in-person	Sydney	380	0
2024	event	supported	external	University of New South Wales Medical Society events	in-person	Sydney	230	0
2024	event	supported	external	University of Newcastle Medical Society events	in-person	Sydney	50	0
2024	event	supported	external	University of Queensland Psychiatry MD Society events	in-person	QLD	97	0
2024	podcast/panel	supported	external	University of Sydney Psychiatry Society events	online	Sydney	N/A	0

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YEAR	ACTIVITY TYPE	PIF INVOLVEMENT	INTERNAL OR EXTERNAL	ACTIVITY	MODE	LOCATION	ATTENDANCE	PIF SPONSORSHIP
2024	event	supported	external	University of Tasmania Medical Students Society events	in-person	Tasmania	300	0
2024	event	supported	external	AMA Medical Careers expo	in-person	Brisbane	200	0
2024	event	supported	external	NSW Conference	in-person	Sydney	150	0
2024	event	supported	internal	Information evening	in-person	NSW	15	0
2024	event	supported	external	Medical careers expo	in-person	WA	174	0
2024	event	supported	external	Careers expo	in-person	Darwin	120	0
2024	event	supported	external	Various Australian Medical Students' Association events	in-person	Sydney, Melbourne, Perth, Adelaide	N/A	0
2024	event	supported	external	Conference	in-person	Adelaide	5	5
2025	webinar	supported	internal	PIF introduction to psychiatry online short course	online	N/A	103	0
2025	event	supported	internal	Branch social sundowner	in-person	WA	1	0
2025	event	supported	internal	PIF retreat	in-person	Melbourne	23	0
2025	event	supported	internal	branch conference	in-person	SA	8	8
2025	event	supported	internal	RANZCP workshop	in-person	Cairns	3	0
2025	event	supported	internal	PIF networking activity	in-person	Tasmania/NSW	15	0
2025	event	supported	external	Curtin University Rural Health Club events	in-person	Perth	120	0
2025	event	supported	external	Monash University Medical Society events	in-person	Melbourne	130	0
2025	event	supported	external	Adelaide University Psychiatry Society events	in-person	Adelaide	25	0
2025	event	supported	external	University of Melbourne Psychiatry Students' Interest Society events	in-person	Melbourne	382	0
2025	event	supported	external	University of New South Wales Psychiatry Society events	in-person	NSW	215	0
2025	event	supported	external	University of Notre Dame events	in-person	WA/NSW	40	0
2025	event	supported	external	University of Queensland Psychiatry MD Society events	in-person	QLD	37	0

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YEAR	ACTIVITY TYPE	PIF INVOLVEMENT	INTERNAL OR EXTERNAL	ACTIVITY	MODE	LOCATION	ATTENDANCE	PIF SPONSORSHIP
2025	event	supported	external	AMA Medical Careers expo	in-person	Brisbane	200	0
2025	event	supported	external	Flinders NT medical careers expo	in-person	Darwin	120	0
2025	event	supported	external	MDSC Careers conference	in-person	Melbourne	1500	0
2025	event	supported	external	Careers pathway event	in-person	Mt Gambier, Riverland, Murray Bridge, Victor Harbour, Barossa	55	0
2025	event	supported	external	Rural health summit	in-person	Perth	4	4
2025	event	supported	external	Careers conference	in-person	Melbourne	N/A	N/A
2025	event	supported	external	AMSA National Convention	in-person	Sydney	4	4
2025	event	supported	internal	Rural placement scholarship	N/A	N/A	N/A	3
2025	resources	supported	internal	PIF resource updates	N/A	N/A	N/A	N/A
Total								341

UNK = unknown

PIF program data

Table 10.14 and Table 10.15 provide PIF membership data.

Table 10.14: PIF members by jurisdiction and MM setting in focus groups

ROW LABELS	MM1	MM2	MM3	MM4	UNKNOWN	GRAND TOTAL
NSW	4	1			1	6
med student	3				1	4
PGY1–2		1				1
PGY3+	1					1
QLD	1					1
med student	1					1
PGY3+	1					1
SA	1					1
PGY3+	1					1
VIC	7	3	1	1		12
med student	5	2	1			8
PGY1–2	1			1		2
PGY3+	1	1				2
WA	2					2
med student	1					1
PGY1–2	1					1
Total	15	4	1	1	1	22

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Table 10.15: MM2-7 and Indigenous PIF members sponsored 2022 to 2024

	MM2–7 PIF MEMBERS	INDIGENOUS PIF MEMBERS
2022	15	7
2023	33	12
2024	24	15
Total	72	34
% of total PIF members sponsored	21%	10%

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PIF financial data analysis

Table 10.16 to Table 10.20 provide analysis of PIF financial data, including event and activity costs, average program costs per PIF member transition and PIF staff resourcing estimates.

