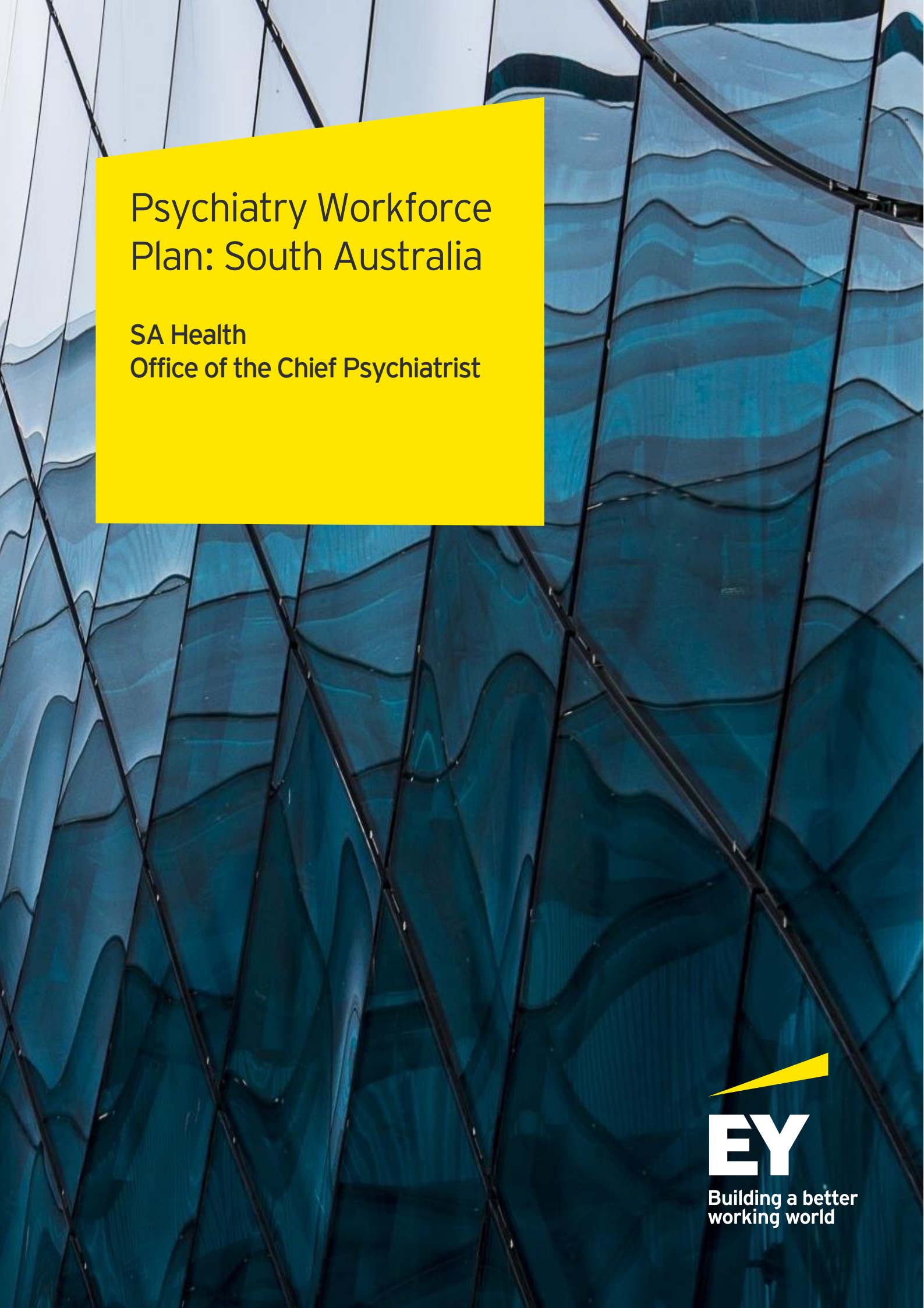

Psychiatry Workforce Plan: South Australia

SA Health
Office of the Chief Psychiatrist

Building a better working world

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Ernst & Young ("EY") was engaged on the instructions of SA Health ("Client") to develop a psychiatry workforce plan which includes modelling and supply options for the future psychiatry workforce needs over the next 10 years ("Project"), in accordance with the engagement agreement dated 10 October 2023 ("the Engagement Agreement").

The results of EY's work, including the assumptions and qualifications made in preparing the report, are set out in EY's report dated 23 September 2024 ("Report"). The Report should be read in its entirety including any disclaimers and attachments, the applicable scope of the work and any limitations. The limitations to the modelling are outlined throughout the Report, including in Modelling approach – Supplementary information. A reference to the Report includes any part of the Report.

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Executive summary

Executive summary

South Australia's psychiatry workforce is an important part of the state's mental health workforce. It provides essential services to some of the state's most vulnerable people. SA Health's Office of the Chief Psychiatrist (OCP) engaged EY to develop a workforce plan that identifies and addresses the state's psychiatrist shortage, with a specific focus on child and adolescent mental health services. The South Australian Government is committed to not only addressing immediate needs, but also laying the foundations for future generations.[1] This work was undertaken as part of an election commitment from the current government, to invest in developing a long-term workforce plan addressing critical workforce shortages in psychiatry in South Australia (State). The intention of the commitment was to have a specific focus on child and adolescent mental health services, given this had been observed by the OCP as a key pressure point in the State's ability to train new psychiatrists.

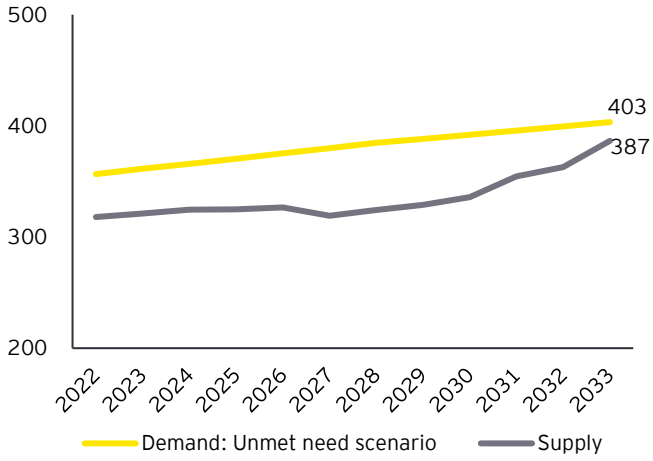
The South Australian Government has invested in a Mental Health Services Plan 2020-2025 (the Plan) with the accountability for Local Health Networks (LHNs) and non-government organisations (NGOs) commissioned to deliver the outcomes of the Plan. As LHNs progress their implementation of the Plan, they should have a model of care that translates the way in which services are provided using contemporary evidence. Models of care operationalise how best practice care can be delivered at the individual person, service, or systems level and should be developed to improve clinical and process outcomes, translate evidence into practice, and use resources efficiently. A contemporary model of care should describe the way in which the mental health workforce provides evidence-based interventions, including how psychiatrist time is planned.

The workforce modelling in this assessment is based on current models of care in South Australia, utilising currently available data. Changes to the models of care (e.g., by implementing recommendations in this plan) may have a significant and material impact on the estimate of psychiatry demand and projected workforce shortages or surpluses. Further information is provided in Box 1 on page 5.

Considering current practices, the number of psychiatrists is not expected to meet demand over the next 10 years, with the largest shortfall in 2027

In 2022, there were 318 full time equivalent (FTE)[2] psychiatrists in South Australia, a shortfall of 39 to meet unmet demand under current practices and models of care. The current workforce is ageing and unevenly distributed across regions; regional and remote areas have fewer psychiatrists relative to the population than for urban areas. Other issues impacting the current workforce include that some psychiatrists work substantially more than the 40-hour work week, and there are currently estimated to be 17 open but unfilled roles in South Australia, increasing to 23 in late 2025 due to the opening of new mental health units.

Figure 1 Projected supply and demand of psychiatrists (without intervention), FTE, 2022-33, South Australia



Over the next 10 years, the demand for psychiatry services is projected to increase in volume. During this time, the number of psychiatrists in South Australia is forecast to increase to 387 FTE. Despite this increase, the projected number of psychiatrists is not expected to meet demand by 2033.

Psychiatry shortages are expected to intensify over the next 3 to 5 years, as the demand is forecast to grow concurrently with potential psychiatrist retirements. While the shortfall of psychiatrists is projected to be 17 FTE in 2033[3], the gap is forecast to be largest in 2027, with supply projected to fall short of demand by 61 FTE.

[1] *Better mental health for young people including innovative virtual care program* (2024) *Premier of South Australia*. Available at: https://www.premier.sa.gov.au/media-releases/news-items/better-mental-health-for-young-people-including-innovative-virtual-care-program (Accessed: 23 July 2024).
[2] FTE is considered 40 hours of work per week for psychiatrists, including both clinical and non-clinical time. However, some psychiatrists work more than 40 hours.
[3] Note the 2033 shortfall varies slightly from the difference between supply and Unmet demand presented in the figure, due to rounding.

A key area of shortage is child and adolescent psychiatry

Within the sub-speciality area of child and adolescent psychiatry, there is forecast to be a shortage of 8 FTE psychiatrists in South Australia by 2033. This forecast considers the projected psychiatry need of the population aged 0-17 years, as well as the number of psychiatrists qualified to treat this population at the current estimated caseload. However, if there was a change in caseloads in order to meet a target ratio of 4.0 FTE per 100,000 population[4,5] a much greater number of child and adolescent psychiatrists would be required (see Box 1 on page 5).

South Australia psychiatry 10-year workforce plan

Implementing a range of actions in the SA Psychiatry Workforce Plan is expected to help reduce the projected workforce shortages over the next 10 years. This has the potential to close the shortfall by 2033. However, to address the largest projected shortfall of 61 FTE by 2027 is far more challenging, as there are limited strategies to increase supply within this timeframe.

The following table presents an overview of the key outcomes from the 10-year psychiatry workforce plan.

PLAN OUTCOME 1	Address the projected short- to medium-term shortfall with a dedicated workforce surge strategy	Place an immediate focus on strategies which will increase and/or retain workforce in the next 3-5 years. Deliberately over-recruit now (international/interstate), particularly in shortage areas such as child and adolescent psychiatry. Retain the existing workforce and slow down retirements. Review models of care and use adjacent workforces (such as GPs, clinical psychologists and nurse practitioners with a mental health specialty) to support psychiatry where possible. Extend access to telehealth which can be provided by interstate psychiatrists further in rural and remote area and metropolitan SA3 areas with limited supply.
PLAN OUTCOME 2	Increase the projected growth of the South Australian psychiatry workforce over the next decade	Expand training positions by 2 annually over the next decade. Recruit at least 10 psychiatrists from international or interstate sources. Prioritise specialties such as child and adolescent psychiatry and older person's psychiatry, and align recruitment with the projected peak in shortages expected in 2027. Purposeful recruitment of First Nations and CALD (Culturally and Linguistically Diverse) psychiatrists.
PLAN OUTCOME 3	Enable reskilling and redistribution to critical areas of need through systematic support	Reskill a number of practising psychiatrists and reassign them to high-demand areas. Prioritise child and adolescent psychiatry, with the objective of retraining at least 6 psychiatrists in this specialty by 2027, aligning with projected peak shortages. Concurrently, train GPs with psychiatry qualifications to help manage patient load. Use adjacent workforces (e.g., clinical psychologists, nurse practitioners with a mental health specialty) to support workload where possible.

[4] Every-Palmer S, Grant ML, Thabrew H. Young people don't tend to ask for help more than once: Child and adolescent psychiatrists' views on ailing mental health services for young New Zealanders. Australasian Psychiatry. 2022;30(6):684-688. doi:10.1177/10398562221115624

[5] https://www.parliament.nsw.gov.au/ladocs/submissions/58760/Submission%2054%20-%20Royal%20Australian%20and%20New%20Zealand%20College%20of%20Psychiatrists.pdf

PLAN OUTCOME 4	Modernise working experiences for psychiatrists, including streamlined administrative processes, a contemporary model of care for the mental health workforce and regular data-driven workforce planning	Retain the existing workforce via flexibility, mentorship, and professional development. Evaluate activities and tasks of psychiatrists, particularly administration. Review the current model of care. Prioritise implementation of changes which will increase the capacity of the existing psychiatry workforce. Ensure data-driven workforce planning and regular re-evaluations to effectively adapt to changes in supply and demand.
PLAN OUTCOME 5	Expand coverage of rural psychiatric demand	Implement recommendations from the Rural Mental Health Services Review. Over the next decade, incentivise and fund 10 full-time psychiatry positions in Country Local Health Networks. Maintain the Fly-in Fly-out model to supplement rural South Australian psychiatry services, with a view to expanding coverage as needed.

Box 1: Changes to models of care and improving estimates of emergency department demand could materially impact results

Changes to models of care

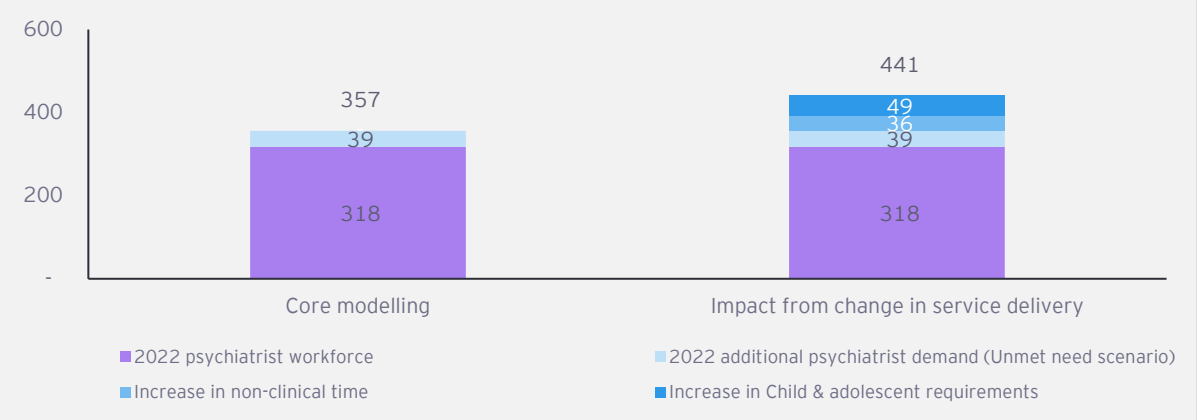
The workforce modelling has been based on current models of care in South Australia. The modelling would need to be updated should new models of care be introduced, and this could significantly change the results.

To illustrate, the Australian Government's National Mental Health Workforce Strategy 2022-32 utilises alternative model of care assumptions. The strategy estimates that about 60% of psychiatry demand is met nationally. This contrasts with this report's starting point, which suggests 89% of psychiatry demand is met in South Australia.

Changes to care models can greatly impact the projected need for psychiatrists, as demonstrated by the following examples:

- If psychiatrists spend 30% of their time on non-clinical activities[6] (up from 23% currently), an additional 36 psychiatry FTE would have been required in 2022. Non-clinical activities refer to important tasks such as research, teaching, quality, and safety.
- If a future model of care adopted a higher ratio of child and adolescent psychiatrists, such as 4.0 full-time equivalents per 100,000 people[7,8], the number of psychiatrists needed to meet current demand would approximately triple. This would mean an additional 49 full-time child and adolescent psychiatrists would have been required in 2022.s

Figure 2: Illustrative analysis: Impact on demand for psychiatrists from change in service delivery, Unmet need scenario, FTE, 2022, South Australia



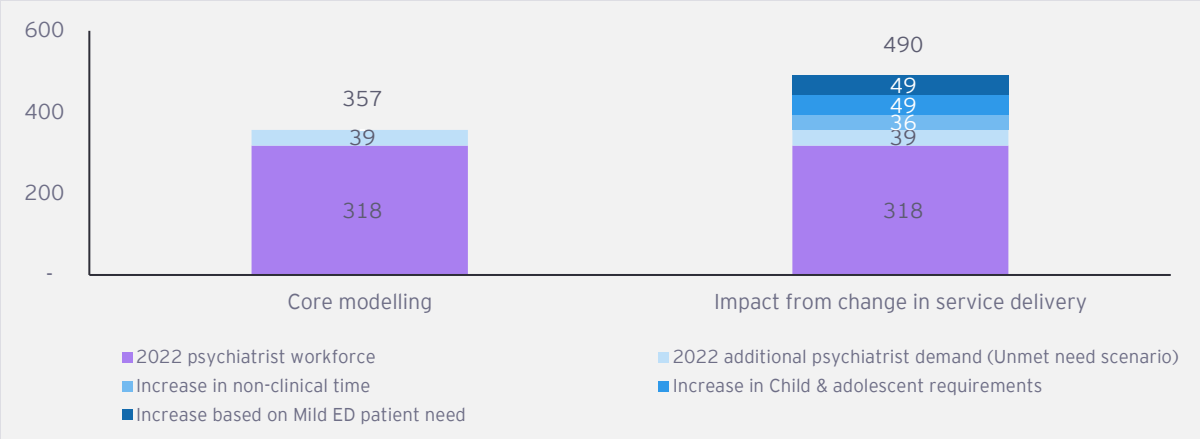
Improving estimates of psychiatry demand in emergency departments

The workforce modelling estimates psychiatry need based on South Australians estimated to have severe or moderate mental health conditions (see sections 1.3.4 and 3.1.2 for further detail). Accordingly, patients accessing mental health ED services are assumed to have severe or moderate need, but may actually have lower levels of need (for example, they may have a mild condition, see Appendix E for more detail). This would mean total need for psychiatrists is underestimated, as only severe and moderate need populations are included. If lower-need groups that use mental health ED services are included, the projected psychiatric demand would be higher and shortages greater.

For illustrative purposes, under an arbitrary assumption that 80% of unique mental health ED patients had mild or moderate conditions[9] that were not captured in the current need estimate, including these people would mean an additional 49 psychiatry FTE would have been required to service total demand in 2022.

Compared to the core modelling, the three examples in this Box would increase the estimated shortage from 39 to 172 psychiatrists in 2022 (Figure 3, below). Under these assumptions, the modelling suggests only 65% of psychiatry demand is met in South Australia.

Figure 3: Illustrative analysis: Impact on demand for psychiatrists from change in service delivery and ED, Unmet need scenario, FTE, 2022, South Australia



The analysis has limitations due to data gaps and assumptions about models of care and need for psychiatry. The workforce modelling results should be considered with these limitations in mind, noting that they could change the results in a material way. See Appendix E for further detail on the limitations of the analysis.

[6] The current agreement between SA Health and SASMOA is that approximately 30% of clinicians' time should be spent on these tasks, which includes approximately 10% on Professional Commitments, 5% on Teaching, 5% on Research, 7.5% on Quality and Safety and 2.5% on Audit.

[7] Every-Palmer S, Grant ML, Thabrew H. Young people don't tend to ask for help more than once: Child and adolescent psychiatrists' views on ailing mental health services for young New Zealanders. Australasian Psychiatry. 2022;30(6):684-688. doi:10.1177/10398562221115624

[8] https://www.parliament.nsw.gov.au/ladocs/submissions/58760/Submission%2054%20-%20Royal%20Australian%20and%20New%20Zealand%20College%20of%20Psychiatrists.pdf

[9] See section 3.1.2 for share of people with a moderate condition estimated to require psychiatry care.

1. Introduction

1. Introduction

1.1 Project background

Australian psychiatrists play a critical role in many aspects of mental health care management. They conduct extensive assessments, including physical exams and psychological evaluations, to accurately diagnose a multitude of mental health conditions. They offer treatments ranging from psychotherapy and psychopharmacology to other mental health interventions. Many Australian psychiatrists also dedicate themselves to research in their respective fields, contributing valuable findings and pioneering treatments. They train and educate other health care professionals. Aside from their specific roles, psychiatrists advocate for mental health awareness and policy reform in health care settings and communities. Their involvement extends to preventing the emergence of mental health illnesses, thereby minimising the likelihood of worsening symptoms and experiences for people with mental illness.

The South Australian Government has recognised a critical workforce shortage in psychiatry across both the public and private sectors and has subsequently committed to partner with psychiatrists to develop a long-term workforce plan. This report focuses specifically on workforce requirements for child and adolescent psychiatry, addressing both critical intervention needs and workforce supply challenges.

Research shows that sustained psychological distress and mental illness are particularly detrimental for children and adolescents. This issue can lead to an increased likelihood of low school engagement and poor academic performance. Other potential outcomes include high welfare dependency, involvement with the child protection system, and poor mental health into adulthood. Longer term risks encompass criminal activity, insecure housing, drug and alcohol dependency, and premature death. The plan is aims to identify and address current and future workforce shortages in psychiatry in South Australia.

Psychiatrists play a crucial role in mental health care, assessing, diagnosing, treating, and preventing mental health disorders. They lead mental health teams, providing leadership and guidance for treatment planning. The wider medical and allied health workforce, including GPs and psychologists, are already operating at or near full capacity in providing mental health support services. Access to quality mental health care requires an appropriate workforce supply of many disciplines, including psychiatrists.

This workforce plan responds to the existing and projected supply-demand gap in psychiatrists available for the next decade. Modelling has quantified this gap. This plan acknowledges several other recent reviews relevant to this initiative, including (but not limited to):

- The National Mental Health Workforce Strategy 2022-2032.[10] This paper details four strategic pillars through which workforce shortages will be addressed. These are: Attract and train; Maximise, distribute and connect; Support and retain; and Data, planning, evaluation and technology.
- The South Australian State Government 2020-2025 Mental Health Services Plan[11] which outlines the strategic vision, values, and goals for the state's Mental Health sector. Key priorities are for access to community alternative treatment pathways and focusing on the human rights of those involved in services. The plan emphasises greater consideration and availability of a peer workforce, effective suicide prevention, and access to therapies. It also prioritises equity of access to services. The plan aims to deliver personalised, integrated, safe and high-quality mental health care across the state.
- Review of Rural Mental Health Services in South Australia[12], which describes significant resourcing and clinical support gaps in rural South Australia, and a lack of visibility of these challenges to government.
- The Review of the Oakden Older Persons Mental Health Services and associated reform agenda for older persons in care.

[10] Australian Government Department of Health and Aged Care (2023) National Mental Health Workforce strategy 2022–2032, Australian Government Department of Health and Aged Care. Available at: https://www.health.gov.au/resources/publications/national-mental-health-workforce-strategy-2022-2032?language=en (Accessed: 03 July 2024).
[11] SA Health Mental Health Services Plan 2020-2025 (no date) SA Health. Available at: https://www.chiefpsychiatrist.sa.gov.au/mental-health-services-plan (Accessed: 02 July 2024).
[12] Coleman, M., Roberts, R., English, L. (2023). Review of Rural Mental Health Services in South Australia

- Youth Mental Health Service Provision in South Australia[13], which describes a significant level of dissatisfaction regarding the failure of the implementation of a statewide Youth Model of Service Delivery and concern about the lack of service provision available to young people.

1.2 Scope of the plan

The purpose of this document is to provide a psychiatry workforce plan for the South Australian government, with a special focus on Child and Adolescent psychiatry. This plan recommends actions to support an appropriately sized and distributed psychiatry workforce across public and private practice areas in South Australia.

Recommendations are informed by both modelling and qualitative evidence regarding mental health service delivery, focusing specifically on the psychiatrist's role as a key enabler of mental health care.

For clarity, this document does not include detailed analyses of current or future service models, nor workforce modelling and strategies for mental health professionals outside of psychiatry. It does not involve actual recruitment and procurement of psychiatrists or direct management of mental health services, instead focusing on workforce planning and strategy.

1.3 Approach to developing the plan

This workforce plan's recommendations have been informed by desktop analysis, stakeholder consultation and workforce modelling. Analyses of key issues and their root causes informed the development of these recommendations. The recommendations were then tested through two main methods:

1. The project control group (as described in 1.3.3), provided feedback on various drafts, assessing the practicality and feasibility of implementation.
2. A future-case modelling scenario (refer to section 5) models the projected impact of the recommendations on psychiatrist supply over 10 years.