Table 10.16: 2023 PIF expenditure on activities

ACTIVITY	TOTAL SPENT (EX. GST)	% OF TOTAL SPENT
External events & activities		
AIDA, Tasmania)	$18,582	8%
Sponsorships	$14,545	
Other costs (staff travel, registration)	$4,036	
AMSA	$30,931	14%
Sponsorships	$26,720	
Other costs (staff travel, speaker fees)	$4,211	
PIF Support to Rural School or Regional Training Hub	$703	0%
Sponsorships	$703	
External career expo	$200	0%
Other costs (speaker fees)	$200	
Grant to the University Medical and Psychiatry Society	$14,360	6%
Sponsorships	$14,360	
Internal events & activities		
Branch sponsorships	$2,207	1%
Sponsorships	$2,207	
Facilitated Networking Activity	$4,600	2%
Other costs (speaker fees)	$4,600	
PIF Introduction to Psychiatry Online Short Course	$1,100	0%
Other costs (speaker fees)	$1,100	
PIF Introduction to Psychiatry Short Course (Darwin)	$22,697	10%
Other costs (catering, speaker fees, staff travel)	$8,976	
Sponsorships	$8,881	
Accommodation and catering	$4,840	
PIF program at Congress (Perth)	$80,597	36%
Other costs (booth, catering, staff travel, speaker fees)	$14,610	
Sponsorships	$65,987	
PIF Retreat (Melbourne)	$31,289	14%
Other costs (catering, speaker fees, excursion)	$5,335	
Sponsorships	$25,955	
Webinar	$550	0%
Other costs (speaker fees)	$550	
Essay competition	$2,295	1%
Other costs (advertising and promotion)	$544.67	
Other costs (Prize money to top three winners)	$1,750	
Merchandise & Resources		7%
Order, print and postage	$14,603	
Booklet – First Nations resources	$1,750	

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ACTIVITY	TOTAL SPENT (EX. GST)	% OF TOTAL SPENT
Total	$226,464	100%

Table 10.17: 2024 PIF expenditure on activities

PIF EVENTS & ACTIVITIES	TOTAL SPENT (EX. GST)	% OF TOTAL SPENT
External events & activities		
AMSA	$31,790	13%
Other costs (staff travel, speaker fees)	$4,913	
Sponsorships	$26,876	
Pacific Region Indigenous Doctors Congress (PRIDoC, Adelaide)	$25,097	10%
Sponsorships	$22,727	
Other costs (staff travel)	$2,370	
PIF Support to Rural School or Regional Training Hub	$1,000	0%
Sponsorships	$1,000	
External career expo	$2,025	1%
Other costs (speaker fees)	$450	
Sponsorships	$1,575	
Faculty of Forensic Psychiatry – Networking evening	$213	0%
Other costs (staff travel)	$213	
Grant to University Medical and Psychiatry Society	$11,998.73	5%
Sponsorships	$11,998.73	
Internal events & activities		
Branch sponsorships	$3,694	2%
Sponsorships	$3,694	
Facilitated Networking Activity	$2,699	1%
Other costs (speaker fees, venue, catering, speaker travel)	$2,699	
PIF Introduction to Psychiatry Online Short Course	$1,658	1%
Other costs (speaker fees)	$1,658	
PIF Introduction to Psychiatry Short Course (Orange)	$20,277	8%
Other costs (catering, speaker fees, staff travel, speaker travel)	$10,540	
Sponsorships	$9,737	
PIF program at Congress (Canberra)	$81,922	34%
Other costs (booth, catering, staff travel, speaker fees)	$11,063	
Sponsorships	$70,859	
PIF Retreat (Brisbane)	$33,528	14%
Other costs (staff travel, venue hire, IT support for recordings, catering, speaker fees & parking)	$13,028	
Sponsorships	$20,500	
Webinar	$900	0%
Other costs (speaker fees)	$900	
Essay competition winners	$1,750	
Merchandise & Resources		10%
Order, print and postage	$18,581	
Booklet – First Nations resource	$6,489	
Total	$241,875	100%

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Table 10.18: 2025 (Jan–Jun) PIF expenditure on activities

PIF EVENTS & ACTIVITIES	TOTAL SPENT (EX. GST)	% OF TOTAL SPENT
External events & activities		
AMSA	$19,141	12%
Other costs (staff travel, speaker fees)	$2,097	
Sponsorship	$17,043	
External career expo	$1,154	1%
Other costs (speaker fees, staff travel)	$1,154	
Grant to the University Medical and Psychiatry Society	$15,000	9%
Sponsorships	$15,000	
Internal events & activities		
Branch sponsorships	$1,363.63	1%
Sponsorships	$1,363.63	
PIF Introduction to Psychiatry Online Short Course	$1,300	1%
Other costs (speaker fees)	$1,300	
PIF program at Congress (Gold Coast) Note: *Estimated costs provided, as there are some pending internal reconciliations related to the Congress event	$80,346	50%
Other costs (booth, catering, pre-Congress session venue, speaker fees and staff travel)	$19,170	
Sponsorships	$61,176	
PIF Retreat (Melbourne)	$25,569.39	16%
Other costs (catering, speaker parking, excursion to Dax centre, speaker fees)	$6,294.09	
Sponsorships	$19,275.3	
Essay competition winners	$2,000	1%
Merchandise & Resources		
Order, print and postage	$15,565	10%
Total	$161,439	100%

Table 10.19: Average cost per PIF member transitioned in 2023 and 2024

	2023	2024	AVERAGE 2023 AND 2024
Total PIF expenditure	$738,953	$837,924	$788,439
Number of PIF members who transition to RANZCP	306	357	332

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	2023	2024	AVERAGE 2023 AND 2024
fellowship training			
Average cost per PIF member	$2,415	$2,347	$2,378

Table 10.20: PIF staff resources

PIF STAFF FTE	2023	2024	2025 (JAN TO JUN)
Total staff FTE	3.4 FTE	3.6 FTE	4.0 FTE
Average staff FTE (due to staff turnover)	3.06 FTE	3.5 FTE	3.37 FTE

PIF staff include one manager, two project officers, one administrative officer, and one marketing and administrative officer

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