Recommendations have been assigned suggested timeframes for implementation: short-term (up to 2 years), medium-term (2-5 years), and long-term (5-10 years). A suggested implementation plan is included in this report at Appendix C.

1.3.1 Desktop research

This plan is informed by a review of existing literature, data, reports and online resources relevant to the psychiatrist workforce. These sources are referenced throughout this document. EY's modelling and data analysis were tested against the literature, enriching the findings and providing context. (Refer to sources in the footnotes for a comprehensive list.)

1.3.2 Stakeholder consultation

A diverse range of stakeholders were consulted (refer to Appendix A) to understand the challenges facing South Australia's psychiatry workforce and to gather ideas for potential improvements. The aim was to identify barriers to an appropriately supported psychiatry workforce and explore potential solutions. Participants included clinical directors, training and education professionals, people with lived experience, early career and trainee psychiatrists, workforce and strategy professionals and employee representative groups.

Qualitative data from semi-structured interviews underwent thematic analysis, with cross-checking for quality assurance. Insights from psychiatry, mental health, and workforce planning networks informed the development of actionable recommendations.

Ethical considerations guided all data collection. Participants were informed about the research purpose, methods and intended use. All data was de-identified, kept confidential, and securely stored to protect

- [13] Youth Mental Health Service Provision in South Australia – Final Report (2019). Available at: https://s3-ap-southeast-2.amazonaws.com/sahealth-ocp-assets/general-downloads/Youth-Mental-Health-Review-Final-Report.pdf (Accessed: 20 July 2024).

participant privacy. Participants were advised that input would inform general findings rather than be quoted individually.

1.3.3 Project Control Group

A project control group (PCG) was established at the project's commencement to provide oversight, guidance, and decision-making authority. The PCG met monthly, with additional ad-hoc meetings as required.

The PCG members were selected collaboratively by the Office of the Chief Psychiatrist and the EY team. The PCG was chaired by Dr John Brayley, South Australia's Chief Psychiatrist. Members included psychiatrists from the RANZCP, DHW Human Resources, psychiatrists who had roles in child and adolescent psychiatry, psychiatrist training, private psychiatry, an Aboriginal psychiatrist, as well as having a psychologist. The project also received lived experience input. The meeting was attended by a part time project officer engaged by the RANZCP to support the work.

1.3.4 Overview of approach to modelling demand and supply of psychiatry

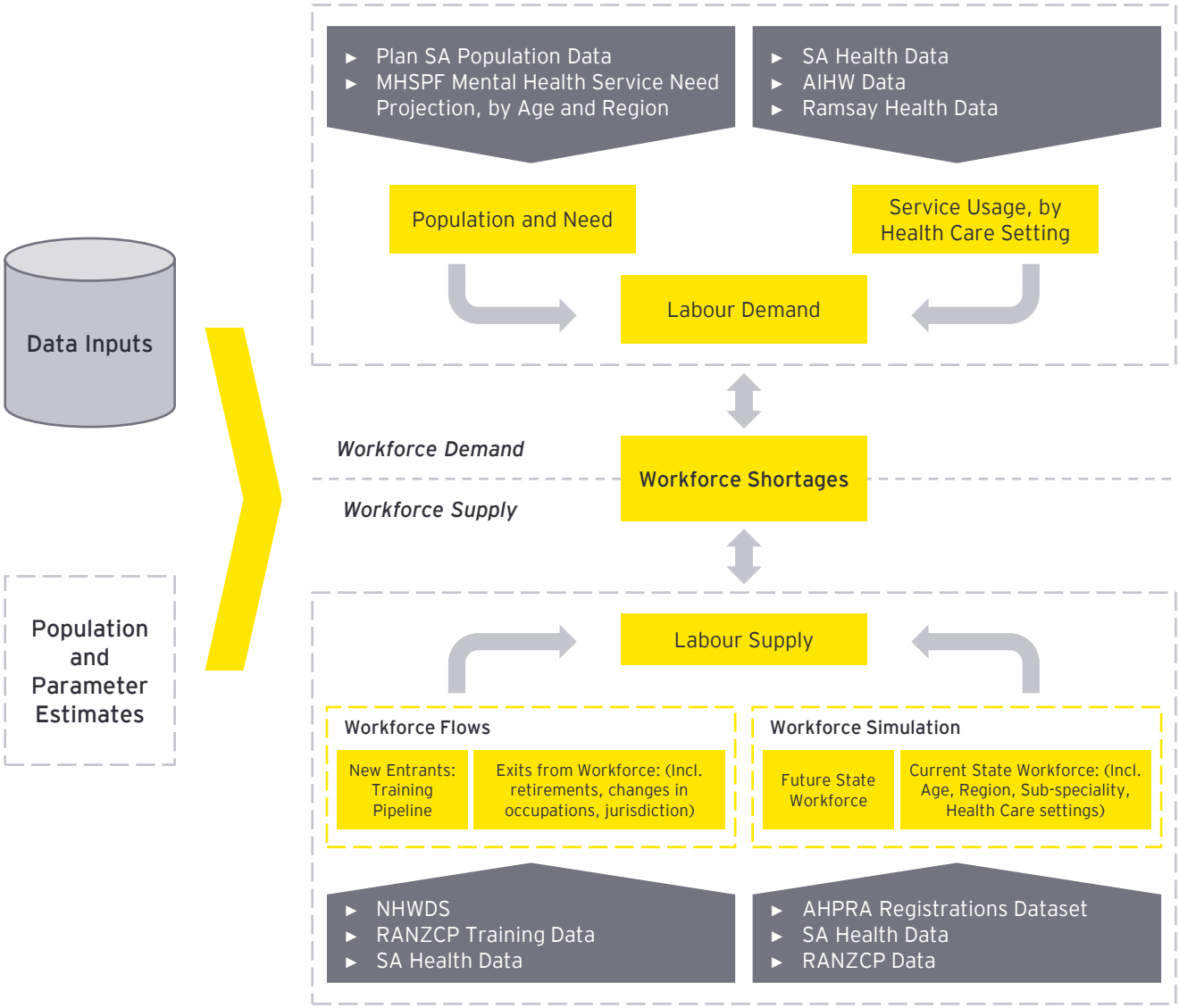
Understanding the current and potential future supply-demand gap in the availability of psychiatrists is a core component of this workforce plan. This analysis aims to identify existing shortages and project how they may change over the next decade.

To inform the workforce plan, a quantitative evidence base was established. This complements other information sources by modelling the demand, supply and shortfall or surplus of psychiatrists across South Australia. All projections involve uncertainty and require assumptions, especially in complex fields like psychiatry services. To address this, a transparent approach to workforce modelling was used. This method allows for clear estimation of future workforce needs. It also enables testing of interventions against various demand scenarios.

This psychiatrist demand and supply modelling is a pioneering effort in South Australia. It represents the first comprehensive assessment of potential current and future supply gaps. The complex and fragmented data landscape posed significant challenges and limitations throughout the analysis. The modelling adapts a standard workforce analysis framework to consider factors impacting workforce demand and supply. EY's application, called EY-WORKER, has been used across various sectors, including health care specialties. It combines a conceptual framework with modelling tools and lessons-learned, tailored to the specific workforce.

Figure 4 below provides a diagrammatic illustration of the modelling architecture utilised to project psychiatrist demand and supply over 10 years in South Australia. Under this approach, demand and supply are projected separately to consider mutually exclusive factors. Demand is primarily driven by the size of the population needing psychiatry services, based on NMHSPF data, and the models of care used. Supply is driven by retention of existing psychiatrists, the pipeline of new Fellows, and the time spent treating public and private patients. Mismatches between demand and supply can occur across time, sub-specialisations, health care settings, or geographic areas.

Figure 4: Psychiatry workforce modelling architecture



The remainder of this section outlines the approach to modelling demand and supply, including the scope and data sources. Section 3.1 presents the analysis results and further explains the approach with relevant assumptions. Appendix E provides supplementary technical notes and a list of assumptions and limitations.

1.3.4.1 Approach to estimating demand for psychiatrists

Psychiatrists play a pivotal role in mental health care, particularly for those with severe or complex conditions. They conduct extensive assessments to diagnose mental health conditions and offer a variety of treatments, including psychotherapy and electroconvulsive therapy. Psychiatry services are provided across hospitals, outpatient clinics, private practices and community settings.

The primary driver of demand for psychiatry services is the number of people needing them, which can vary based on age, gender, location and Indigenous status. Mental health care needs have been changing over time due to various social and other factors. This 'need' for psychiatrists is the most holistic measure of demand, as it includes all who require services, regardless of access.

'Realised demand' refers to the population currently accessing services. This can differ based on personal characteristics, such as their age and location. Where people live can restrict the type of services they can access. For example, there is limited access to private psychiatrists in regional and remote areas of South Australia.

Fewer people access psychiatry services than need them. A comparison of actual patient access to estimated need for services in 2022 confirms this at the state level (see section 3.1.2). Some people needing a psychiatrist may face geographic or financial barriers, while others choose not to seek help for various other reasons. This gap between those requiring services and those accessing them is referred to as 'unmet need'.

Modelling the demand for psychiatrists

To project demand, the first step was estimating how many people currently need and access psychiatry services. Demand was estimated by patient age, location and health care setting:[14]

- Need for psychiatry services: Data from the National Mental Health Service Planning Framework (NMHSPF) was used as a starting point and was updated with latest population data from PlanSA. The NHMSPF estimates mental health service needs, based on condition prevalence and severity, age group, and Indigenous status.[15] The focus was on NHMSPF estimates for moderate or severe conditions to determine psychiatrist-specific demand.
- Current access to psychiatry services: Data on patient access across key health care settings was gathered from relevant data custodians (including SA Health and Ramsay Health) and AIHW public data.

Measuring current psychiatry service delivery time (FTE) is straightforward, comparing patient counts with workforce data. However, estimating psychiatry time required for unmet demand requires assumptions. The psychiatrist time (FTE) spent on services in each health care setting and location (urban vs regional/rural) was compared to the number of patients accessing these services. This comparison estimated the psychiatry FTE required for unmet need.

A limitation of this approach is the lack of data on whether people with unmet need require different services or health care settings compared to those accessing services. This limitation is discussed further in Appendix E.

Future demand projections for the next 10 years were based on the NMHSPF need data, updated with latest PlanSA population projections. Two estimates of demand were considered:

1. Base case: Reflects a continuation of the current service mix, patient-to-psychiatrist ratios, and net access levels (accounting for current geographical availability of services and individual choice to access services).
2. Unmet need scenario: Builds on the base case, considering total need for psychiatry services, regardless of current access. In other words, it captures the total number of people that have a medical need for psychiatry services, regardless of whether they currently access services. This scenario provides insight into the current and projected potential total psychiatry demand, over and above the current levels of services actually delivered.[16]

These projections use constant patient-to-psychiatrist ratios, assuming no changes in care models or service delivery. This limitation is acknowledged, as services and models of care may change over time. As they do, the modelling would require updating, and results could change in a material way.

1.3.4.2 Approach to estimating supply of psychiatrists

Psychiatrists are a highly specialised workforce that require many years of training to become qualified. The minimum required time to complete psychiatry training is five years following completion of a medical degree. RANZCP data indicates the average time to complete training is 6.1 years. Given the long training time, psychiatrists tend to be older upon entering the workforce, and work later in life than some professions. Section 2.4 provides further detail on the demographic characteristics of psychiatrists.

The current workforce size is limited to the number of registered psychiatrists. Future workforce size of is influenced by:

- Current registered psychiatrists and their work patterns: The workforce size (FTE) can increase or decrease based on hours worked. Generally, hours decrease with age. Changing preferences for part-time work and work-life balance may mean a greater number of psychiatrists are required to deliver the same care for a given number of patients.

[14] Psychiatrists were classified into the following health care settings: hospital, community (including outpatient services), private practice and other (including psychiatrists working in educational facilities).

[15] Note that it does not account for other factors which may influence the need for services, such as gender.

[16] Note that the number of patients demanding services was estimated according to patient age and location (by SA3 region). The number of patients requiring care within each health care setting was estimated based on the current usage of each setting and adjusted to align with projected service growth rates by health care setting according to NMHSPF data.

- Expected workforce exits: This includes retirements, moves to other jurisdictions and career changes. Age is a key factor in retirements, with more occurring among older workers. Recent survey evidence suggests burnout in the psychiatrist workforce (RANZCP, 2024), potentially leading to earlier retirements.
- New Fellows entering the workforce: Psychiatrists must complete mandatory training to become Fellows. The expected number of new Fellows can be estimated from training program enrolment, noting not all psychiatrists complete the program. RANZCP data indicates high demand training, with the number of applicants to the training program exceeding the number of available places in recent years (see section 3.3.1).

Migration of qualified psychiatrists could potentially increase workforce size. However, this analysis did not consider migration due to the low proportion of current psychiatrists trained abroad.

Modelling the supply of psychiatrists

The current psychiatrist workforce size and characteristics were synthesised using data from the National Health Workforce Dataset, RANZCP and SA Health. Multiple sources were necessary due to a lack of unit record data on the psychiatrist workforce (see Appendix E for further detail).

Future workforce projections were based on:

- The previous year's workforce size
- Number of psychiatrists leaving the workforce[17]
- Number of new Fellows entering the workforce[18]
- Changes in the working hours for existing and new psychiatrists, based on age.

Supply projections used a microsimulation framework which simulates outcomes at an individual level. This approach offers greater precision than cohort-based models when considering worker behaviours, such as likelihood of retirement. New Fellows added to the workforce each year were modelled based on existing workforce attributes (age, gender, sector, location and sub-specialty). Limitations of the supply modelling are detailed in Appendix E.

1.3.4.3 Approach to estimating workforce gaps

Supply and demand projections were analysed together to identify potential workforce gaps where projected supply may be insufficient to meet demand. These gaps were modelled by linking psychiatrists with common characteristics of location and health care setting. The analysis covers a 10-year projection period, extending to 2033.

The gap analysis assumes current supply meets current realised demand for psychiatrists (excluding unmet need). However, evidence suggests this may not be the case. If so, actual shortages could be greater than those presented in this report's core results. Section 3.1 provides exploratory analysis on potential current state shortages.

1.3.4.4 Data sources

Workforce data was collected from a variety of sources which quantify psychiatrist demand and supply in South Australia. Supply data included numbers of trainees, practicing psychiatrists in private and public sectors, and those leaving the workforce. Workforce demand was modelled using data on current population use of psychiatrist services across public hospitals, community mental health centres, private practices, and private hospitals.

Table 1: Demand data sources

Item	Data source
Need for services	
People requiring mental health services	National Mental Health Service Planning Framework
Population projections	Plan SA

[17] The probability of retirement of each Fellow was based on their age, reflecting data from the NHWDS.
[18] The new Fellows were added to the workforce based on RANZCP data on the psychiatry training pipeline, considering the historical trainee dropout rate.

Item	Data source
Projected growth by health care setting	National Mental Health Service Planning Framework
Number of patients accessing psychiatry services (2021-22)	
Public community service and residential patients	SA Health CBIS data and CCCME data
Public hospital patients	SA Health APC data & AIHW mental health related admitted patient data
Public emergency department patients	SA Health ED data
Private patients	AIHW mental health related Medicare subsidised patient data and Medicare-subsidised GP, allied health and specialist health care across local areas: 2021–22
Private hospital patients	Ramsay Health

Notes on use of National Mental Health Service Planning Framework data

The National Mental Health Service Planning Framework (NMHSPF) underpins key aspects of the demand modelling. For accurate data interpretation, please consult the NMHSPF framework documentation, including relevant caveats, available at: https://www.aihw.gov.au/nmhspf/support-material.

Table 2: Supply data sources

Item	Data source
Current workforce characteristics	National Health Workforce Dataset, SA Health (including rural workforce data) and RANZCP
Training program data	RANZCP
Trainee dropout rate	RANZCP
Workforce age and probability of retirement	National Health Workforce Dataset

An overview of the key data issues, assumptions and limitations is provided in Appendix E.

Please note this report does not reflect 2024 South Australian state budget commitments.

2. Overview of psychiatry in South Australia

2. Overview of psychiatry in South Australia

2.1 Mental health

2.1.1 Mental health prevalence across Australia

According to the Australian Bureau of Statistics (ABS), 42.9% of Australians aged 16-85 years have experienced a mental health disorder at some point in their life.[19] The need for services to support these individuals grows as Australia's population continues to increase in size and as help-seeking behaviour increases. Almost a third of people in Australia will experience an anxiety condition in their lifetime, and one in seven will experience depression. In 2020-21, one in seven people in Australia experienced high or very high psychological distress.[20]

The most recent budgetary figures released from the Australian government show that 16.8% ($170.8b) of the Australian Government's total expenditure was on health,[21] with 6.8% of this ($11.6b) specifically for mental health care. However, COVID-19 pandemic measures inflated this figure, and a decrease in government health care spending is projected for the coming years.[22]

2.1.2 Child and adolescent mental health

Data from the National Survey of Mental Health and Wellbeing 2020-2022 indicates young people typically face a greater prevalence of mental health issues compared to other age groups. In South Australia, over one-third of 16–34-year-olds (34%) reported a 12-month mental health disorder, compared to 17% of 35–64-year-olds and 14% of 65–85-year-olds. Up to 50% of mental health disorders begin to develop before age 15, affecting a considerable proportion of Australian children aged 4-17 years.[23] Over any given 12-month period, 14% of children meet diagnostic criteria for a mental health illness, and a further 10% are impacted by symptoms of mental ill-health.[24]

For the adolescent and young adult population specifically, the ABS reported that 38.8% of people aged 16-24 years had a 12-month mental health disorder at some point over 2020-2022.[25] Various pressures contribute to these outcomes, including COVID-19, social media, challenging family environments, school transitions, puberty, domestic violence, substance use, over-scheduling, gender identity, and cultural barriers. Transitions between youth and adult mental health systems can also create challenges.

Despite these challenges, mental health literacy has increased in recent years, particularly among younger people since the introduction of mental health literacy intervention programs throughout schools.[26] This education has improved young people's ability to recognise personal mental health status and provide peer support.

Epidemiological data shows that 75% of people suffering from a psychiatric disorder experienced its onset by 24 years of age.[27] Research indicates that investment in youth mental health has the greatest long-term impact and social return on investment. Early case identification and intensive treatments during the first episodes of illness are most effective in reducing the prevalence, cost, and morbidities of these disorders.[28]

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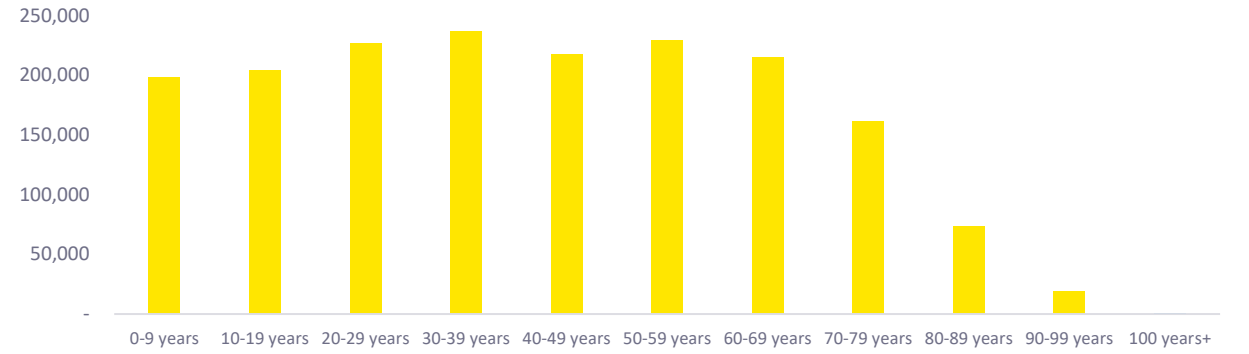
[19] Australian Bureau of Statistics. (2020-2022). *National Study of Mental Health and Wellbeing*. ABS. https://www.abs.gov.au/statistics/health/mental-health/national-study-mental-health-and-wellbeing/latest-release.
[20] Ibid.
[21] Vines, E. (2022). Health Overview, Parliament of Australia.
[22] Ibid.
[23] Murdoch Children's Research Institute, (2024). Mental health in children and adolescents.
[24] Ibid.
[25] Australian Bureau of Statistics, (2020-2022). National Study of Mental Health and Wellbeing. ABS.
[26] Bennett H, Allitt B, Hanna F. A perspective on mental health literacy and mental health issues among Australian youth: Cultural, social, and environmental evidence! Front Public Health. 2023 Jan 18;11:1065784. doi: 10.3389/fpubh.2023.1065784. PMID: 36741953; PMCID: PMC9891461.
[27] Patrick D McGorry, Rosemary Purcell, Ian B Hickie and Anthony F Jorm, Med J Aust 2007; 187 (7): S5. || doi: 10.5694/j.1326-5377.2007.tb01326.x
[28] Kadel R, Stielke A, Ashton K, Masters R, Dyakova M. Social Return on Investment (SROI) of mental health related interventions-A scoping review. Front Public Health. 2022 Dec 9;10:965148. doi: 10.3389/fpubh.2022.965148. PMID: 36568774; PMCID: PMC9780590.

2.2 South Australian demographics

2.2.1 Age

At the time of the 2021 Census, South Australia had a population of 1.8 million people. The median age in South Australia has been increasing over time and is currently the highest in Australia at 46.8 years old (2022).[29]

Figure 5: Age distribution of South Australians, 2022



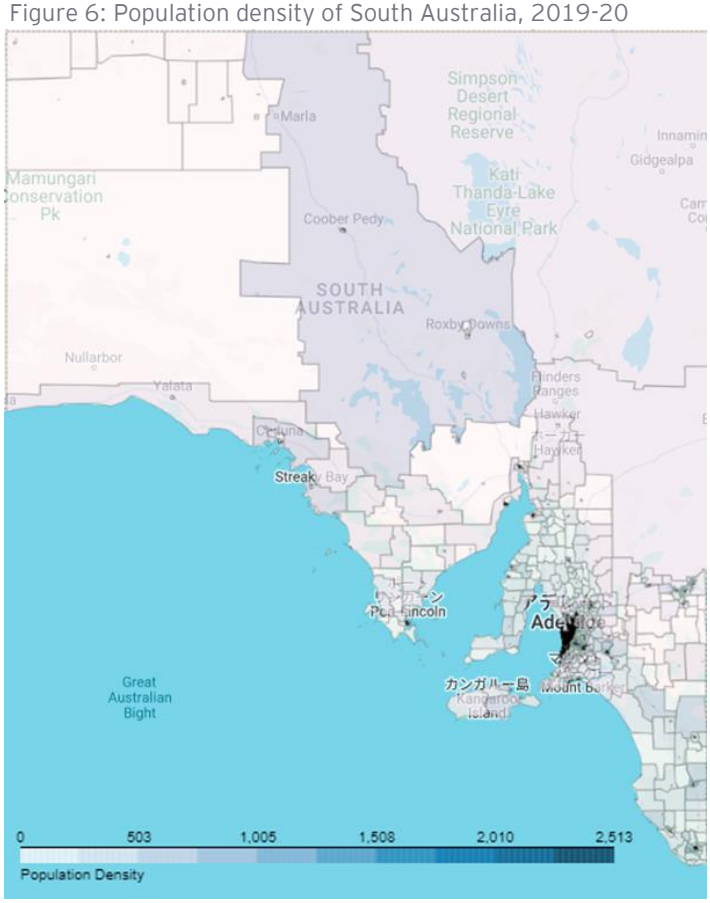
Source: ABS, Regional Population by age and sex, 2022

2.2.2 Geographical distribution

South Australia's population is primarily concentrated in and around Adelaide, with some small regional centres. Regional and remote areas have low population density.[30] However, Aboriginal and Torres Strait Islander peoples disproportionately live outside major cities.[31]

Across South Australia, 2 in 5 people aged 16-85 years reported experiencing a mental disorder at some point in their life. Approximately 3% of this group was estimated to have seen a psychiatrist in their lifetime during 2020-22.[32]

Figure 6: Population density of South Australia, 2019-20



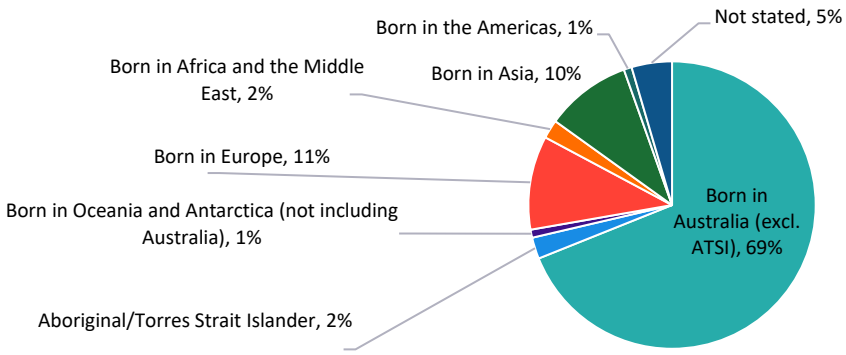
Source: ABS Census, 2021, Regional Population 2019-20: population grid

[29] ABS, Regional Population by age and sex, 2022
[30] ABS, Regional Population 2019-20: population grid
[31] ABS, Estimates of Aboriginal and Torres Strait Islander Australians, 2021
[32] 2020-2022 National Survey of Mental Health and Wellbeing

2.2.3 Cultural diversity

Country of birth is one measure of cultural diversity, though it has limitations. It does not capture those born in Australia who identify with another country's culture, or those people identifying with multiple cultures. Most South Australians were born in Australia, with a significant portion born in Europe and Asia. Additionally, approximately 2.4% of the South Australian population identify as being of Aboriginal and/or Torres Strait Islander descent.

Figure 7: South Australian's country of birth, 2021



Source: ABS Census, 2021

2.3 Public and private psychiatry

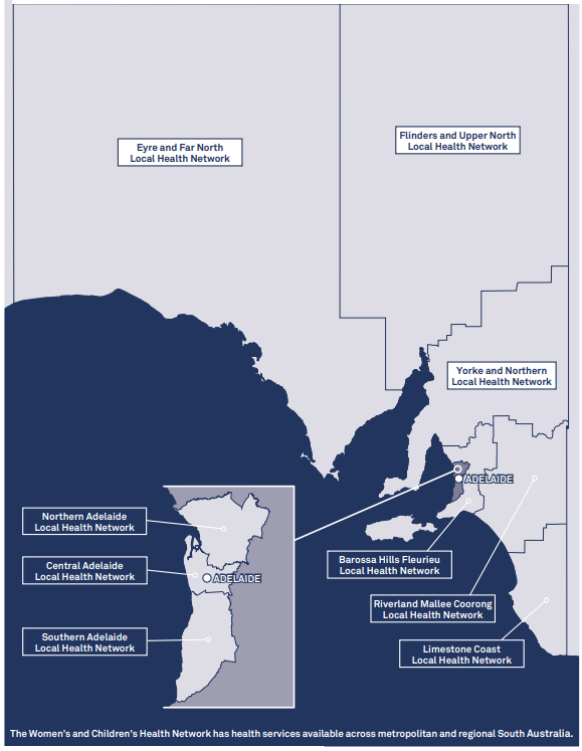
2.3.1 Public system

SA Health operates under a Local Health Network (LHN) model. 10 LHNs across South Australia serve specific geographical areas, providing public hospital and community-based health services as determined by the state. This system allows for health care services to be delivered in a way that best meets local community needs. LHN services include public hospital care, mental health services, aged care assessment, rehabilitation, pregnancy and childbirth services, and community-based health services.

This model enables patient-centred care informed by local health trends and demographics. It also allows for easier adjustment to changing community health needs over time.[33]

Within South Australia, approximately two-thirds of psychiatrists work in the public sector.[34] In 2021-22, an estimated 34,900 patients accessed psychiatric care in public settings, slightly above the 30,400 in private settings.[35] Public psychiatrists often see patients with acute conditions or experiencing mental health crises, frequently in hospital emergency departments. They typically care for the most unstable/unwell patients, many requiring intensive servicing.

Figure 8: Map of SA Local Health Networks



Source: SA Health, 2024

[33] *The Australian Health System* (2022) *Australian Government Department of Health and Aged Care*. Available at: https://www.health.gov.au/about-us/the-australian-health-system (Accessed: 05 July 2024).
[34] According to analysis of the National Health Workforce Dataset, 2022.
[35] According to analysis of publicly available AIHW MBS data and data from a range of custodians, including SA Health and Ramsay Health.

Public psychiatrists work in both hospitals and community settings, often leading multi-disciplinary teams including mental health nurses, nurse practitioners, psychologists, GPs, social workers, occupational therapists, and peer workers. They also have the right to practice privately whilst in their public role, and to see patients privately in public facilities.

2.3.2 Private psychiatry

In 2022, 98 out of 315 psychiatrists (31%) primarily offered services in private practice and through telehealth appointments. Approximately 30,000 patients are seen privately, with slightly more seen publicly.

Private psychiatry in South Australia plays an important role in the mental health care system, complementing public services. Private psychiatrists often work with multi-disciplinary teams, including GPs, psychologists, mental health nurses, dieticians, counsellors, and other allied health professionals.

Typically, private psychiatry patients receive care within private hospitals, private psychiatry room-based practices, or via telehealth. While private psychiatrists often treat outpatients, they may also work with people in acute phases of mental illness. They can select the nature of patients they see and their practice methods, which may involve higher or lower acuity cases.

Private psychiatrists are less likely to admit patients to hospital compared with public psychiatrists. They report working more independently within private hospitals than is typical in public and interstate services.

South Australia has only one private in-patient psychiatric facility: the *Ramsay Clinic Adelaide*. This 83-bed hospital has 101 private psychiatrists with admittance rights, though currently only 30-40 use these admission rights. Ramsay Clinic has been open for approximately 35 years, and since 2000 has operated under a financial model of care that is prospectively paid by private insurers.

2.4 Psychiatrists in South Australia

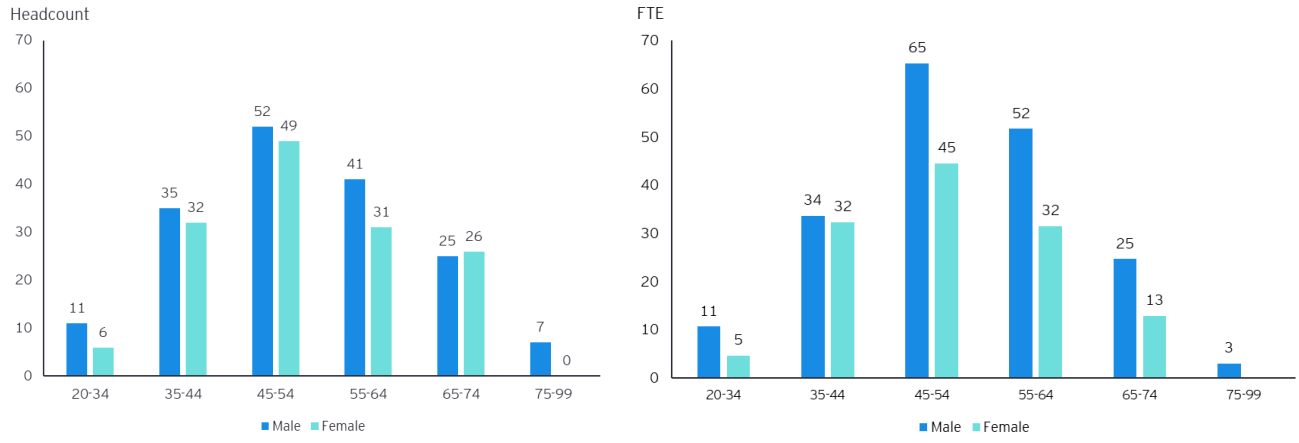
2.4.1 Demographics

As of 2022, South Australia had 315 practising psychiatrists, equating to 318 FTE positions. The workforce was approximately equally split between genders, with 54% male and 46% female. The average age was 52 years.

Male psychiatrists aged 45-64 worked the longest hours. They represented 30% of the workforce by headcount but performed 37% of the work in FTE terms. (Note 1 FTE = 40 hours work per week according to the National Health Workforce Dataset).

Female psychiatrists typically worked fewer hours compared to males. They have a lower FTE than headcount across most age bands, indicating a greater tendency for part-time employment within this demographic.

Figure 9: Number of psychiatrists in SA by age and gender



Source: NHWDS, 2022

Most psychiatrists work primarily in urban locations. Analysis of the National Health Workforce Dataset indicates that approximately 7% of the psychiatry workforce (in terms of FTE) is estimated to work in regional and remote locations.[36]

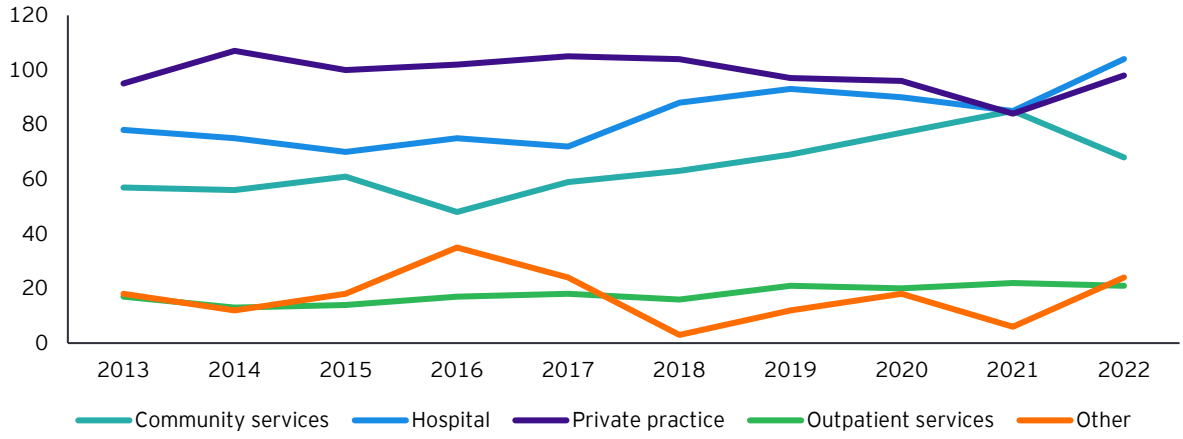
Service delivery modes vary by location. Patients in or near Adelaide typically receive in-person care from psychiatrists at hospitals, community clinics or private practice. However, very few psychiatrists work outside of the Adelaide region, presenting challenges for regional and rural access to psychiatry services.

Rural or remote patients typically receive care via telehealth appointments or in-person at regional centres. These regional in-person appointments are predominantly run by locum or fly-in-fly-out (FIFO) psychiatrists. These professionals dedicate scheduled periods to on-site work before returning to their usual practice in metropolitan locations.

2.4.2 Job settings by private / public sector

Psychiatrists primarily work in hospitals, private practice, community settings and outpatient services. According to the National Health Workforce Dataset, these settings collectively represented the primary workplace for 291 out of 315 psychiatrists in 2022. Across all job settings, the number of practitioners has increased from 2013 to 2022.

Figure 10: South Australian psychiatrists in key job settings, headcount, 2013-22



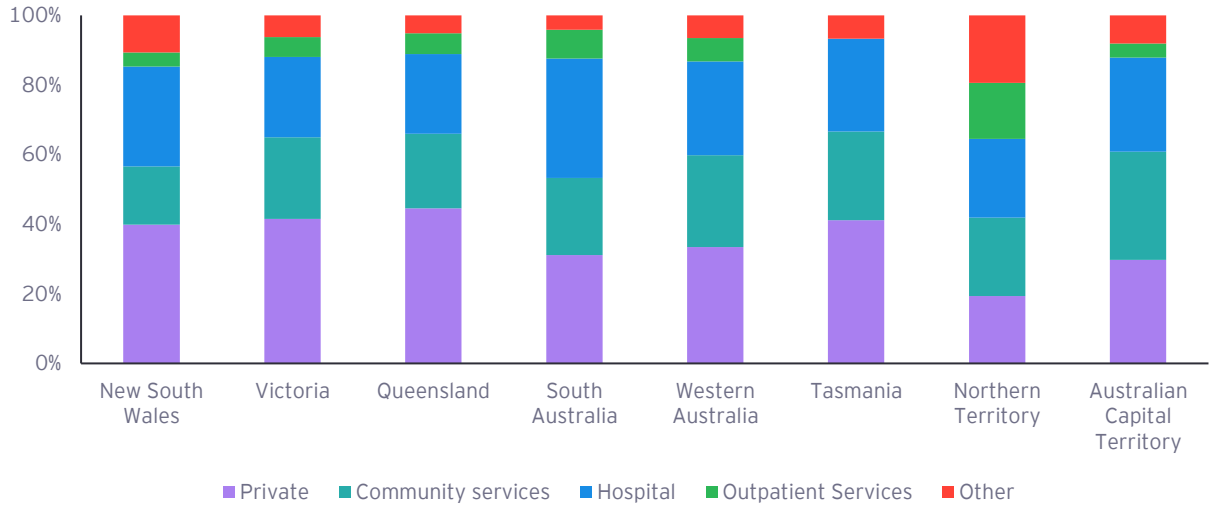
Note: "Other" includes residential services, educational facilities, commercial / business services, and other government departments or agencies.

Source: NHWDS, 2022

According to the National Health Workforce Dataset, the share of South Australian psychiatrists reporting they worked primarily in private job settings is lower than the share for all other states except the Northern Territory. However, this does not account for private hours worked by psychiatrists primarily in public job settings (see analysis below).

[36] Regional and remote locations are defined as ABS remoteness areas that are not *Major Cities*.

Figure 11: Number of psychiatrists in key job settings by jurisdiction, headcount, 2022

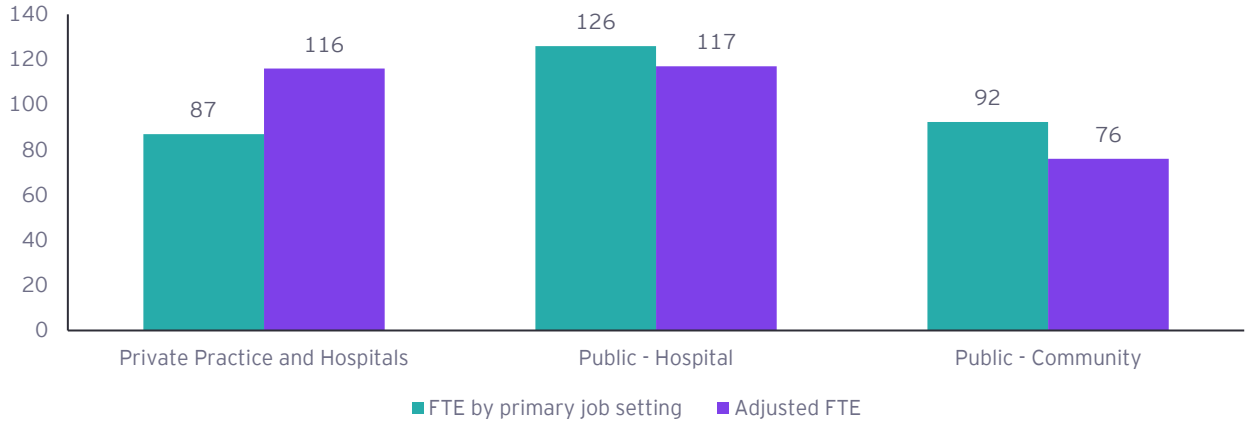


Source: NHWDS, 2022

While the above analysis considers the primary job settings, some psychiatrists work across multiple job settings. For example, a psychiatrist primarily working in a public hospital may also provide private care.

To better understand public and private care provision, the psychiatrist FTE worked in each job setting was estimated, including time spent outside primary settings. Figure 12 shows the differences between hours worked in primary job settings and the 'adjusted' FTE, which accounts for hours worked elsewhere. For instance, there were 126 psychiatrists (FTE) working primarily in public hospitals, but the adjusted FTE delivered in public hospitals was estimated at 117, accounting for time spent in private settings.

Figure 12: South Australian psychiatrist FTE in key job settings, 2022



Source: NHWDS, 2022

2.4.3 Areas of sub-specialisation

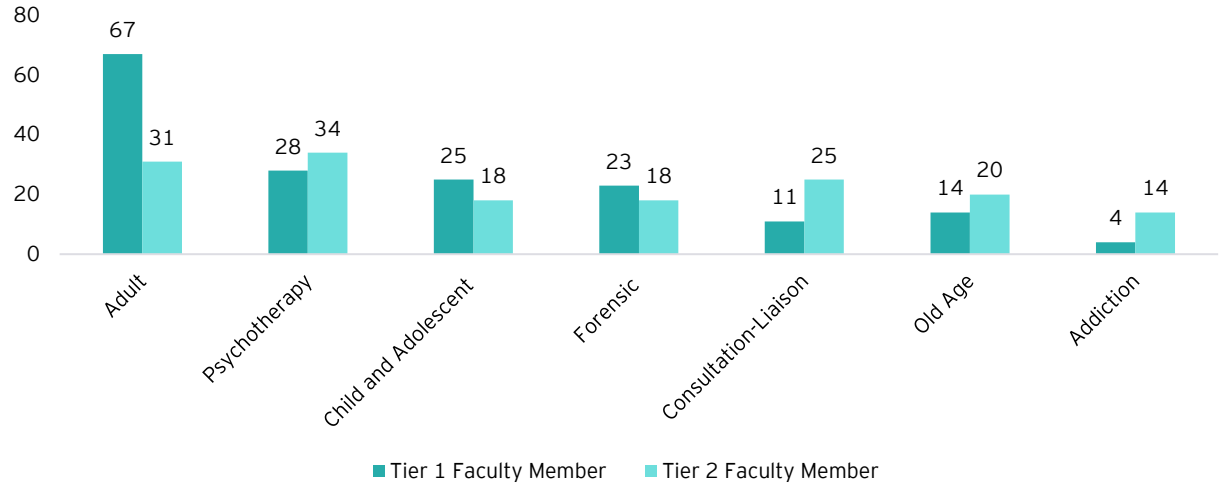
After completing of the initial three years of the five-year training program, trainees must complete either generalist psychiatry training or an advanced certificate in a sub-specialty area. According to RANZCP, these sub-specialities are:

- **Adult psychiatry**: Mental health care for adults, addressing conditions like schizophrenia, bipolar disorder, depression, and anxiety disorders.
- **Psychotherapy**: Explores connections between meaning, motivation, feelings, thoughts, and behaviour and is not limited by age or diagnosis, with varied approaches.
- **Child and adolescent psychiatry**: Focuses on young people's mental health. Addresses developmental disorders like ADHD and autism as well as early episodes of depression, anxiety disorders, anorexia nervosa or schizophrenia.

- **Forensic psychiatry**: Intersects criminal law and psychiatry, assessing and treating for mentally disordered offenders and assisting courts in determining criminal responsibility.
- **Consultation-liaison psychiatry**: Addresses the interaction between physical and mental health, offering psychological or pharmacological support to those with physical health conditions who are also experiencing mental health difficulties. Consultation–liaison psychiatrists work with patients, medical colleagues and also systems outside mental health.
- **Older persons psychiatry**: Focuses on the mental health of older adults, addressing ageing effects, medical factors, and social, psychological, cultural, and spiritual issues.
- **Addiction psychiatry**: Deals with addiction and substance misuse, aiming to limit addictive behaviour and assist in recovery maintenance.

In South Australia, adult psychiatry has the highest number of faculty members, followed by psychotherapy and child and adolescent psychiatry. Tier 1 faculty member status is granted to those that have completed a Certificate of Advanced Training or have had formally recognised expertise in that area.

Figure 13: Number of South Australian psychiatrists as members of each Tier / Faculty

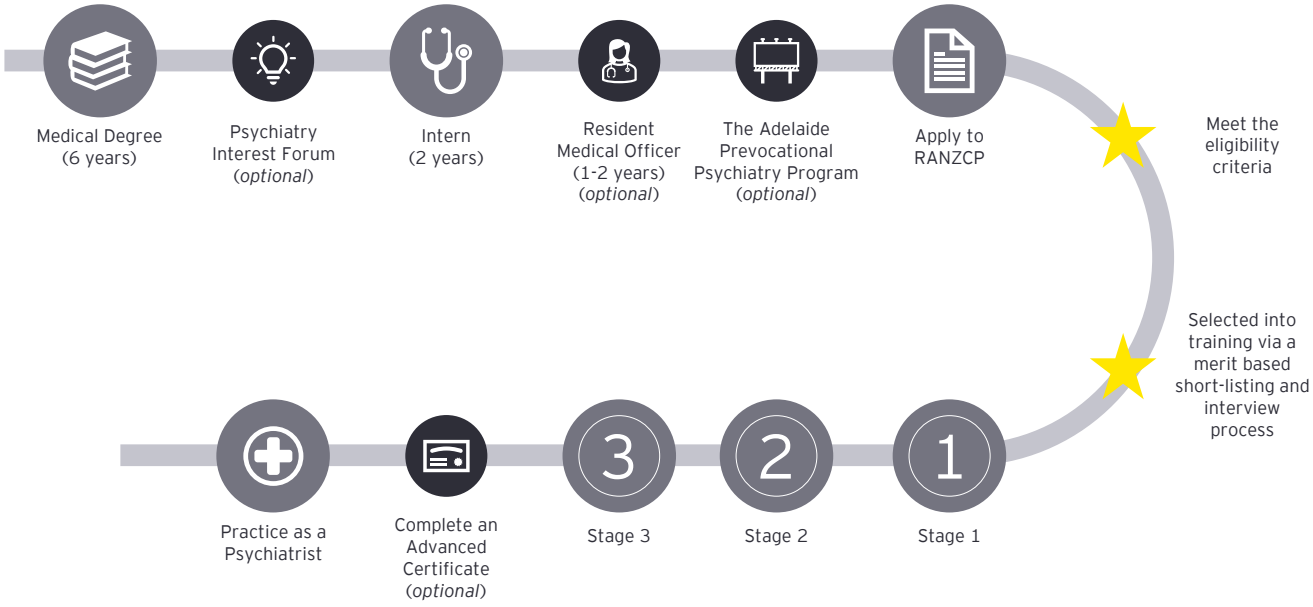


Source: RANZCP, 2023

2.4.4 Training and career pathways

A psychiatrist's career path may vary based on personal interest, market trends, and changing health care policies. Challenges faced by psychiatrists can differ depending on their training and career stage. Figure 14 shows a typical training and career pathway of a psychiatrist in South Australia. A more detailed description of this pathway is presented in Appendix B.

Figure 14: Training and career pathway of a psychiatrist in South Australia[37]



[37] Training and career pathway as validated in focus groups, and by training representatives within the PCG

3. Findings

3. Findings

Stakeholder engagement and data modelling have produced eleven key finding areas:

1. **Workforce supply and demand projections:** South Australian psychiatrists are projected to increase from 318 to 387 FTE from 2022 to 2033. Despite potential retirements, the workforce is expected to grow by 65 psychiatrists over the next decade. A total shortage of 17 FTE psychiatrists is projected by 2033, peaking at 61 FTE in 2027.

2. **Access to services:** Stakeholder feedback, including from lived experience groups, revealed significant challenges in accessing psychiatry services. Issues include limited availability of psychiatrists accepting new patients and inadequate continuity of care across the health system.

3. **Training:** Current issues include a shortage of senior leaders and restrictions on expanding training positions. Increasing training capability and capacity is necessary.

4. **Culturally appropriate practice:** South Australia is home to a culturally diverse population including Aboriginal and Torres Strait Islander communities, as well as immigrants, refugees, and asylum seekers. Mental health services are not always provided equitably across culturally diverse backgrounds. Implementing culturally appropriate practices is crucial, particularly for Aboriginal and Torres Strait Islander people.[38]

5. **International recruitment:** While international recruitment is proposed to address specialty area gaps, time-consuming registration requirements pose significant barriers. These administrative hurdles are more challenging than immigration laws or visa applications.

6. **Child and adolescent psychiatry:** The child and adolescent population requiring psychiatry services is projected to increase by 10% from 2022 to 2033. By 2033, a shortage of 8 child and adolescent psychiatrists is expected in South Australia. To achieve a ratio of 4.0 psychiatrist FTE per 100,000 population (as described in section 3.1.3.2) an additional 63 FTE would be needed over the next decade. Congestion at the mandatory child and adolescent rotation stage of training currently limits the increase of training places in this specialty.

7. **Rural psychiatry:** Rural regions face higher rates of mental health difficulties and suicides compared to non-rural areas. However, the ratio of psychiatrists to population is significantly lower in rural areas. Proposed solutions include increasing resident psychiatrists and improving mental health system governance.

8. **Psychiatry service model:** Psychiatrists reported spending considerable time on administration tasks and lower acuity work. This reduces time for complex cases and limits capacity for new patients. There are also notable differences in psychiatrist roles and tasks between public and private sectors.

9. **Support and retention of psychiatrists:** Many psychiatrists have reported heavy workloads, isolation, and burnout. Younger registrars face pressure to fill shortages. There appears to be a lack of succession planning and mentorship. Concerns exist about future gaps in leadership, academia, and research as senior professionals retire. Non-clinical demands limit time for research, slowing the development of emerging practices.

10. **Access to and use of data:** Opportunities exist to improve data collection through a centralised, user-friendly system. This would enable more robust data-informed decision making. Currently, data linking psychiatry time to service activity is estimated from multiple datasets. Improving data systems could enhance patient outcomes and allow more regular re-forecasting of projected psychiatry workforce shortages.

11. **Broader health system related findings and funding mechanisms:** Structures like the Medicare Benefits Schedule (MBS) and Rights of Private Practice, can create disincentives for critical patient care. Recommendations include a clearer delineation of MBS items, more effective use of the Rights of Private Practice, and streamlined National Disability Insurance Scheme (NDIS) assessment processes.

[38] Mental Health in Multicultural Australia, Framework for Mental Health in Multicultural Australia, 2014

3.1 Projected supply and demand for psychiatrists (without intervention)

This 10-year projection supports the development of the workforce plan. It analyses the current workforce and demand for psychiatry services, forming a base for future projections. The modelling in this section shows projected supply and demand without any of the recommended interventions described in section 4 of this report. Considerations include:

- Patient age and residence
- Psychiatrist workplace location
- Health care setting of treatment
- Psychiatrist sub-specialisation (including child and adolescent psychiatry).

Future projections account for key factors, including:

- Training pipeline and expected retirements (supply side)
- Population growth, prevalence of mental health conditions, and service access (demand side).

Limitations exist due to a lack of detailed data and assumptions on the models of care, which could significantly impact results. For further detail on the limitations, see Appendix E.

3.1.1 Projected supply of psychiatrists

The projected future supply of psychiatrists is driven by two main factors:

1. Expected workforce exits (including retirements, transfers to other jurisdictions and career changes)
2. The number of new Fellows entering the workforce from the training pipeline.

Workforce exits are age-dependent, with older psychiatrists more likely to retire. The main inflow is new Fellows completing the five-year minimum psychiatry training program after medical school. Based on analysis of RANZCP South Australian psychiatry training program data, at any given time an estimated 27% of trainees have not completed or are not actively engaged in training.[39]

In the modelling, new Fellows are assumed have similar attributes to the existing workforce (age, gender, sector, location, and sub-speciality). The impact of migration was not considered due to low numbers of foreign-trained psychiatrists. Interstate moves were not considered due to lack of data.[40]

Modelling approach

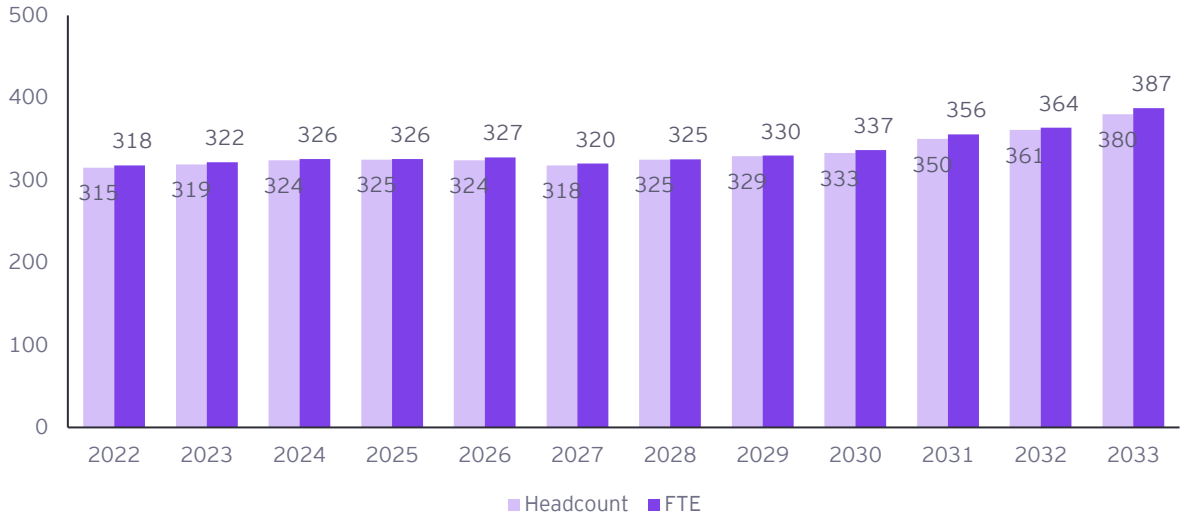
A microsimulation model was used to simulate the changing circumstances of individual practitioners over time. This method captures the unpredictability of individual behaviours, allowing for a range of possible outcomes. For example, while a simulation might show multiple retirements in one year, fewer may actually retire if there are workforce shortages at the time.

Projected growth

According to the National Health Workforce Dataset (2022), South Australia had 315 psychiatrists in 2022. This number is expected to increase by 21% to 380 by 2033. In terms of full-time equivalent psychiatrists (FTE), the workforce is expected to increase by 22% over the projection period, from 318 FTE in 2022 to 387 in 2033.[41]

[39] This rate was held constant throughout the period.
[40] However, potential outflows from South Australian psychiatrists moving to other states are implicitly considered.
[41] Current values based on the National Health Workforce Dataset.

Figure 15: Projected supply of psychiatrists by headcount and FTE, 2022-33, SA (without intervention)

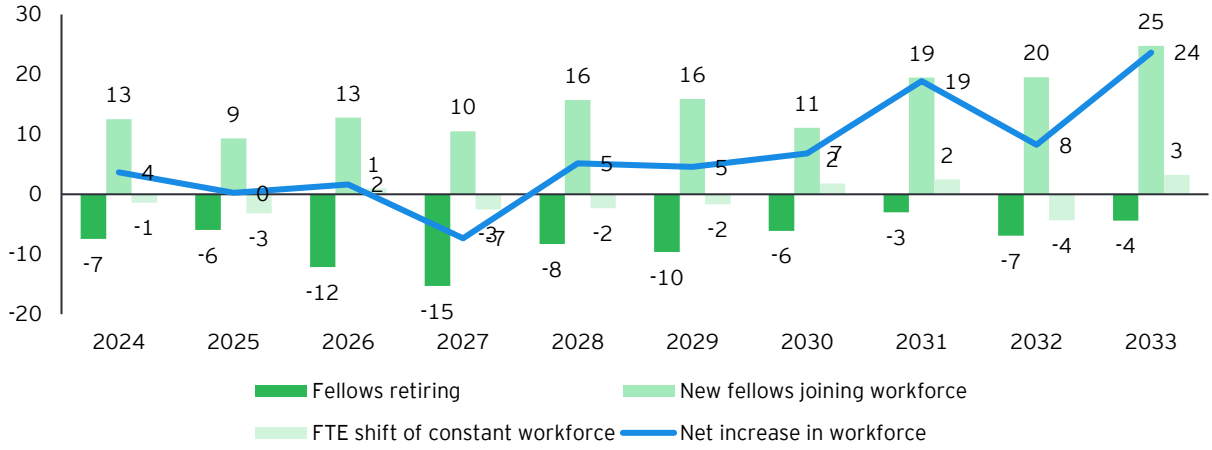


Projected workforce trends

The number of psychiatrists is expected to remain relatively steady initially, while a slight contraction may occur in the medium-term due to potential retirement of older psychiatrists. From 2028, the workforce is projected to increase more rapidly, as new psychiatrists entering the workforce are expected to exceed the number retiring.

The Fellowship program's five-year minimum completion time means current increased trainee intake is not expected to substantially impact practicing psychiatrist numbers until the later in the period.

Figure 16: Projected supply of psychiatrists by FTE, 2024-33, SA (without intervention)



3.1.2 Projected demand for psychiatrists

3.1.2.1 Current need for psychiatry services

Key drivers of psychiatry service demands include population growth, prevalence of mental health conditions, and their severity.

The National Mental Health Service Planning Framework (NMHSPF) estimates the number of people needing mental health services based on the prevalence of mental health diagnoses by age group and Indigenous status, adjusted for service demand.[42] NMHSPF categorises the population into those with mild, moderate, or severe conditions, and those needing prevention services. According to the NMHSPF data, psychiatrists typically treat people with severe or moderate conditions.

[42] Further information on the approach can be found in the NMHSPF technical appendices at: <https://www.aihw.gov.au/nmhspf/support-material/general-documentation>.

Mild, moderate and severe are defined by the NMHSPF as:

- Mild refers to people who have diagnosed mental illness that has a low impact on their day-to-day lives. For example, their mental illness does not impact heavily on their ability to attend school or work and maintain healthy relationships.
- Moderate refers to people who have a diagnosed mental illness that has a moderate impact on their day-to-day lives. They may experience problems with psychosocial functioning that impede their ability to attend school or work, carry out household responsibilities or maintain healthy relationships.
- Severe refers to people who have a diagnosed mental illness that has high impact on their day-to-day lives. This includes Complex cases, where people have severe, persistent, or episodic mental illness and many experience significant social and environmental stressors. It also includes Standard cases, where people experience lower risks and/or fewer problems with their psychosocial functioning than those in the Complex category.

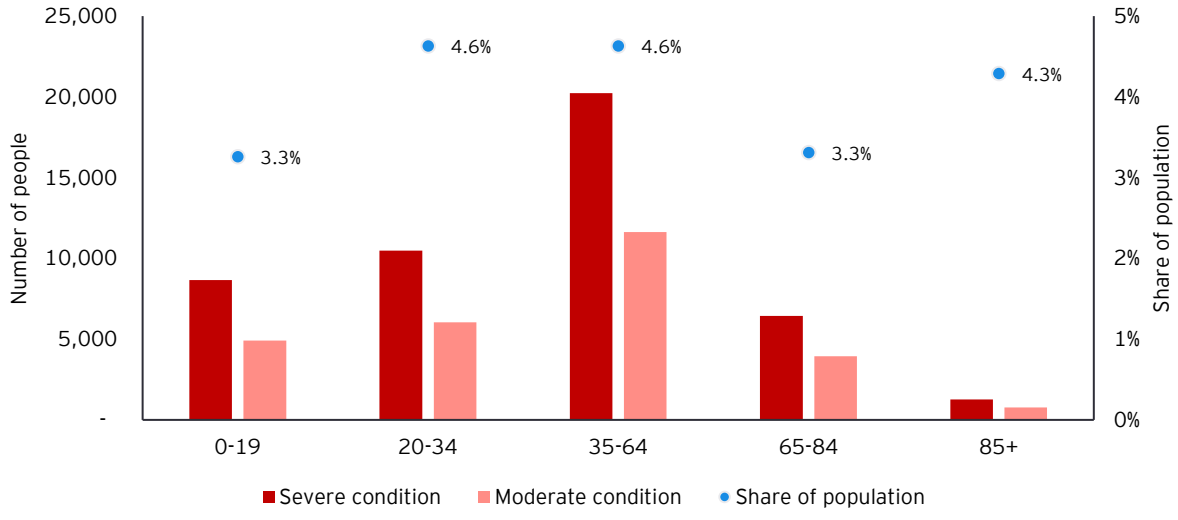
The 2021-22 estimated need for psychiatric care was based NMHSPF data. It considers the various need groups (care profiles), based on age, condition severity and Indigenous status. The estimation considered the services required by people with a moderate or severe condition and the resulting requirements for care from a psychiatrist (from the NMSHPF care profiles). However, there are several factors that would mean the actual need could be higher or lower, including that some disorders that psychiatrists treat (e.g., autism spectrum disorder and substance use) are out of scope in the NMHSPF, and some care profiles had lower shares of the population requiring access to a psychiatrist. Further detail is provided in section 1.3.4 and Appendix E.

Total need for psychiatry services includes all who require services, regardless of actual access. This considers 'unmet need' due to lack of psychiatrist availability, financial barriers, or personal choice not to seek help.

Based on NHSMPF data for 2021-22, 100% of people with a severe condition and 29.5% of people with moderate conditions needed psychiatric care, totalling 74,769 people. Note there may be some people not included in this cohort that do require care from a psychiatrist, and others within this cohort that do not require care from a psychiatrist.

An estimated 4.6% of people aged 20–64 years required care, higher than younger and older age groups. According to NMHSPF data, the reason younger cohorts require fewer psychiatry services is that that they tend to have more mild conditions or require preventative services. These circumstances are typically addressed by health professionals other than psychiatrists.[43]

Figure 17: South Australians requiring psychiatry services and proportion of population by age, 2021-22

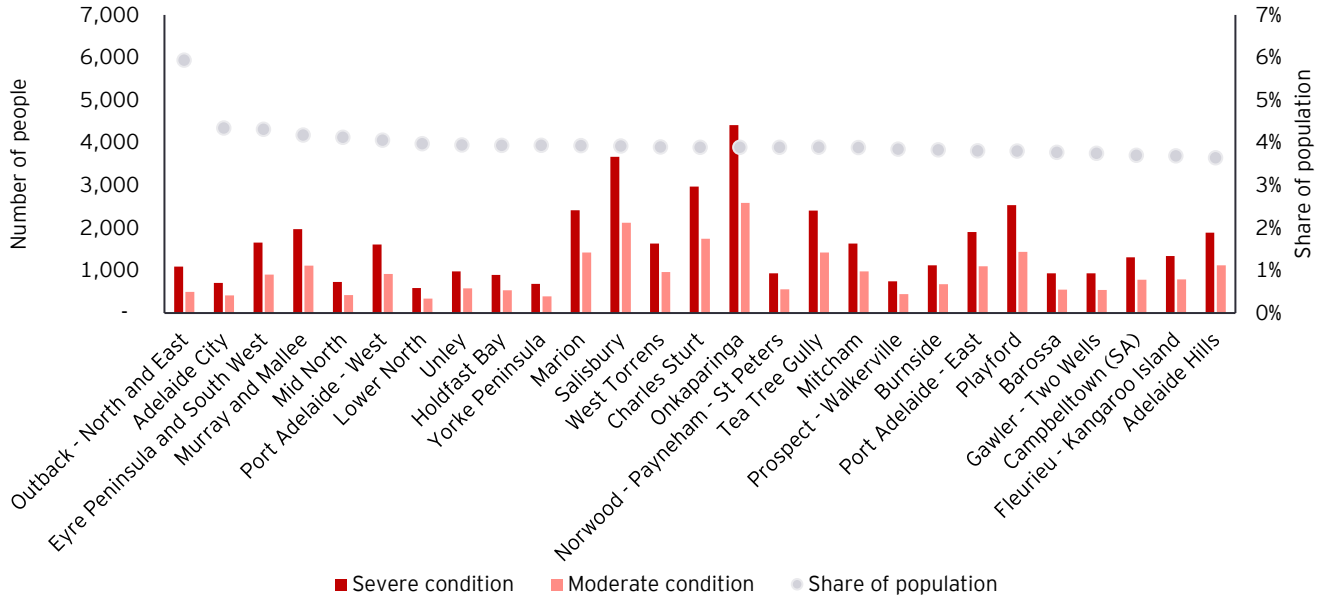


Source: EY analysis of NMHSPF data

[43] When mild conditions and prevention services are considered in addition to moderate and severe conditions, the 0–19-year-old population has the same share of people requiring mental health services as the 20–64-year-old population, at 22%, given the 0-19 population has a relatively greater prevalence of mild conditions and need for prevention services.

People in regional and remote areas tend to be more impacted by mental health conditions. According to NMHSPF data, 6 of the 8 regions with the greatest need for services are located in regional and remote areas. This reflects the age profile and Indigenous status of people living in these regions. The Outback – North and East region shows a relatively higher need, with 6% of its population estimated to require care from a psychiatrist.

Figure 18: South Australians requiring psychiatry services and share of population by SA3 region, 2021-22



Source: EY analysis of NMHSPF data

Note: Data for the Limestone Coast has been omitted due to potential data inconsistencies.

3.1.2.2 Current access to psychiatry services

Patients can access psychiatrists through various health care settings: private clinics, hospitals, and community settings. Data on patient access was obtained from relevant data custodians to assess current demand for psychiatry services in South Australia.

In 2021-22, patient access to psychiatry services was as follows:

- 30,363 patients accessed a private service, including a small subset in private hospitals (AIHW data on Medicare-subsidised mental health services provided by a psychiatrist; and Ramsay Health data)
- 19,394 accessed public community services, including outpatient services, and 434 accessed residential services (SA Health CBIS and CCCME data)
- 6,759 patients were admitted to a public hospital (SA Health and AIHW data)
- 16,204 patients presented at public hospital emergency departments (SA Health data).

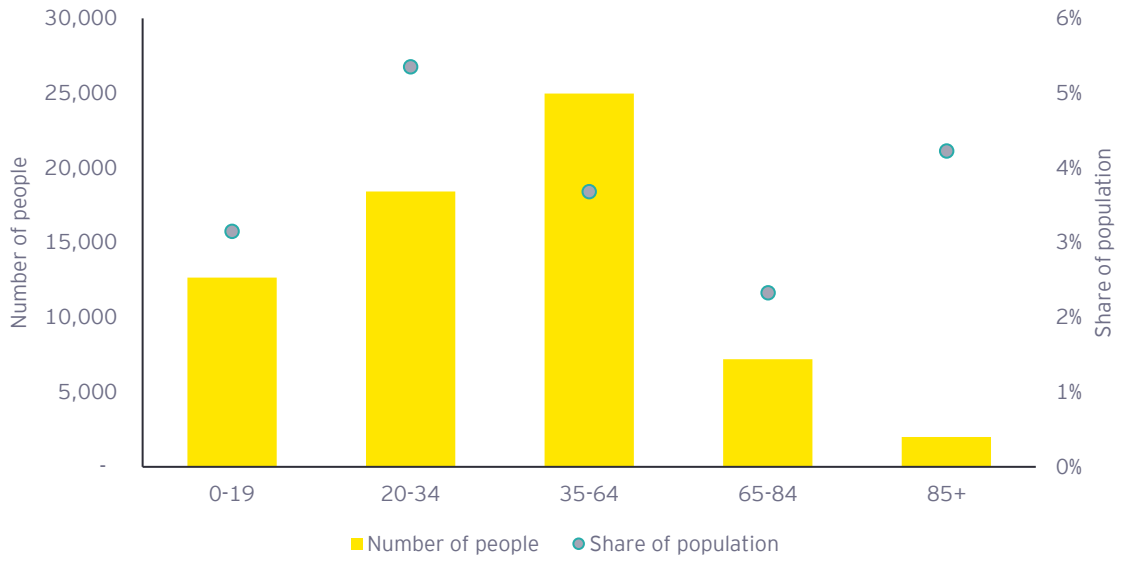
Many patients accessed care in multiple settings, so the total number of unique patients is lower than the sum of patients across all settings. After accounting for this overlap, estimates show:

- 34,879 patients accessed care in public settings
- 30,363 patients accessed care in private settings.

Data was not available to account for patients accessing care in both private and public settings. Therefore, the total number of patients estimated represents an upper bound. However, according to stakeholder consultations, the number of patients accessing care across both settings is expected to be small (Appendix E provides further detail). Additionally, some psychiatry services may be delivered by a registrar, but psychiatrists are expected to provide some input or oversight.

Analysis of this patient data revealed characteristics of patients that accessed psychiatric care. Young people aged 20 to 34 had the highest rate of access to psychiatric care, at 5.3% of the population (Figure 19).

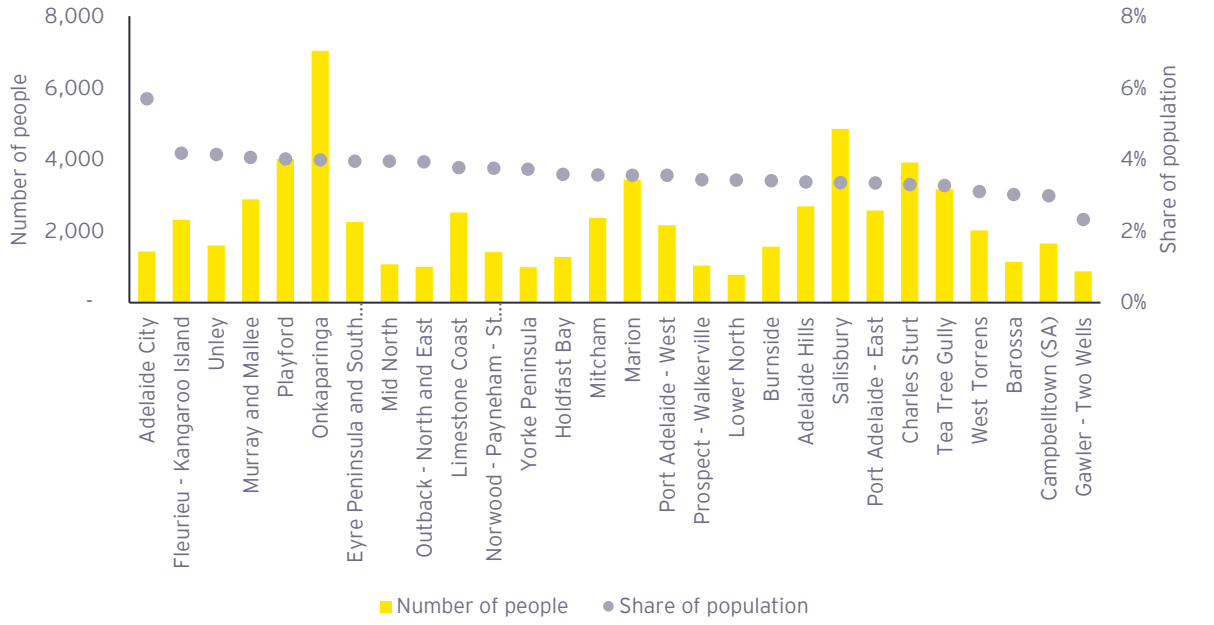
Figure 19: Number and share of people that accessed care from a psychiatrist by age group, 2021-22



Source: Census 2021, Patient data from various sources (SA Health, Ramsay Health, AIHW)

In terms of patient access based on residence, the share of the population accessing services was relatively consistent, ranging from 3-4% in most regions. Adelaide City had a higher rate at 6%, while Gawler–Two Wells had a lower rate at 2% (Figure 20).

Figure 20: Number and share of people that accessed care from a psychiatrist by location of residence (SA3 region), 2021-22



Source: Census 2021, Patient data from various sources (SA Health, Ramsay Health, AIHW)

3.1.2.3 Projected demand for psychiatrists to 2033

The key drivers of demand for psychiatrists include population growth in South Australia, the prevalence of mental health conditions, and the need for services. As the population increases, the demand for psychiatrists naturally rises. Population growth projections were sourced from Plan SA, categorised by age group and location (by SA3 region). The demand for mental health services is based on the prevalence of mental health diagnoses by age group, and adjusted for those requiring services, using data from the NMHSPF.

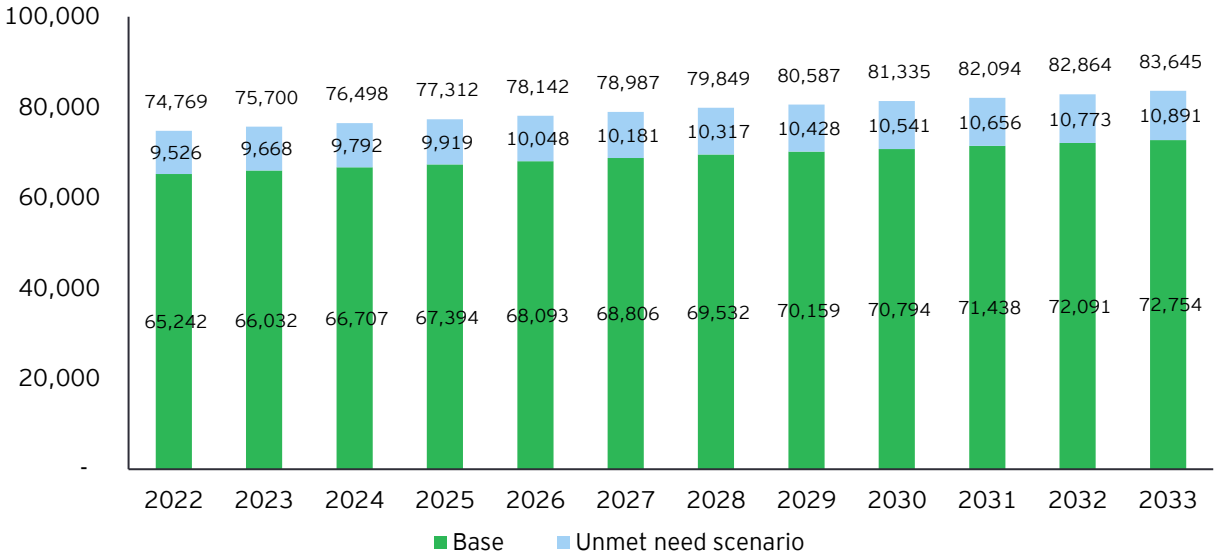
Two estimates of demand were considered in the analysis:

1. Base case: Reflects the continuation of the current service mix, psychiatry-to-patient ratios, and net access levels (accounting for both service availability and individual choice to access services).

2. Unmet need scenario: Builds on the Base case by considering the total need for psychiatry services. This scenario captures the total number of people with a medical need for psychiatry services, regardless of current service access. It provides insight into the total psychiatry demand beyond current service levels.[44]

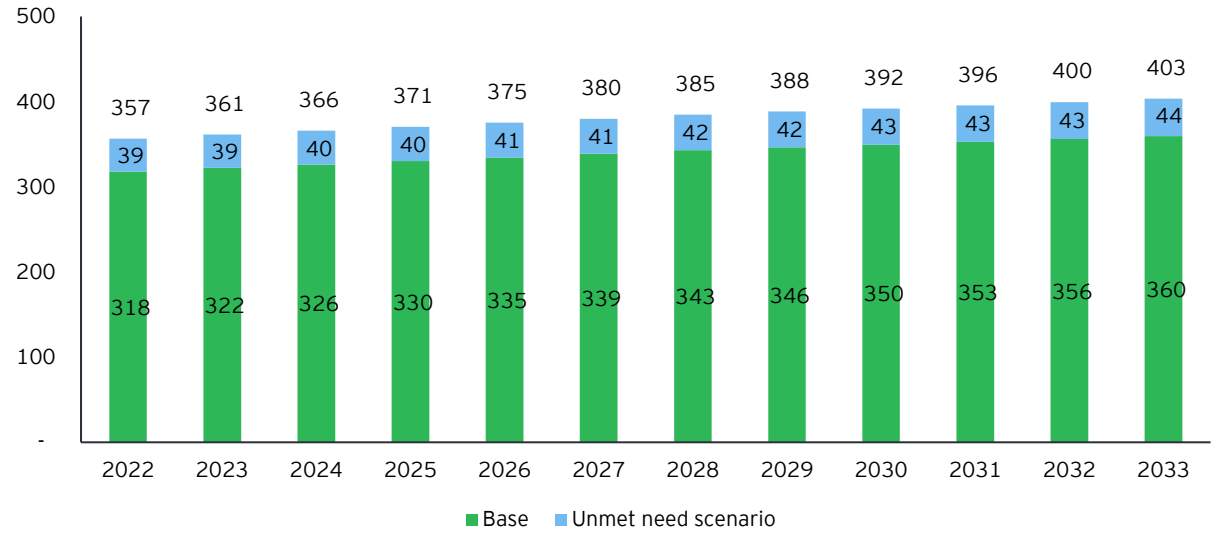
The number of patients requiring psychiatric services is expected to increase from approximately 65,242 people in 2022 to 72,754 in 2033 in the Base case, and 83,645 in the Unmet need scenario. Note that the Unmet need scenario builds on the Base case projections.

Figure 21: Projected patients requiring psychiatry services, 2022-33



Accordingly, the demand for psychiatrists increases from 318 FTE in 2022 to 360 FTE in 2033 (Base case) and from 357 FTE in 2022 to 403 FTE in 2033 (Unmet need scenario).

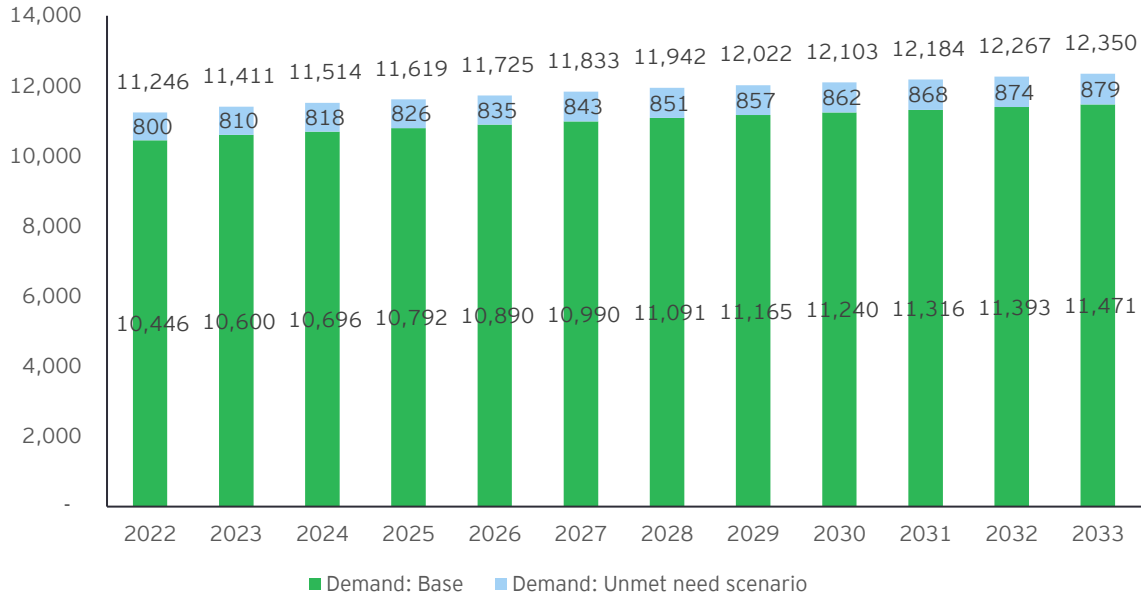
Figure 22: Projected demand for psychiatrists, headcount, 2022-33



[44] Note that the number of patients demanding services was estimated according to patient age and location (by SA3 region). The number of patients requiring care within each health care setting was estimated based on the current usage of each setting and adjusted to align with projected growth rates by health care setting according to NMHSPF data.

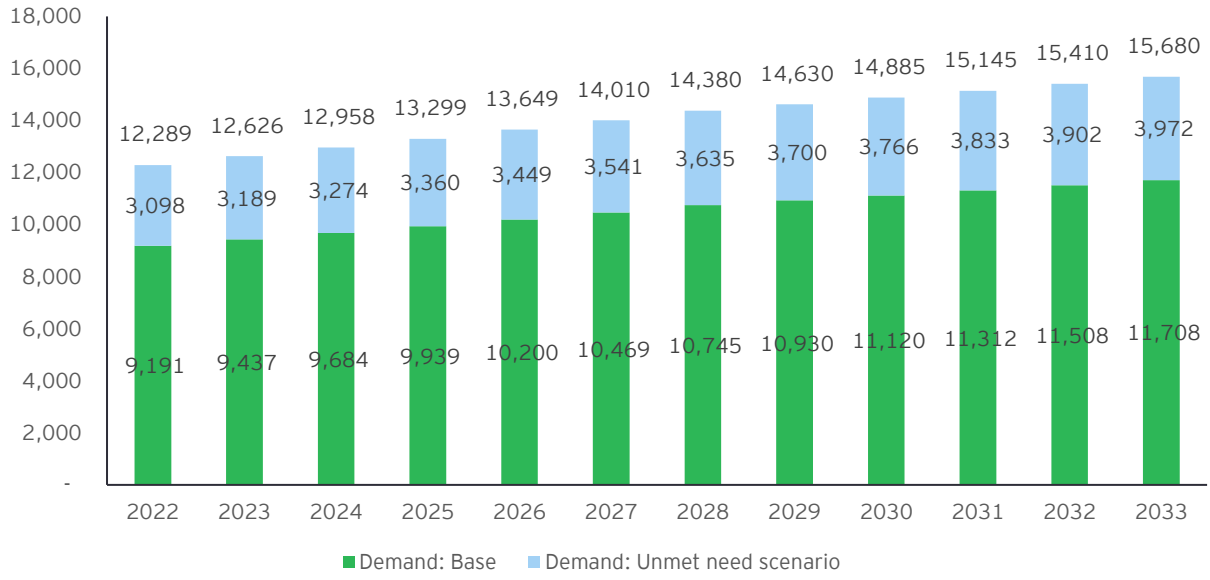
In terms of specific populations, there is projected to be a 10% increase in the child and adolescent population requiring psychiatry services from 2022 to 2033.

Figure 23: Projected patient demand for psychiatry services: 0-17 population, FTE, 2022-33



The demand for psychiatry services among the older population (65+) is projected to increase by 28% over the period, reflecting the strong projected population growth of this cohort.

Figure 24: Projected patient demand for psychiatry services: 65+ population, FTE, 2022-33



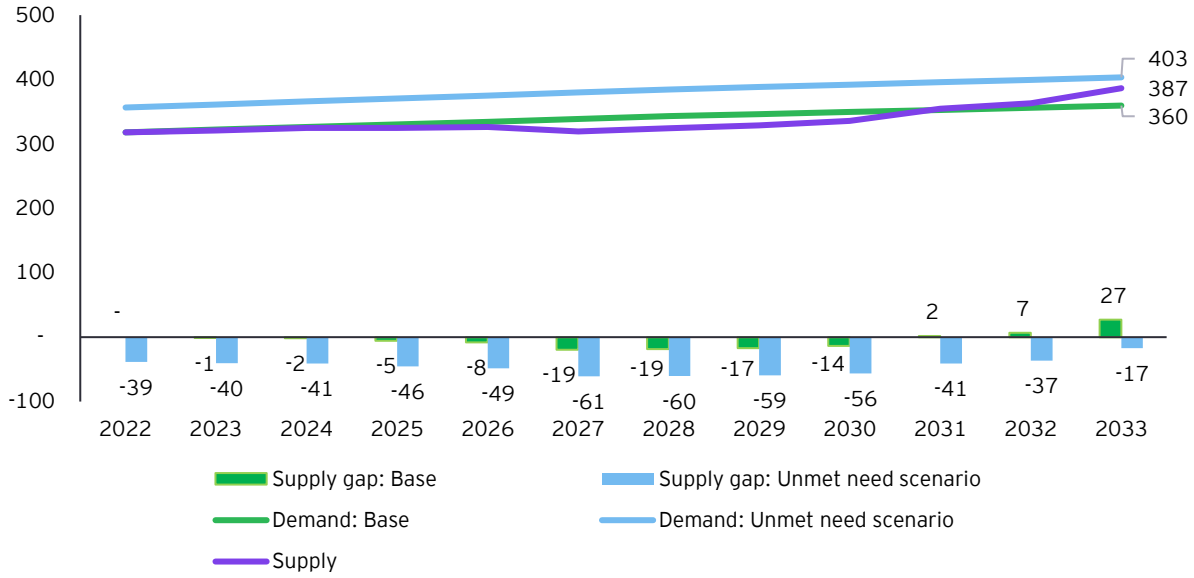
Commencing late 2025, 3 new 24-bed rehabilitation mental health inpatient units in CALHN, NALHN and SALHN will open which will require an estimated 6 consultant and 6 trainee psychiatrists across all. These vacancies may be filled by existing psychiatrists, those currently in training or by international recruitments. Although these extra beds were not incorporated into the modelling, they will be classified as unfilled positions in the development of the recommendations.

3.1.3 Projected workforce gaps

Considering the projected supply and demand for psychiatrists reveals potential workforce shortages over the projection period.

- In the Base case, supply is expected to initially meet demand at the start of the period. However, from 2026 to 2030, shortages are anticipated due to potential retirements, highlighting workforce shortages during this period. Towards the end of the period, surpluses are projected as more trainees join the workforce.
- In the Unmet need scenario, which considers additional demand, workforce shortage is expected to peak at 61 FTE psychiatrists in 2027, gradually decreasing to 17 by 2033.

Figure 25: Projected supply, demand and shortage of South Australian psychiatrists, headline, FTE, 2022-33



Note: The gap in 2033 varies slightly from the difference between supply and Unmet demand presented in the figure, due to rounding.

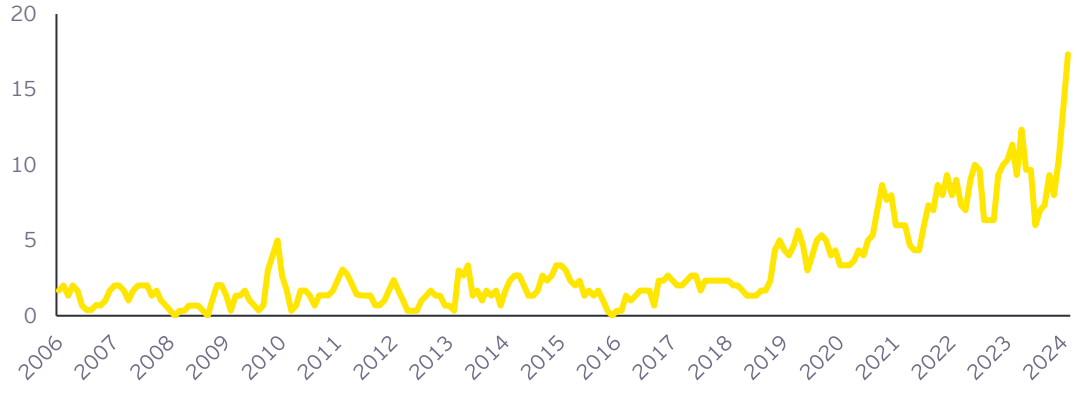
3.1.3.1 Factors not considered in the core modelling

The analysis assumes that the current workload managed by the psychiatry workforce is sustainable. However, emerging evidence suggests otherwise. This analysis is not incorporated in the core report findings due to its preliminary nature, warranting further investigation.

1. Open and unfilled psychiatry roles

Data from Jobs and Skills Australia shows 17 unfilled psychiatry roles in South Australia currently advertised online. These vacant roles are typically driven by workforce turnover and growth. As such, these roles could be considered as part of the current workforce shortage; meaning existing patient workload is spread across fewer psychiatrists than needed.

Figure 26: Number of psychiatrist job vacancies, South Australia, 2006-24



Source: Jobs and Skills Australia, Internet Vacancies Index, 2024

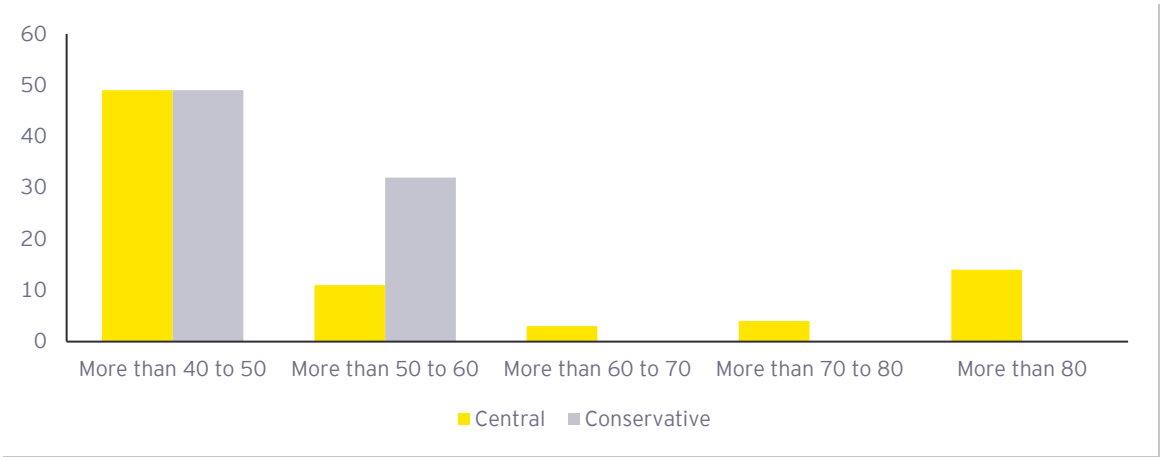
2. Overtime worked

It is important to consider whether current work hours are sustainable. The 2023 NHWDS data shows many psychiatrists working well over 40 hours per week, with some reporting over 80 hours. Whilst common among medical specialists, expecting such high workloads long-term may be unreasonable for both existing and new specialists.

The AHPRA registration survey[45] asks about the hours worked in the prior week. If it is assumed this represents a typical year:

- Central approach: Extra hours worked (above 40 hours a week) represent 30 FTE.
- Conservative approach: Assuming all psychiatrists reported to work over 50 hours actually worked 55 hours on average, extra hours represent 18 FTE.

Figure 27: Number of psychiatrists working overtime, by hours worked in a week, South Australia, 2023



Source: National Health Workforce Dataset, 2024

3. Qualitative evidence

Recent surveys indicate many psychiatrists are considering leaving the profession in the near term. A recent survey from RANZCP (February 2024) on psychiatrist wellbeing and job satisfaction found:

- 3 in 10 psychiatrists are considering leaving the profession in the next five years.[46]
- Approximately 80% of respondents believe workforce shortages contribute to burnout among psychiatrists.

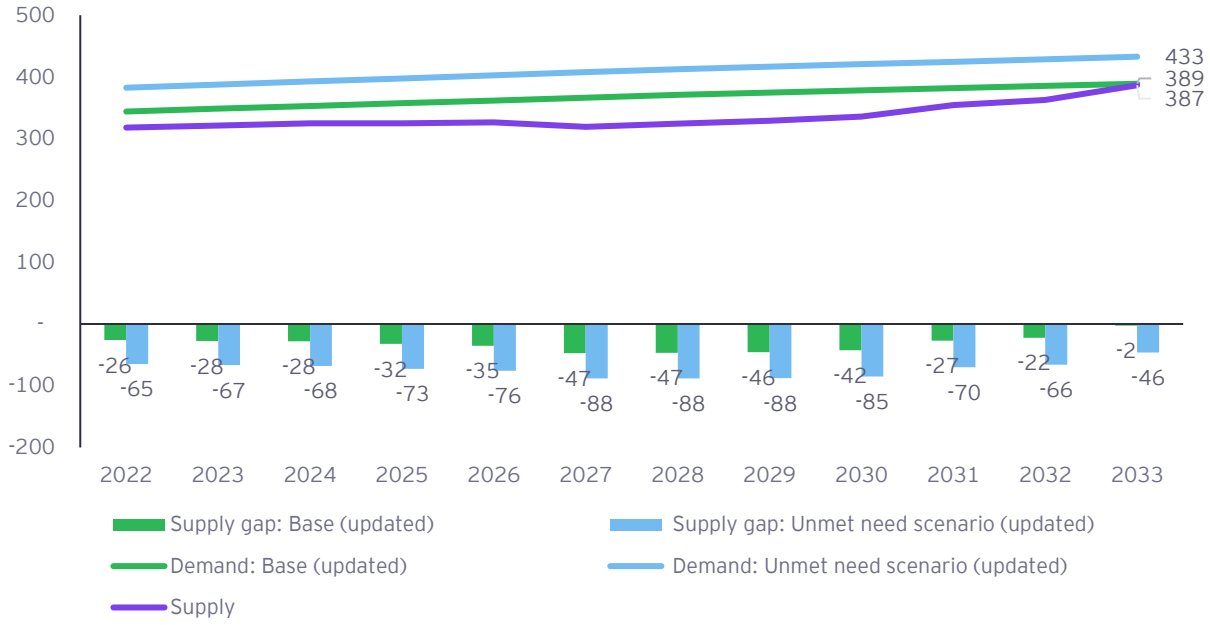
Impact on projected workforce gaps

If these sustainability concerns are considered in the analysis, the projected shortages would increase. Indicative analysis[47] shows:

- In 2022, the shortage increases from 0 to 26 FTE in the Base case, and the shortage increases from 39 to 65 FTE in Unmet need scenario.
- In 2033, there is a change from a 27 FTE surplus to a 2 FTE shortage in the Base case, and the shortage increases from 17 to 46 FTE in the Unmet need scenario.

[45] This survey is a key input to the National Health Workforce Dataset.
[46] *9 in 10 psychiatrists say workforce shortages are risking patient care in Australia* (2024) *RANZCP*. Available at: https://www.ranzcp.org/news-analysis/9-in-10-psychiatrists-say-workforce-shortages-are-risking-patient-care-in-australia (Accessed: 04 July 2024).
[47] This reflects approximately half of the current vacancies (8 FTE), as well as the conservative approach to the excess FTE analysis (18 FTE).

Figure 28: Projected supply, demand and shortage of South Australian psychiatrists – Updated to reflect current shortages, headline, FTE, 2022-33



3.1.3.2 Projected workforce gaps in sub-specialty areas

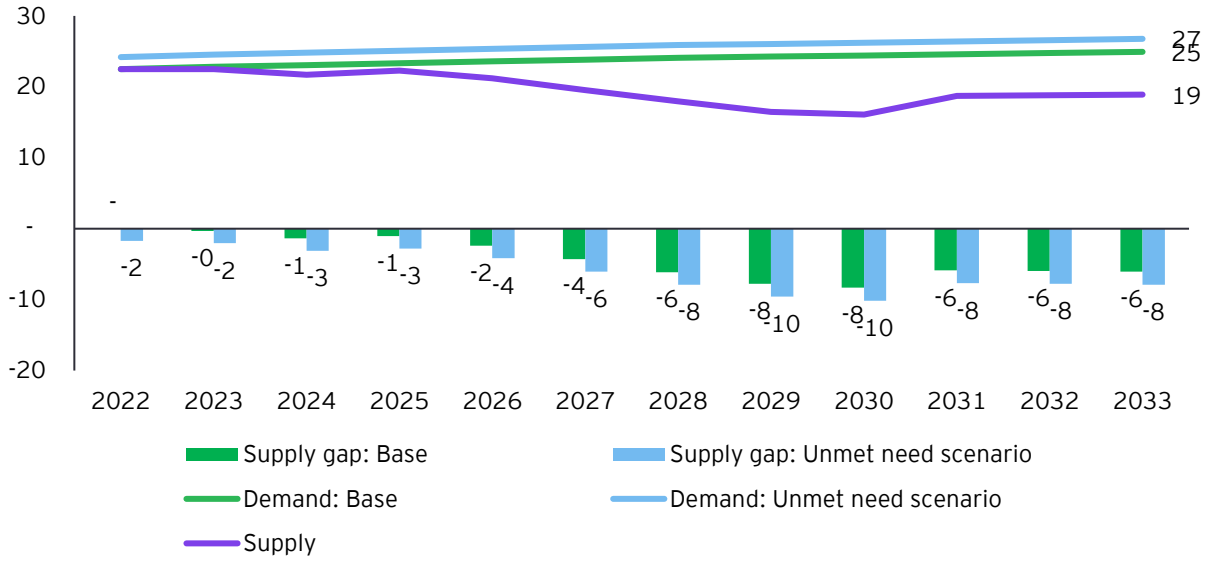
The workforce gaps for psychiatrists in specialised areas were assessed to identify key pressure points. A psychiatrist is considered a specialist if they are a Tier 1 Faculty member, having completed a Certificate of Advanced Training or gained formally recognised expertise in that area.

Child and adolescents

Currently there are 25 psychiatrists with a Tier 1 faculty membership in child and adolescent psychiatry equivalent to 22 FTE. The number of FTE psychiatrists may decrease to 16 by 2030. A slight recovery to 19 FTE is projected by 2033. This decline is attributed to an ageing workforce, potential retirements, and reduced working hours over this period.

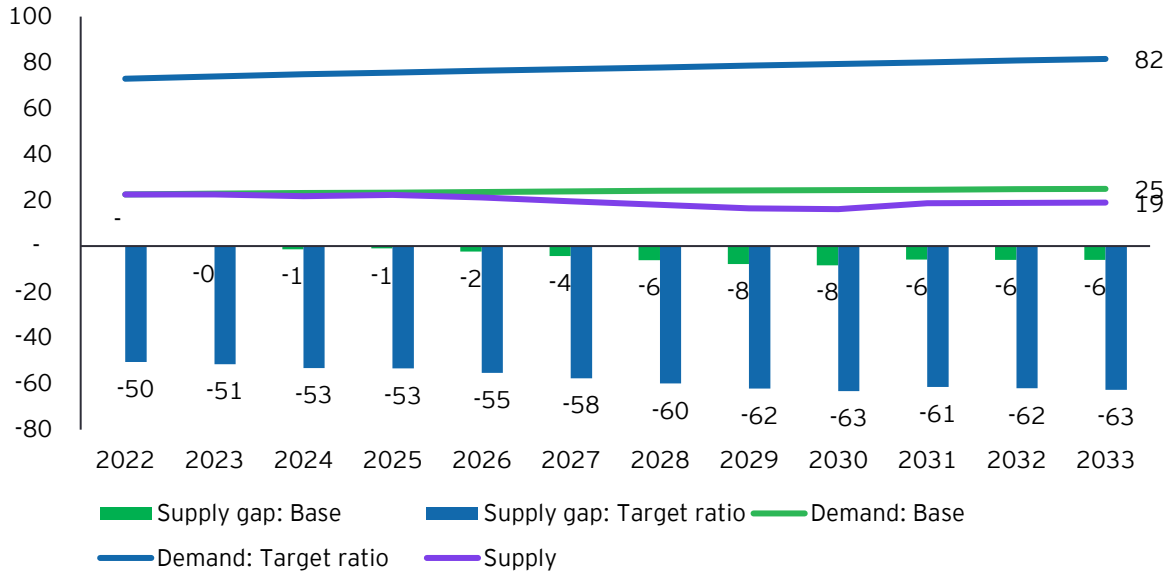
Shortages are anticipated throughout the forecast period under both the Base case and Unmet need scenario. The supply gaps are projected to be most significant in 2029 and 2030. These larger gaps are primarily due to a potential reduction in the workforce.

Figure 29: Projected supply, demand and shortage of child and adolescent psychiatrists, FTE, 2022-33



In 2022, South Australia had 1.2 FTE child and adolescent psychiatrists per 100,000 population. This falls short of the 4.0 FTE recommended in relevant literature.[48,49] This shortage suggests either insufficient psychiatrists to serve the population or that psychiatrists are handling larger than optimal patient loads. Achieving the 4.0 FTE target would require a significant increase in child and adolescent psychiatrists. This would result in more severe workforce shortages compared to the core modelling, as illustrated in Figure 30.

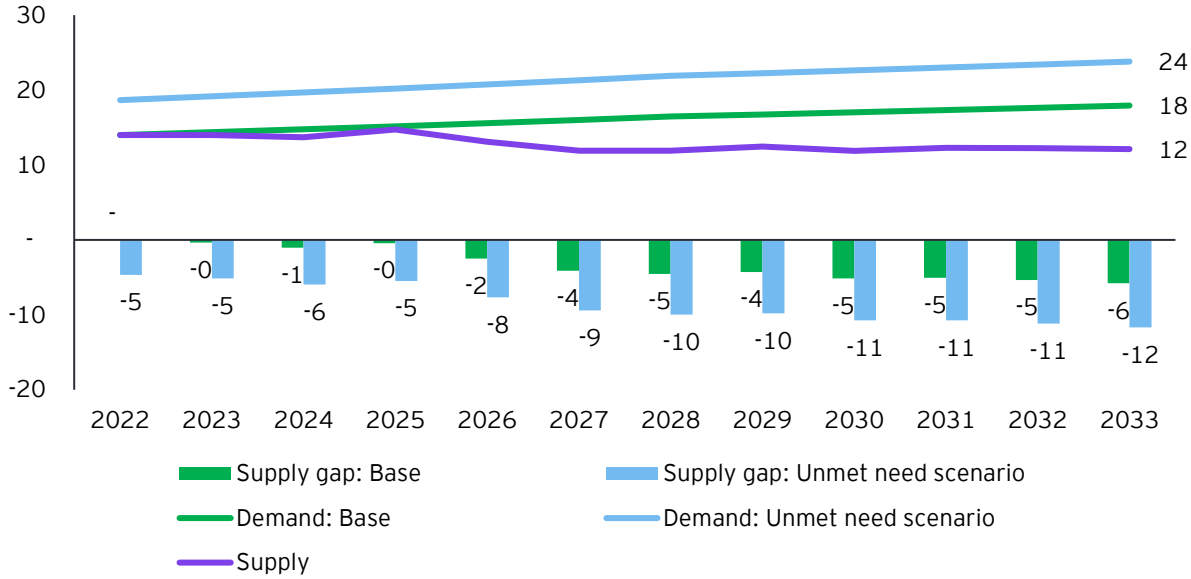
Figure 30: Projected supply, demand and shortage of child and adolescent psychiatrists, *Indicative analysis considering child and adolescent psychiatrist target*, FTE, 2022-33



Older persons psychiatry

Currently, there are 14 psychiatrists with a Tier 1 faculty membership in older persons psychiatry. If there is little uptake of training in this speciality, shortages are expected across the forecast period. These supply gaps are likely to increase each year. This trend is driven by a substantial increase in the older population over the next 10 years, resulting in increased demand for psychiatry services.

Figure 31: Projected supply, demand and shortage of older persons psychiatrists, FTE, 2022-33



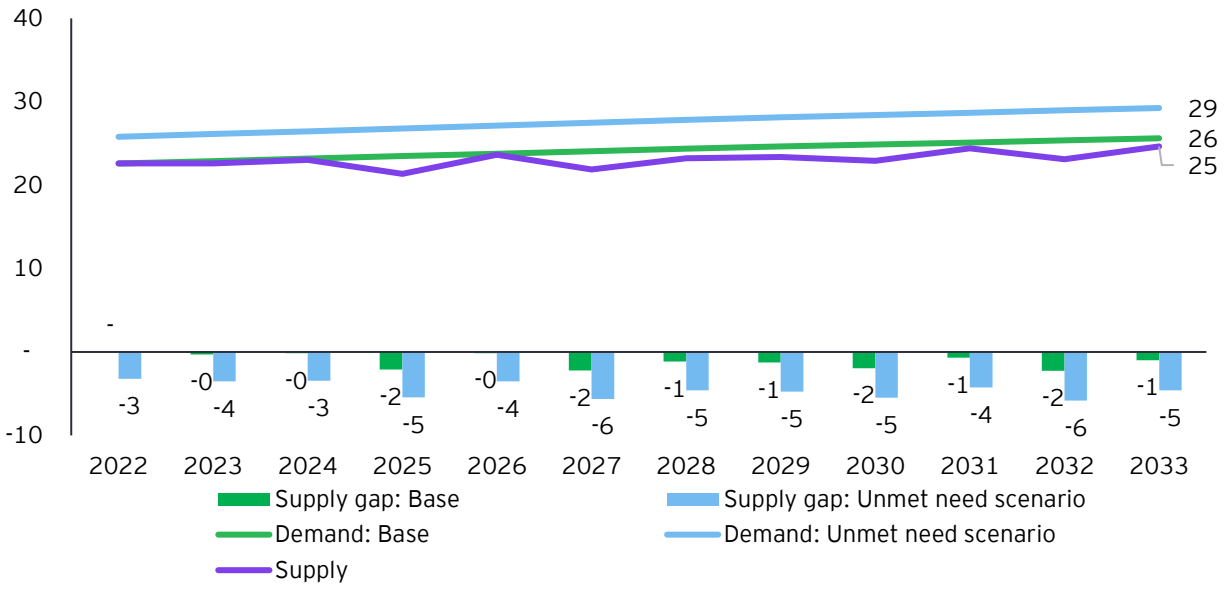
[48] Every-Palmer S, Grant ML, Thabrew H. Young people don't tend to ask for help more than once: Child and adolescent psychiatrists' views on ailing mental health services for young New Zealanders. Australasian Psychiatry. 2022;30(6):684-688. doi:10.1177/10398562221115624

[49] https://www.parliament.nsw.gov.au/ladocs/submissions/58760/Submission%2054%20-%20Royal%20Australian%20and%20New%20Zealand%20College%20of%20Psychiatrists.pdf

Forensic psychiatry

Currently 23 psychiatrists have Tier 1 faculty membership in forensic psychiatry. The estimated patient demand for forensic services is based on the share of community patients treated by a forensic psychiatrist in 2022. This share is held constant throughout the period, meaning demand grows in line with community services. In the Base case, supply falls slightly short of demand. However, when unmet demand is considered, greater supply gaps emerge.

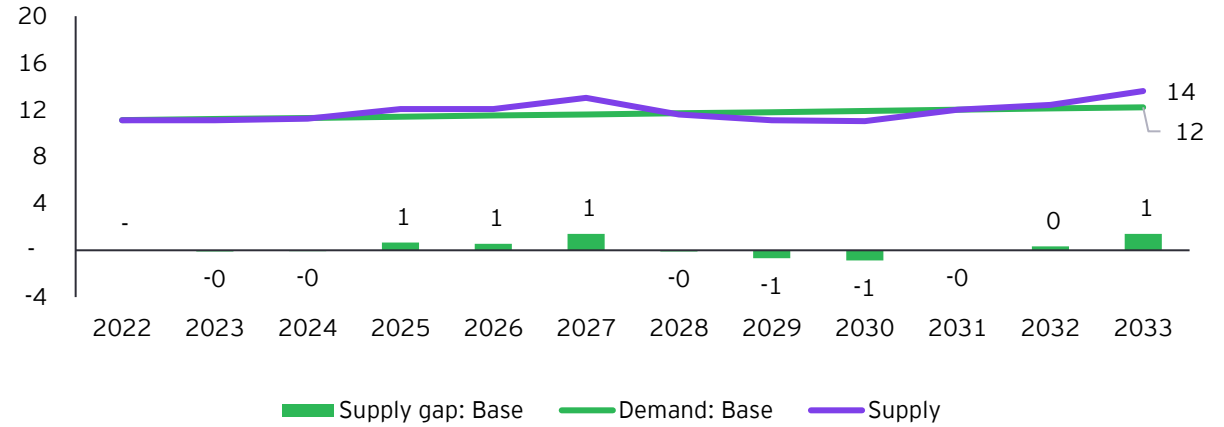
Figure 32: Projected supply, demand and shortage of forensic psychiatrists, FTE, 2022-33



Consultation-liaison psychiatry

There are 11 psychiatrists with a Tier 1 faculty membership in consultation-liaison psychiatry. Demand for these specialists is expected to increase by about 10% from 2022 to 2033, based on growth rates from the NMHSPF (Base case). Supply is broadly expected to meet this demand. Supply gaps might emerge in the Unmet need scenario, but this could not be estimated due to lack of data on patients treated by consultation-liaison psychiatrists.

Figure 33: Projected supply and shortage of consultation-liaison psychiatrists, FTE, 2022-33



3.1.3.3 Potential workforce gaps in regional and remote areas

The limited number of psychiatrists in regional and remote areas may indicate differences in care levels compared to urban areas. On average, there is one psychiatrist available to service every 857 people estimated to require a service in regional / remote areas.

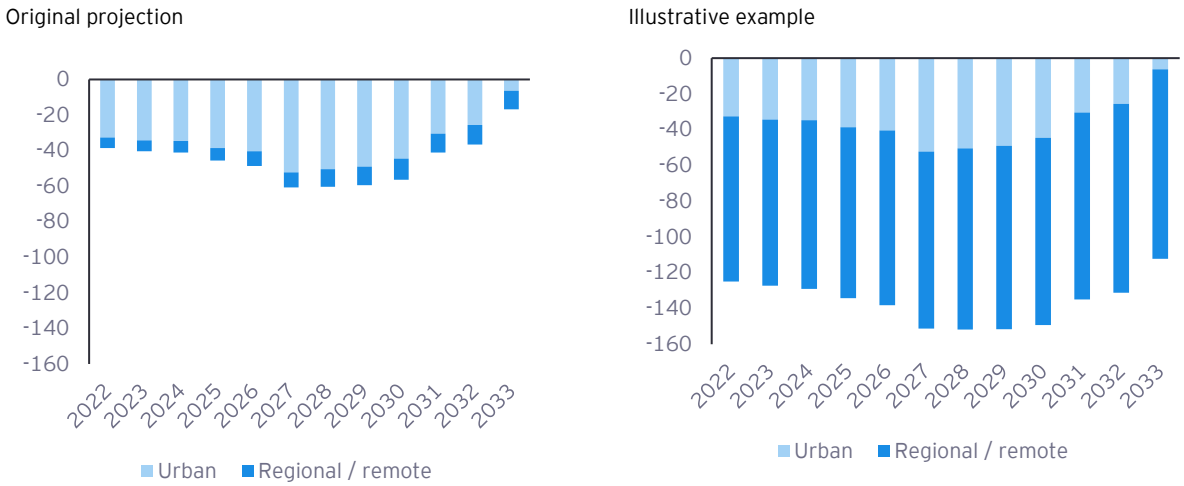
Table 3: Number of people requiring psychiatry services per FTE, in Urban and Regional / remote areas

	Need for psychiatry services	Psychiatrist (FTE)	Number of people requiring psychiatry services, per FTE
Urban	55,637	296	188
Regional / remote	19,131	22	857

Sources: NHWDS (2022) and various patient data sources (AIHW, SA Health, Ramsay Health)
Note: A region is classified as Urban where the majority of it sits within an ABS Major Cities *remoteness area, otherwise it is classified as Regional / remote.*

The modelling assumes the current high patient volumes seen by regional / remote psychiatrists will continue. If these psychiatrists were to achieve FTE to patient ratios consistent with urban levels, significantly more psychiatrists would be needed in regional / remote areas. This would increase projected supply gaps in regional/remote areas, as shown in Figure 34.

Figure 34: Projected psychiatrist shortages in Urban and Regional / remote areas, Unmet need scenario, FTE, Original and Illustrative example, 2022-33



Note: The illustrative example applies Urban patient-to-psychiatrist ratios in Regional / remote areas.

3.2 Access to services

The modelling analysis findings align with feedback from lived experience groups. They groups reported several challenges:

1. Difficulty accessing services, which can be particularly distressing when an urgent medication review is required.
2. Burden on patients or carers to find available psychiatrists. The RANZCP "Find a psychiatrist" webpage is helpful, but private psychiatrists must update their availability.
3. Patients and carers struggle to find psychiatrists accepting new clients. When appointments are available, wait times are long or the practitioner may not suit the patient's needs.
4. Families face the challenge of navigating complex and costly disability and mental health systems.
5. Desire for relationship-based services. Patients seek psychiatrists who show ongoing commitment and with whom they can build trust and rapport.
6. Continuity of care is particularly concerning for those transitioning from child and adolescent to youth and adult services.

3.3 Training

3.3.1 Training positions

The growth of the psychiatry workforce in South Australia is limited by available training places. In the past five years, eligible applicants have outnumbered available positions. At present, only about half of eligible candidates are admitted to the Fellowship training program. The two main factors limiting training places are:

1. Funding of training positions
2. Availability of existing psychiatrists to supervise trainees in placements.

Table 4: SA trainee enrolment summary, selection year 2019-2023

Stage of application process	Commencing in 2020 (Selected 2019)	Commencing in 2021 (Selected 2020)	Commencing in 2022 (Selected 2021)	Commencing in 2023 (Selected 2022)	Commencing in 2024 (Selected 2023)
1. Training places	21	19	24	24	23
2. All applicants	46	54	54	44	43
3. Met criteria for shortlisting / interview	36	53	50	44	42
4. Shortlisted for interview	31	27	30	29	28
5. Suitable for training	26	27	30	29	28
6. Offered a place	22	20	26	26	24
7. Accepted	21	19	24	24	23

In the 2024 cohort, 42 candidates met eligibility criteria, but only 23 places were available. This represents a potential surplus psychiatry workforce who are restricted by the limited positions.

The two mandatory rotations of Child and Adolescent Psychiatry and Consultation-Liaison Psychiatry are often cited as the primary reason for the shortage of training places. Increasing places depends on both funding and additional supervisors.

3.3.2 Training stages

Stage 1: First year of psychiatry training. Surplus potential workforce applies to enter at this point.

Stage 2: A 24-month placement, including 6 months each in child and adolescent psychiatry and consultation-liaison psychiatry (both mandatory), and 12 months in elective areas. Challenges arise here due to limited placements in mandatory rotations, capped by supervisor availability and funding.

Stage 3: 24-month training in general psychiatry or sub-specialties. Trainees complete four elective rotations with increased responsibilities (refer to Appendix B Employee lifecycle). This is the third stage in the career journey where congestion occurs. Limited positions here restrict advanced specialised training opportunities.

To address current training bottlenecks, funding could be distributed to both Stage 2 and Stage 3 positions, ensuring opportunities for training in advanced certificates. As advised in *Australia's Future Health Workforce – Psychiatry* report, changes should be implemented across all three training stages to avoid shifting congestion from one area to another.[50] Stakeholders suggested relocating The Adelaide Prevocational Psychiatry Program (TAPPP) positions to registrar placements, especially in Child and Adolescent Psychiatry and Consultation-Liaison Psychiatry.

3.3.3 Type of training

The increasing demand for psychiatric services necessitates an appropriate spread of generalist and specialist psychiatrists. South Australia currently has up to 172 specialist psychiatrists, with some holding multiple specialisations. Beyond the projected shortages in child and adolescent and older persons psychiatry, stakeholders report workforce gaps in disability, alcohol and other drugs (AoD), and rural health. These

[50] Department of Health 2016: Australia's Future Health Workforce – Psychiatry

findings underscore the need for more generalists and a redistribution of specialists across underserved areas.

Psychiatrists have expressed interest in rotation options for disability, private practice, AoD, and rural psychiatry. While these topics are covered in RANZCP coursework, practical experience is lacking. Introducing these rotations could potentially increase attraction to and skills in these fields. For private psychiatry placements, both hospital and room-based rotation options can provide a comprehensive understanding of different work environments and practical skills.

Consultations highlighted the importance of cultural awareness in delivering high-quality psychiatric services. For example, metropolitan psychiatrists working in regional or rural area would need cultural safety training and community integration. This also applies to internationally qualified psychiatrists, requiring appropriate training to prepare them for safe practice in the Australian health system. The independent review into overseas health practitioner regulatory settings supports this finding.[51]

There is high demand for college trainee positions. It is estimated that at any given time, 27% of trainees have not completed or are not actively engaging in training. A survey also found that over 3 in 10 respondents intended to leave the profession. Reasons for breaking in training or leaving include interstate relocation, career breaks, workload, family responsibilities, sabbaticals and career changes (e.g., to General Practitioner). To improve retention, it is important to ensure registrars have positive rotation experiences. This includes manageable patient loads, appropriate supervision, and opportunities to explore areas of interest.

3.4 Culturally appropriate practice

3.4.1 Aboriginal and Torres Strait Islander people's access

Aboriginal and Torres Strait Islander communities often face significant barriers to accessing culturally safe psychiatric care. These populations can be marginalised in mental health service delivery and may engage differently with the psychiatric system, sometimes presenting in crisis or end-stage situations.[52] There is generally a preference to receive health care within Aboriginal Community Controlled Health Organisations (ACCHOs), which provide a more culturally safe experience. Aboriginal and Torres Strait Islander populations disproportionately reside in rural and remote areas, which generally experience lower levels of access to psychiatrists.

To build culturally appropriate services, stakeholders suggest increasing psychiatry presence in ACCHOs and providing registrar opportunities within them. A shared care approach, involving collaboration between traditional and medical practitioners, can help create a comprehensive and supportive network, enhance service provision, and build the capacity of psychiatrist services in the community. Stakeholders also note that the SA and Commonwealth Government are jointly building a statewide Aboriginal and Torres Strait Islander Mental Health and Wellbeing Centre which will support collaborative care and provide training placements. It will seek to support Aboriginal and Torres Strait Islander people seeking to train in health professions.

3.4.2 Care for culturally and linguistically diverse populations

South Australia is home to a diverse population, with 430,000 people born overseas and 792,000 having at least one parent born overseas. The top 10 international countries of birth are England, India, China, Vietnam, Italy, Philippines, New Zealand, Scotland, Germany, and Malaysia. South Australians come from 214 countries, speak 248 languages, and practice 128 different religions.

The prevalence of mental illness and patient experience in culturally and linguistically diverse (CALD) communities in Australia is underrepresented in national mental health research and monitoring.[53] This lack of data can hinder best-practice diagnosis, with mental health services struggling to bridge language and cultural barriers. Immigrants, refugees, asylum seekers, and their families face lower access to mental health services, higher acute and involuntary admissions, and longer periods in wards.[54]

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[51] Independent review of Australia's regulatory settings relating to overseas health practitioners, Robyn Kruk, 2023

[52] *3.10 access to Mental Health Services* (2023) *AIHW Indigenous HPF*. Available at: https://www.indigenoushpf.gov.au/measures/3-10-access-to-mental-health-services (Accessed: 04 July 2024).

[53] Mental Health in Multicultural Australia, Framework for Mental Health in Multicultural Australia, 2014

[54] Mental Health in Multicultural Australia, Framework for Mental Health in Multicultural Australia, 2014

3.5 International recruitment

International recruitment has been a strategy discussed throughout consultations. It has also been part of the independent review into overseas health practitioner regulatory settings. This "Kruk" review recommends improving the efficiency and effectiveness of the regulatory process for international health professionals.[55] It emphasises that regulatory settings should signal Australia as an attractive destination for internationally qualified health practitioners, without discouraging recruitment and retention of global talent.

Countries with directly recognised training, such as New Zealand, Canada, and the United Kingdom, allow for faster Australian registration. However, onboarding can take up to 2 years. The main barriers for recruiting international psychiatrists are associated with registration requirements rather than immigration laws or visa applications (often expedited). The independent review suggests reforming the end-to-end journey for applicants to enhance support and focus on their needs.

There are variations in the willingness of different local health networks to recruit internationally. Some stakeholders raised concerns about ensuring ethical recruitment, particularly from jurisdictions with fewer psychiatrists per population than in South Australia. Others believe international recruitment should focus on academia to bring international best practices and establish a centre of psychiatry excellence in Adelaide.

Stakeholders emphasised the need to balance international recruitment with 'growing our own' local psychiatry workforce. This approach can complement other strategies to address workforce shortages.

3.6 Child and adolescent psychiatry

Child and Adolescent psychiatry faces significant challenges according to workforce modelling and stakeholder consultations. This sub-specialty was identified as one of the areas with the greatest workforce shortage. Refer to section 3.1.3.2 for relevant workforce projections.

Evidence from stakeholder feedback indicates a perceived lack of adequate resources, funding, and support for child and adolescent mental health services. In hospital settings, there is an anecdotal lack of multi-disciplinary and junior medical staff, leading to inefficient service models where administration heavily burdens psychiatrists.

Systemic reasons for these challenges include inadequate training and exposure in this specialty, cultural issues, burnout, short-term contracts, lack of support, and limited time for governance and research. These issues are prevalent across psychiatry but appear most acute in child and adolescent psychiatry.

The implications of these challenges are concerning, particularly as this age group is where a large portion of mental illnesses first present. Many psychiatrists in this specialty have expressed a desire to leave the public sector for private practice. This could further exacerbate the shortage and potentially lead to increased emergency department presentations and reduced access to specialised care for children and adolescents with mental health needs.

3.7 Rural psychiatry

3.7.1 Review of Rural Mental Health Services in SA

The *Review of Mental Health Services in South Australia,* released in May 2023, highlights the increased prevalence of mental health issues in rural areas, with suicide rates of over twice that of major cities. To meet national averages, an additional 81.3 FTE of psychiatrists' time is required to service rural South Australia. The review recommended a minimum increase of 50 FTE, and that 2 per regional LHN would provide immediate improvements. Considering what is realistic over the next 10 years, stakeholders suggested a smaller initial increase of 10-12 FTE, with the goal to reaching an additional 50 FTE over time.

The report recommends short, medium and long-term strategies for continuity of care and establishing resident psychiatrists. It calls for improved regional and central mental health system governance, differentiated regional workforce incentives, enhanced training and remuneration, and organisational cultural change. The review emphasised the importance of clinicians living within the community, as highlighted in this quote:

[55] Independent review of Australia's regulatory settings relating to overseas health practitioners, Robyn Kruk, 2023

"What contrasts rural versus metropolitan staff is the direct connection of rural clinicians and support staff with the communities they serve. This direct local (sometimes familial) accountability can be observed in the committed work ethic reviewers witnessed during the review. Without this local 'skin in the game' the system would surely fail."[56]

3.7.2 Access to rural services and prevalence

Patients in regional or rural South Australia face additional challenges in accessing psychiatrist treatment and ongoing care. With only an estimated 22 FTE psychiatrists providing public services in these areas (refer to workforce modelling in section 3.1.3.3), alternative care models such as telehealth appointment and monthly FIFO rosters have been implemented.[57] However, stakeholders report that while these models may increase accessibility, they can be challenging due to the lack of cultural and contextual knowledge about rural life and its impact on mental health. This was also reflected in the Review of Rural Mental Health Services in SA (see above quote in 3.7.1) and was corroborated by Kavanagh et al. (2023), whose study results suggested that there can often be a lack of contextual rural understanding, which acts as a barrier to receiving appropriate mental health care.[58] Patients also seek continuity of care and to develop a relationship with their psychiatrist. In some instances, this can be inhibited by FIFO or telehealth appointments, where there is not a continuous commitment over a long period of time to a region. Stakeholders acknowledged that where a living and working regional psychiatrist is not available, FIFO allows access to a psychiatrist that would otherwise not be possible.

3.7.3 Rural model of care

Rural and remote areas in South Australia face a significant shortage of psychiatrists, with only an estimated 22 FTE psychiatrists servicing these regions. This scarcity has led to a heavy reliance on FIFO and telehealth appointments. Psychiatrists have identified several barriers to rural practice, including a lack of incentives such as MBS rebates, limited residency options, and insufficient transport provision. Additionally, there is a notable absence of rural rotations and specific rural training in psychiatrist programs.

To address these challenges, enhancing support and incentives may encourage more psychiatrists to work in rural areas. Potential measures include improving MBS rebates, providing transport and housing for registrars, and reducing after-hours responsibilities. Many psychiatrists report that current incentives are not strong enough to attract them to rural work.

Stakeholders have also highlighted the increased difficulty in assessing patients and managing risk through telehealth appointments. Where locum or telehealth psychiatry is necessary, it is important to establish appropriate structures for ongoing continuity of care. This can be achieved through strengthening the patient's relationship with their GP or allied mental health professionals. Furthermore, communication pathways between visiting psychiatrists and rural health care teams should be robust and frequent to ensure effective patient care.

This approach aims to balance the need for accessible psychiatric care in rural areas with the challenges of remote service delivery, while addressing the concerns of both patients and practitioners.

3.7.4 Regional LHNs

Historically, there has been a much lower ratio of psychiatrists working in regional and rural locations compared to Adelaide metropolitan regions.[59] To address this disparity, one suggestion is to aim for 1 psychiatrist per 100 cases on the community team, as per the SALHN model. Assuming the current open cases in country South Australia is typical of average cases, this would equate to 12.42 FTE psychiatrists in the community team, an additional 5 FTE above the current number. Having a dedicated resource for community psychiatry could also ensure equitable service of regional and rural locations, along with establishing a recognised system for allocating FTE resources.

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[56] Coleman, M., Roberts, R., English, L. (2023). Review of Rural Mental Health Services in South Australia, p. 48.

[57] Noting regional and rural South Australia includes the ABS remoteness areas that are not classified as *Major Cities*.

[58] Kavanagh, B.E., Corney, K.B., Beks, H. et al. A scoping review of the barriers and facilitators to accessing and utilising mental health services across regional, rural, and remote Australia. *BMC Health Serv Res 23*, 1060 (2023). https://doi.org/10.1186/s12913-023-10034-4

[59] Coleman, M., Roberts, R., English, L. (2023). Review of Rural Mental Health Services in SA, p. 48.

3.8 Psychiatry service model

3.8.1 Public and private psychiatry

Both public and private psychiatry sectors play crucial roles in mental health services delivery in South Australia. Private psychiatrists, while making up about one-third of the workforce, see approximately half of the patients.[60] The private sector typically offers a broader range of services, such as individual, group, and family therapy, catering predominantly to patients who can afford to pay out-of-pocket. Through private health insurance, patients have access to inpatient care at the Ramsay Hospital. There is an increased ability for continuity of care to be attained in the private sector, as patients often see the same psychiatrist over time. In contrast, the public sector generally focuses on patients who cannot afford private treatment, including severe cases needing immediate hospital attention. Continuity of care may be challenging to maintain in public psychiatry due to high demands and rotation of staff. The notable variation in structure and operation between public and private psychiatry reveals a diversity of experiences and challenges which directly influence patient treatment and employee satisfaction.

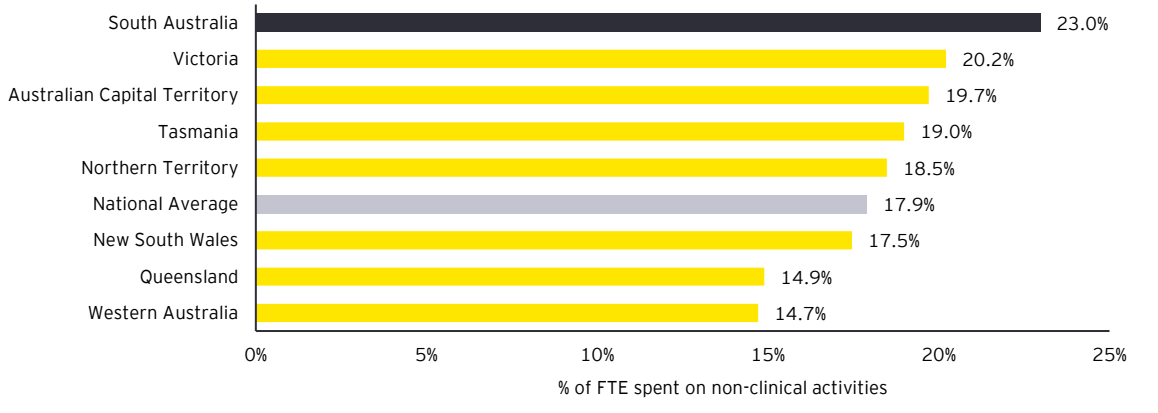
3.8.2 Time usage

Time management is a significant issue for psychiatrists in South Australia. They spend more time than their peers on non-clinical activities (23%) than the national average (18%), according to analysis of the National Health Workforce Datasets. Non-clinical time for psychiatrists encompasses a range of activities specified in their Enterprise Bargaining Agreement (EBA), job specifications, and workplans. These include clinical research, quality and safety assessments, audits, professional commitments, and teaching. While these activities are essential, consultations revealed that psychiatrists are also spending time on additional tasks such as administration, patient 'no-shows', and duties that could potentially be performed by administrative staff and other medical or allied health professionals.

If psychiatrists in South Australia were to reduce its time spent on non-clinical activities from the current 23.0% to 17.9% (the national average), modelling indicates this could free up 16 psychiatry FTE (for example, if this extra time was due to administrative burden). When considering ways to reduce non-clinical activities, administrative tasks should be the primary focus. However, it's crucial to protect time allocated for clinical research, clinical supervision, and mentorship, as these activities are vital for maintaining high quality care and professional development.

It is important to note that the current agreement between SA Health and SASMOA stipulates a higher allocation (30%) for non-clinical duties.[61] If non-clinical time were to increase in line with this, focusing on research, supervision, and mentorship rather than administration, a greater number of psychiatrists would be required. This highlights the challenge of balancing efficiency with the importance of non-clinical activities in workforce planning for South Australian psychiatry.

Figure 35: Non-clinical proportion of psychiatrists time in SA, 2022



Source: National Health Workforce Dataset, 2022

[60] Note that it was not possible to estimate the extent to which patients may have accessed care in both a public and private setting.
[61] The current agreement is that approximately 30% of clinicians' time should be spent on these tasks, which includes approximately 10% on Professional Commitments, 5% on Teaching, 5% on Research, 7.5% on Quality and Safety and 2.5% on Audit.

3.8.2.1 "No-shows"

Patient non-attendance was reported as a significant issue in the public psychiatric sector, with a substantial portion of psychiatrists' time being taken up by missed appointments. Non-attendance makes it difficult to reallocate time for other clinical and non-clinical activities at these times. Specific factors can apply in mental health settings either requiring psychiatrists to undertake home visits or rely on the assistance of team members to bring patients to appointments.

Research indicates that factors such as younger age, substance use, poor English proficiency, and lower socioeconomic status are associated with higher rates of non-attendance.[62] However, studies have shown that appointment reminders via text messages and phone calls can significantly reduce non-attendance.[63]

3.8.2.2 Allied health support

Stakeholder engagement revealed that many psychiatrists believe certain functions could be performed by other professionals, such as psychologists or mental health nurses. This would allow psychiatrists more time to spend on acute or complex patient presentations. There is a desire for a more dedicated approach to multi-disciplinary teams, which could help psychiatrists concentrate on tasks specific to their expertise. For instance, some emergency departments currently require all patients presenting with suicidal ideation to be seen by a psychiatrist, while in other states, experienced mental health nurses often manage these assessments.

Some psychiatrists have raised an additional consideration regarding the alteration of existing care models. They are concerned that focusing solely on the 'top of their scope of practice' might decrease practitioner satisfaction by removing rewarding aspects of their work, such as providing psychotherapy to patients.

3.8.2.3 Administrative burden

Many psychiatrists reported feeling under-supported, with a significant portion of their time consumed by administrative tasks. These include faxing, preparing reports and letters and following up patients. Some psychiatrists estimated spending up to 50% of their time on administrative work. They suggested that additional administrative support should prioritise appointment scheduling, payment processing, and faxing, rather than tasks requiring medical administration skills.

In addition to administrative tasks, psychiatrists can have additional significant legal responsibilities - for example attending to give evidence at tribunal hearings. Psychiatrists reported that this can also be time consuming.

The clinical administrative burden is partly attributed to the high levels of medicolegal risk associated with psychiatric work. Psychiatrists reported feeling that the ultimate responsibility for patient care falls on them, even within multi-disciplinary teams. This creates additional administrative requirements and contributes to increased cognitive burden. Ironically, the time spent ensuring correct paperwork is completed to manage medicolegal risk can reduce the time available for direct patient care.

3.8.3 Private hospital admissions

Stakeholders reported a perceived reluctance among private psychiatrists to admit patients to private hospitals. This shifts the burden to public emergency departments. Two main factors contribute to this issue: remuneration practices by private insurers, and private psychiatrists' unwillingness to see patients outside regular working hours. At Ramsay Hospital, only 30-40 of 101 psychiatrists use their admission rights. This indicates that actual admission numbers do not reflect the potential capacity.

The situation is compounded by an ageing workforce. The average age of admitting psychiatrists is 57 years, suggesting that as these practitioners retire in the near future, private hospital admissions could decrease further. The absence of an on-call roster at facilities like Ramsay Hospital is another factor potentially deterring admissions, as this limits the flexibility for patient care outside standard hours.

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[62] Munasinghe S, Page A, Mannan H, et al, Determinants of treatment non-attendance among those referred to primary mental health care services in Western Sydney, Australia: a retrospective cohort study Open 2020;10:e039858. doi: 10.1136/bmjopen-2020-039858
[63] Miller MJ, Ambrose DM. The Problem of Missed Mental Healthcare Appointments. Clin Schizophr Relat Psychoses. 2019 Winter;12(4):177-184. doi: 10.3371/CSRP.MIAM.112316. Epub 2016 Dec 20. PMID: 27996314.

3.8.4 Physical infrastructure

Physical infrastructure supporting psychiatry is not within the scope of this review. However, the following observations from stakeholder consultations are shared to support continuous improvement for psychiatry professionals.

South Australia offers limited options for patients requiring psychiatrist treatment in hospitals, clinics, or residential treatment facilities. Lived experience groups reported ongoing difficulties accessing necessary care and perceived being discharged from facilities too early.

The state lacks purpose-built facilities for specific needs:

1. Eating disorders
2. Comorbidity of a psychiatric illness with a disability
3. Private facilities for perinatal patients
4. Private facilities for child and adolescent inpatients

Some stakeholders reported that the Mallee Ward in the Women's and Children's Hospital is insufficient to manage state-wide child and adolescent psychiatry hospital demand. Stakeholders believe the spaces do not tailor to the various ages and psychiatric needs of different patients, and as the only option for child and adolescent patients, can be a somewhat unpleasant environment for youth.

Stakeholder consultations, particularly with public psychiatrists, revealed that limitations in emergency department infrastructure contribute to poorer clinical functionality. Some reported conducting patient assessments in open spaces, negatively impacting both patients and the psychiatrists.

For patients, the lack of private assessment spaces can reduce psychological safety. They may be reluctant to share personal experiences in an open-plan environment where others could overhear.

Open-plan office environments were also reported to be problematic, allegedly reducing psychiatrists' productivity. This is consistent with recent research suggesting that open-plan office environments lead to decreased performance levels.[64]

3.9 Support and retention of psychiatrists

3.9.1 Psychiatrist wellbeing

Many psychiatrists report compromised wellbeing due to workload. A recent RANZCP nationwide survey[65] revealed that 82% of psychiatrists experienced burnout symptoms within the last three years. In South Australia specifically, 45% reported difficulty focussing on work-related tasks, and 40% experienced loneliness or isolation contributing to burnout.

Feelings of loneliness intensify when psychiatrists bear the primary burden of patient care without access to a second opinion. For example, we heard that in public hospitals, registrars and early-career psychiatrists sometimes assess, admit, treat, and discharge patients without senior consultation. This can intensify a sense of pressure, especially when decisions are incorrect.

Registrars are occasionally used to fill shortages of psychiatrists, potentially contributing to early-career burnout. Later-career private psychiatrists also face challenges accessing second opinions. Many advocate for more flexible work options in public settings, including part-time opportunities.

Some psychiatrists commented that inter-team dynamics can make it challenging for them. For example, we heard that there is not always a clear approach to model of care for patients, meaning that there can be discrepancies between what different team members believe would be the most appropriate course of treatment for patients. It was suggested that having a clear model of care that is endorsed by all would help alleviate this problem and contribute to a more efficient provision of care for patients.

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[64] Gerlitz, A., Hülsbeck, M. The productivity tax of new office concepts: a comparative review of open-plan offices, activity-based working, and single-office concepts. *Management Review Quarterly* (2023). https://doi.org/10.1007/s11301-022-00316-2

[65] Burnout and moral injury: Australian psychiatry at its limits; Report by The Royal Australian and New Zealand College of Psychiatrists, February 2024

3.9.2 Succession planning

Many stakeholders expressed concern about inadequate succession planning. Senior professionals worry about potential gaps in leadership, academia, and research upon their retirement. Pathways to leadership positions are unclear, and existing psychiatry health programs provide insufficient guidance for succession.

Research and leadership development are often neglected due to demanding clinical responsibilities. A systematic, well-structured succession planning process could support future leaders with necessary training and development opportunities. Enabling time for these activities among junior clinicians has the potential to maintain a strong workforce over time.

3.9.3 Academia, research, and development

Stakeholders told us that enforcing sanctioned research and leadership development time within the routine practices of psychiatrists could be instrumental in helping to ensure the workforce remains up to date with the latest research and evidence-based methodologies. The importance of fostering strong academic ties and promoting constant innovation in practice was emphasised. Sustainable and best practice psychiatrist services require regular and rigorous research. However, many psychiatrists feel non-clinical activities are less pertinent as they reallocate time from patient care. Few psychiatrists have enough time to invest in researching the existing literature or other aspects of academia, such as producing research papers.

3.9.4 Mentorship

There's strong advocacy for enhanced mentorship, particularly for early-careers psychiatrists across all fields. However, specialties with current and projected shortages may struggle to secure sufficient mentorship or clinical supervision for new registrars. Despite this, 51% of respondents in the RANZCP national survey said that supervising or mentoring would contribute to their job satisfaction.[66]

Stakeholders expressed ongoing concern about the lack of clinical psychiatrist academics within universities. To address this and attract more undergraduate medical students to the profession, there is support for:

- Creating more clinical academic positions
- Establishing centres of excellence

These initiatives, led by high-quality professors, are expected to draw high-achieving individuals into psychiatry, particularly areas such as Child and Adolescent and Consultation-Liaison Psychiatry.

3.10 Access to and use of data

3.10.1 Forward workforce planning and data informed decision-making

Effective data collection, storage, and retrieval are crucial for the transparent functioning of public services and forward planning of the workforce. However, throughout this engagement, accessing required data sources proved challenging and time-consuming, causing project delays. The issue appears to be a reoccurring theme throughout the SA psychiatry workforce, reflecting broader challenges within SA Health as noted in independent investigations. [67]

The projected supply and demand of the SA psychiatry workforce should be re-forecast on a regular basis, at minimum every two years. Both quantitative and qualitative data should be used to analyse workforce shortages (or surpluses). This type and regularity of analysis will provide an opportunity for decision-makers to understand the progress made on closing the supply-demand gap in psychiatry and adjust the future direction of workforce strategies as required.

3.10.2 Patient data

While data management falls outside of this review's scope, there is notably an opportunity for SA Health to evaluate the impacts of current patient data storage and access practices. The patient data analysis conducted for this workforce plan identified key data sources for public sector psychiatry services:

- SA Health's CBIS system for community and residential services

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[66] Burnout and moral injury: Australian psychiatry at its limits; Report by The Royal Australian and New Zealand College of Psychiatrists, February 2024

[67] Troubling Ambiguity: Governance in SA Health (2019)

- CCCME system for community and residential services in regional and remote areas
- Sunrise electronic medical records (EMRs)

These EMRs are intended to provide an integrated, secure platform for patient data storage and access across health care professions statewide. However, consultations with psychiatrists revealed that different EMR systems are provided in different sectors and for different products across sectors. The use of multiple systems such as CBIS and CCCME complicates central data storage and collection, leading to inefficient practices. Some psychiatrists resort to paper document storage or have inadequate file storage systems on their computer. These practices potentially lead to patient care delays and risk of privacy breaches. It is important to note that data storage concerns are not exclusive to mental health services but permeate the broader health system.

3.11 Broader health system related findings and funding mechanisms

The South Australian health system's structures can impede optimal provision of psychiatric care. Key challenges include the structure and interpretation of the Medicare Benefits Schedule (MBS), unclear implications of the Rights of Private Practice, and the time-intensive demands of the NDIS assessment process.

3.11.1 Medicare Benefits Schedule

Stakeholder consultations identified the current MBS structure as a significant pain point. Psychiatrists reported issues with the availability of item numbers for their daily work. The private psychiatry workforce expressed concern about ad hoc or administrative tasks without a method for tracking this time against an MBS item code.

One example provided during the consultations was the time spent advising to other clinicians, such as GPs, about patients not currently under psychiatric care. These ad hoc conversations aim to reduce future burden on the health sector through early identification and intervention of mental health issues. However, the lack of an MBS item code for this cross-disciplinary, early care effectively discourages such valuable interactions.

Another concern raised was the disparity in remuneration between private in-patient and out-patient care. The insufficient MBS items for in-patient care fail to account for additional costs, such as travel time and hospital admission paperwork. This shortfall significantly discourages patient admissions.

3.11.2 Rights of Private Practice

South Australian psychiatrists earning public salaries can access Rights of Private Practice (RoPP), allowing them to see and bill private patients within public settings. This means private patients' treatments are funded by Medicare and/or private health insurers, increasing the psychiatrist's income beyond their public salary.

Concerns around the impact this policy include:

1. Equitable access: Salaried psychiatrists might prioritise private patients
2. Accountability: Unclear time and resource allocation between public and private work
3. Potential conflict of interest: Psychiatrists receiving private payments during public hours

Removing RoPP (e.g., via a paid loading) could increase the proportion of public patients seen.

RoPP is contentious across the public health sector due to "double dipping" concerns, lack of governance, and access to care issues[68]. The impact RoPP on public patient care is ambiguous, especially if clinicians are prioritising private patients. Consultations revealed significant concern about its effect on access to public psychiatric care and additional load on the public health system.

RoPP adds complexity due to the unclear division of time clinicians spend on private patients during their salaried hours. In public hospitals, every appointment has the potential to charge that patient as private if the patient has been referred by another practitioner to meet MBS criteria. This raises concerns about clinicians receiving substantial private fees while on public salary, effectively "double dipping" with two income streams.

The governance of RoPP is at the heart of this issue. There is minimal oversight of how clinicians use their time within the public health system. The system lacks clear directives or policies to manage RoPP time for

[68] Troubling Ambiguity: Governance in SA Health (2019)

salaried clinicians. Additionally, there is no consistent and transparent method to track time spent on RoPP versus public patients.

3.11.3 National Disability Insurance Scheme (NDIS)

The NDIS support qualification process requires a mental health assessment by a qualified clinician to prove a significant and permanent psychosocial disability. However, we heard this system overlooks conditions with episodic courses such as bipolar disorder, or which with fluctuating symptoms, like Tourette's syndrome. These conditions have variable acute and debilitating periods that can significantly impact functional ability and may require psychiatric support.

Consultations revealed that specialised psychiatric assessments for NDIS decisions can be time-consuming, increasing the administrative work for psychiatrists. This additional work is not currently recompensed through the MBS. Furthermore, the NDIS staff are not required to participate in multidisciplinary case conferences (MDCCs) to design and communicate treatment plans for individuals with psychosocial disabilities.

The lack of compensation and mechanisms for continued care involving the clinician has become a source of frustration for many psychiatrists. This affects their willingness to engage with the NDIS process.

4. The Workforce Plan

4. The Workforce Plan

4.1 Preliminary note

The South Australian psychiatric workforce operates within highly complex mental health and general health systems. Significant barriers exist that can make implementing recommendations challenging. Known barriers have been considered in developing the recommendations. This plan includes priority actions (labelled in yellow) to directly address the largest workforce shortfall, expected to occur around 2027, and to set a course now for a more sustainable future psychiatry workforce in South Australia through additional training positions. The plan also includes other critical actions (labelled in grey) to achieve a psychiatry workforce better able to meet demand in South Australia over the next 10 years.

4.2 The Plan

4.2.1 Plan outcome 1: Address the projected short- to medium-term shortfall with a dedicated workforce surge strategy

Priority	Deliberately over-recruit now (international/interstate), particularly in shortage areas such as child and adolescent psychiatry.
	Slow down retirements to extend more of the existing workforce over the 2027-2030 period.
	Use adjacent workforces (such as GPs, clinical psychologists and nurse practitioners with a mental health specialty) to support psychiatry where possible.
	Extend access to telehealth which can be provided by interstate psychiatrists further in rural and remote area and metropolitan SA3 areas with limited supply.

4.2.2 Plan outcome 2: Increase the projected growth of the South Australian psychiatry workforce over the next decade

Priority	Increase training positions by 2 each year in the training program over the next 10 years. ► Provide necessary resources such as supervisors, to support the increased training positions. Explore ways to boost the number of supervisors as needed. ► Conduct reviews at 5- and 10-year marks to assess the viability of continuing to increase training places. ► Increase placements in stages 2 and 3 for child and adolescent and consultation-liaison psychiatry. ► Focus on inclusion of First Nations and Culturally and Linguistically Diverse trainees (placements and training design) ► Promote psychiatry as a desirable career option, working with high schools, universities and teaching hospitals.
	In alignment with Kruk review recommendations, recruit at least 10 psychiatrists internationally and/or interstate over the next decade with a focus on: ► Child and adolescent psychiatry (target 2 child and adolescent psychiatrists each year for the next 3 years) ► Psychiatric academics ► Older persons psychiatry Align recruitment with shortage areas and timing, in particular the projected peak in shortages expected in 2027.
	Consider introducing optional rotations in private, rural, disability, AoD psychiatry as part of the Psychiatry Training Program.
	Purposeful recruitment of First Nations and Culturally and Linguistically Diverse psychiatrists.

4.2.3 Plan outcome 3: Enable reskilling and redistribution to critical areas of need through systematic support

Priority	Implement systematic support for psychiatrists to reskill and redeploy in high-shortage areas. These include child and adolescent, older persons, and potentially alcohol and other drugs, disability, and forensic psychiatry. Reskilling and redistribution planning needs to align to projected peak shortages from 2027 onwards. Prioritise redeployment to areas with the greatest expected return on investment, particularly Child and Adolescent psychiatry.
	Upskill General Practitioners with a psychiatry-skills qualification. (Noting RANZCP's Certificate of Postgraduate Training in Clinical Psychiatry) has been designed for this purpose, planned to take initial enrolees from 2025.)
	Increase focus on academic psychiatry by establishing professorial units in South Australia.

4.2.4 Plan outcome 4: Modernised working experiences for all psychiatrists, particularly administrative workflow and training

Priority	Review current psychiatrist activities, considering whether tasks can be reassigned to other medical/allied health professionals, administrative professionals, outsourced or stopped.
	Retain the current South Australian psychiatric workforce through part-time flexibility and mentorship programs. career pathways, succession planning and leadership development for psychiatry professionals
	Provide continued medical educational and professional development opportunities for psychiatrists.
	Understand the reasons behind patient no-shows. Implement interventions to reduce them such as follow-up assist
	Modernise psychiatric training to give clinicians the skills to provide culturally safe care for diverse communities. Increase psychiatrist and registrar placements in Aboriginal Community Controlled Health Organisations.
	Reforecast workforce supply and demand every two years to evaluate the progress made on closing the supply-demand gap in psychiatry, and to adjust the future direction of workforce strategies as required
	Analyse current service models in private and public settings, including MBS codes, rights of private practice and NDIS.

4.2.5 Plan outcome 5: Greater coverage of rural psychiatric demand

	Implement relevant recommendations from the *Review of Rural Mental Health Services in South Australia* for psychiatric care.
	Incentivise and fund 10-12 FTE permanent, locally-based psychiatry positions in country local health networks over the next decade. Focus on general psychiatric care and needed sub-specialisations like child and adolescent psychiatry in rural areas.
	Continue the Fly-In-Fly-Out model to maintain appropriate levels of psychiatric services in rural South Australia.

Refer to Appendix C for a suggested implementation plan and Appendix D for further detail on the expected impact of each enabler, and the links to the findings as detailed in this report.

5. Future state modelling (projections with interventions)

5. Future state modelling (projections with interventions)

The analysis within this section is based on a 'future state' concept. The workforce plan, as set out in section 4, can be implemented in a variety of ways which are interconnected. For example, if international/interstate recruitment does not provide the targeted number of new psychiatrists to South Australia, other levers (such as a slow-down in retirements or increasing access to interstate telehealth providers) may need to be relied upon to a greater extent. The analysis below incorporates recommendations and assumptions from the workforce plan. It models one example scenario of potential impacts to the supply and demand for psychiatrists in South Australia:

i. Impacts to supply from:
    - Increasing psychiatrist training positions to boost supply
    - Recruiting psychiatrists internationally to increase supply
    - Increasing the use of part-time working arrangements (noting this could potentially decrease the available workforce if existing full-time psychiatrists elect to work part-time, and could increase the available workforce e.g., through attraction and slower retirements)
ii. Impacts to demand from:
    - Reducing administrative burdens on psychiatrists, modelled as a reduction in demand
    - Upskilling general practitioners to handle some tasks currently undertaken by psychiatrists, reducing demand
    - Training existing psychiatrists in child and adolescent psychiatry to increase the supply of psychiatrists with this sub-specialty.

5.1 Impacts to the overall workforce

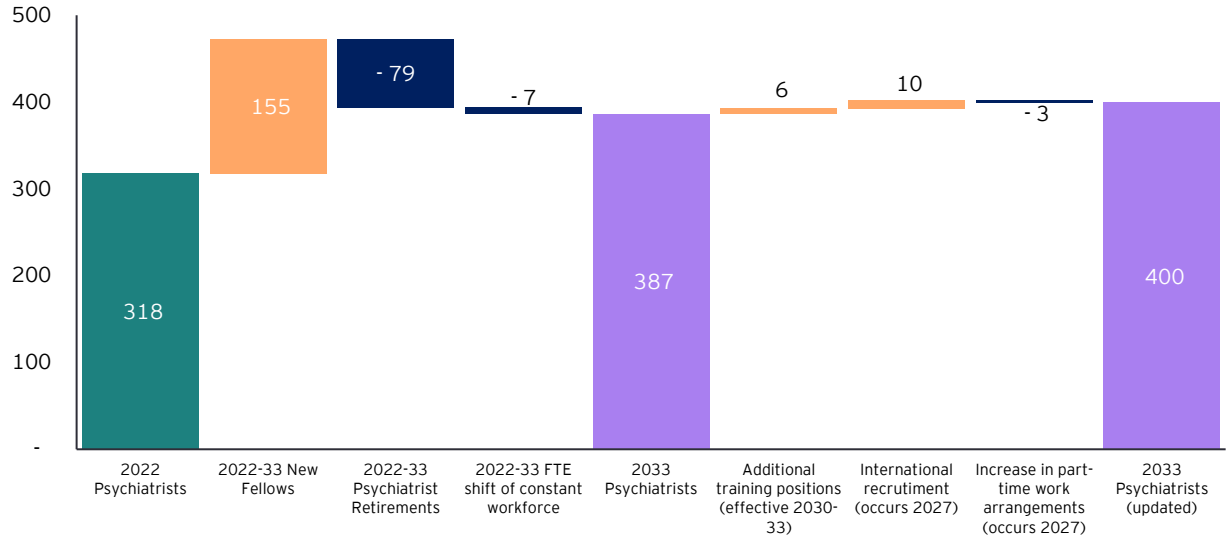
5.1.1 Impacts to the supply of psychiatrists

This future state scenario considers these specific actions from the workforce plan which would impact the supply of psychiatrists:

i. Increase training positions: Adding 2 psychiatry training positions yearly, from 2025. This would increase the workforce by 2 each year from 2030 to 2032 (i.e. 6 over the period), assuming a five-year training period.
ii. International recruitment: Modelled as recruiting 10 psychiatrists in 2027, including 6 child and adolescent psychiatrists and 1 academic psychiatrist.
iii. Increase in part-time work: Modelled as a reduction of 3 FTE from the overall workforce from 2027.

The combined impact to supply is a projected increase the psychiatry workforce from 387 to 400 FTE psychiatrists by 2033, a net increase of 13 FTE.

Figure 36: Potential changes in the supply of psychiatrists, FTE, 2022-33



5.1.2 Impacts to the demand for psychiatrists

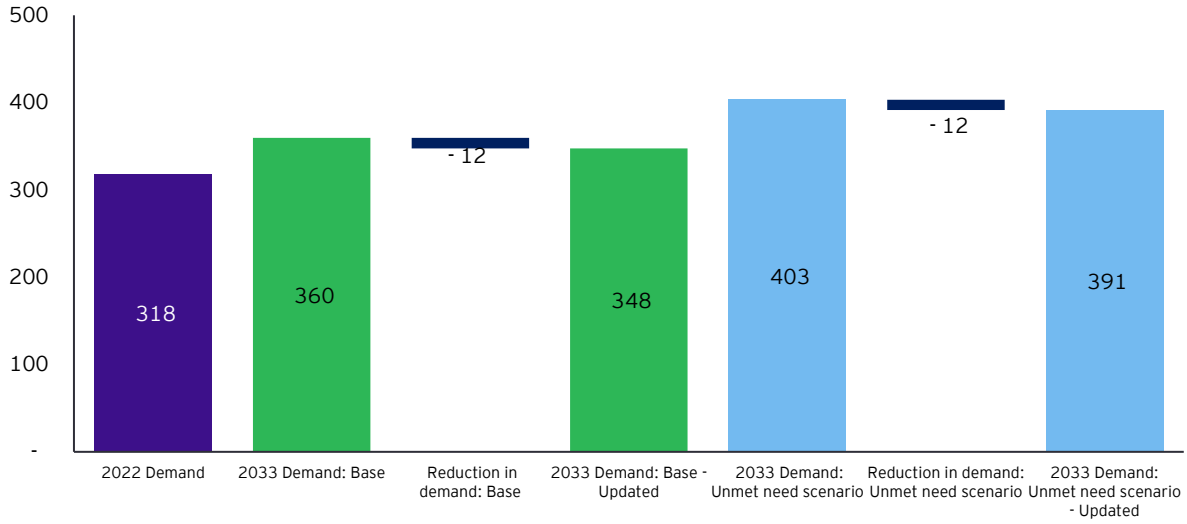
The following plan actions were considered, which could impact the demand for psychiatrists:

iv. Reduce psychiatrists' burden of administration: According to the National Health Workforce Dataset, a large share of psychiatrist time is currently spent on administration, as discussed in section 3.8.2. If some of these tasks could be handled by administrative support or automated, this would free up time for psychiatrists, meaning the same workforce could see a greater number of patients. This was modelled as a reduction in the demand for 8 FTE psychiatrists.

v. Upskill general practitioners to undertake tasks currently handled by psychiatrists: One action from this plan is to upskill general practitioners to undertake some tasks (lower acuity) that are currently handled by psychiatrists, from 2027 onwards. This would free the time of psychiatrists, essentially meaning fewer psychiatrists would be required to handle the same patient need. This action was modelled as a reduction in the required demand for psychiatrists by 4 FTE from 2027 onwards.

The overall impact from these changes is a projected reduction in the demand for 12 FTE psychiatrists, in both the Base case and Unmet need scenario.

Figure 37: Potential changes in the demand for psychiatrists, FTE, 2022-33



5.1.3 Impacts to the projected workforce gaps

When considering the overall impacts of the above changes to supply and demand, the projected psychiatrist shortages reduce across the 2026-33 period, by between 8 and 25 psychiatrists each year (Figure 38 and

Figure 39). In the Base case this mitigates the shortages in the mid-term and results in a surplus from 2029 onwards; and in the Unmet need scenario this reduces shortages throughout the period, with supply sufficient to meet demand by the end of the period (2033). However, shortages still exist in the short- and medium-term. Figure 39 highlights the critical need for the recommendations within 'Plan outcome 1' and 'Plan outcome 2' (section 4.2.1) to be adopted, to address the workforce shortages in the short- and medium-term.

Figure 38: Psychiatrist supply gap by demand scenario (original projection), FTE, 2022-33

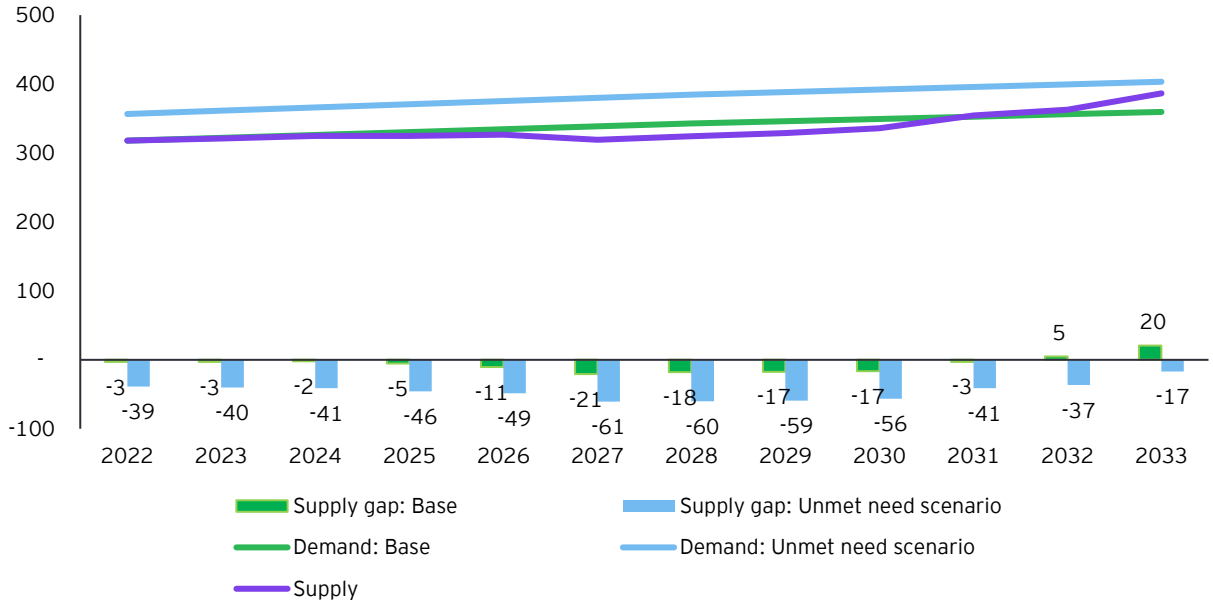
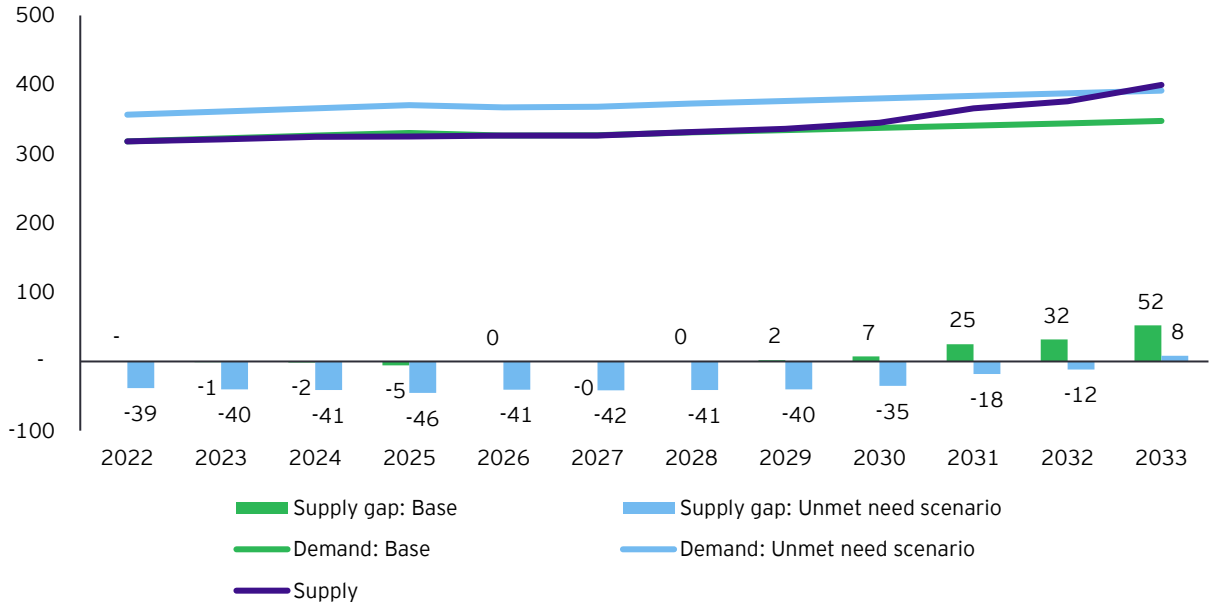


Figure 39: Potential future psychiatrist supply gap by demand scenario (updated), FTE, 2022-33



5.2 Increasing the number of child and adolescent psychiatrists

To address the projected shortages of child and adolescent psychiatrists, psychiatrists with this sub-specialisation could be recruited, or existing psychiatrists could be trained in this sub-speciality. If 6 international child and adolescent psychiatrists are recruited (an additional 2 per year from 2027 to 2029) and 6 psychiatrists are trained in child and adolescent psychiatry (an additional 2 per year commencing training from 2025 to 2027, assumed to enter the workforce from 2027 to 2029), the projected psychiatrist shortfalls in the Base case and the Unmet need scenario would be mitigated from 2028 onwards, according to

Figure 40 and Figure 41. Note the demand impacts from the above section are also considered within this analysis. Refer to section 3.1.3.2 for a benchmarking data comparison.

Figure 40: Supply shortfall of child and adolescent psychiatrists (original projection), FTE, 2022-33

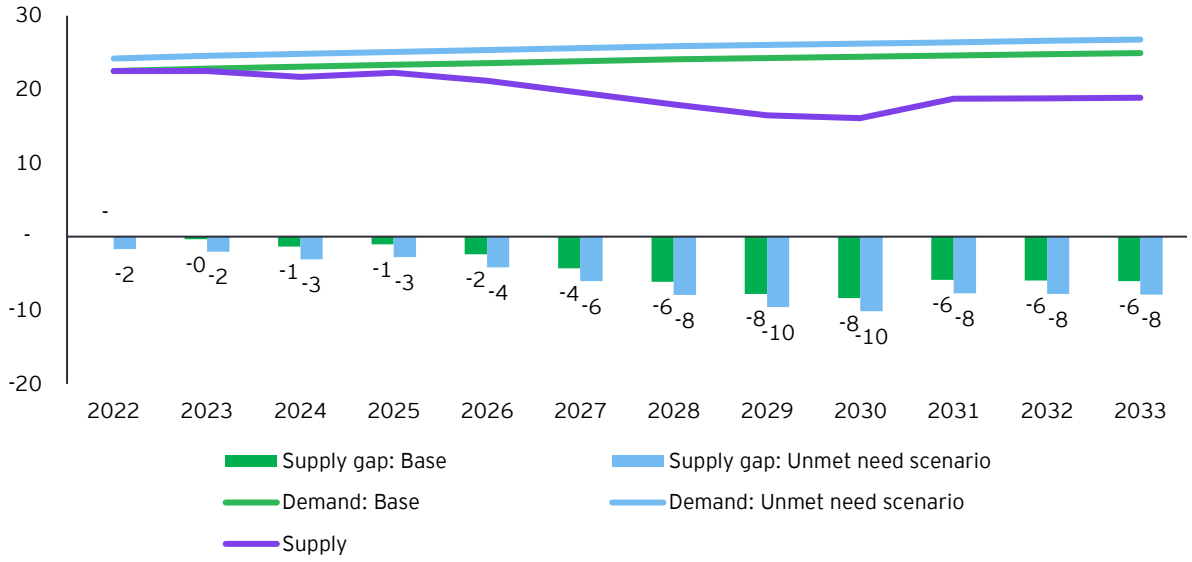
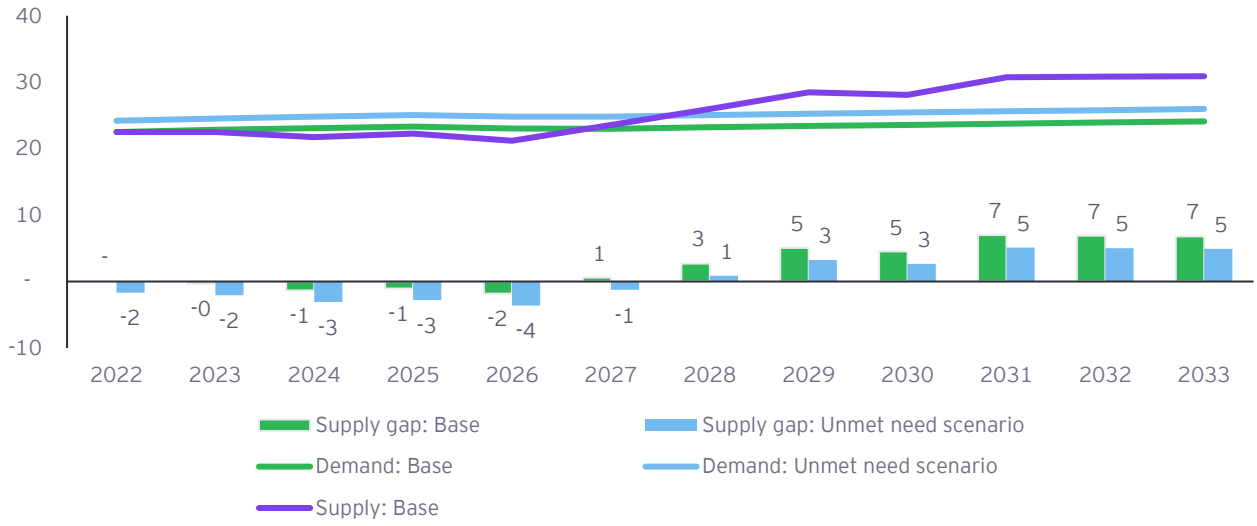


Figure 41: Potential future psychiatrist shortfall of child and adolescent psychiatrists **(updated)**, FTE, 2022-33



Appendices

Appendix A Stakeholders consulted

Dr John Brayley	Chief Psychiatrist, SA Health
Dr Robyn Lawrence	Chief Executive, DHW
Prof Tarun Bastiampillai	Professor of Psychiatry, Flinders University
Dr Elizabeth Moore	President, RANZCP
Dr Patrick Clarke	SA Chair, RANZCP
Dr Michelle Atchison	Chair, RANZCP bi-national Section of Private Practice Psychiatry
Dr Brian McKenny	Clinical Director, Rural and Remote Mental Health Service
Dr Ken Hooper	Chair, SA Faculty of Child & Adolescent Psychiatry
Matthew Hee	Senior Policy & Advocacy Advisor, RANZCP
Dr Marshall Watson	SA RANZCP Aboriginal and Torres Strait Islander Mental Health Committee Representative
Dr Shane Gill	Director of Training, SAPBTC
Melissa Bond	DHW Director, Mental Health Mentoring
Kyra Maher	DHW Director, Workforce Strategy
Dr Paul Furst	Executive Director, Mental Health and SA Prison Health Service, CALHN
Dr Carol Turnbull	CEO, Ramsay Clinic Adelaide
Dr Ken Fielke	Private Psychiatrist (Rural)
Taimi Allan	Mental Health Commissioner
Dr Tom Paterson	Private Psychiatrist
Focus Group: Lived Experience (Parents for Change, Lived Experience Australia)	
Focus Group: Clinical Directors	
Focus Group: DHW Mental Health Leadership Group	
Focus Group: Workforce and Strategy	
Focus Group: Early Career and Trainee	
Focus Group: Training and Education	
HSU Representative	
PSA Representative	
ANMF Representative	
SASMOA Representative	

Appendix B Employee lifecycle[69]

Medical Degree	The student begins their career with a general medical degree, which has a typical duration of 6 years (although can be a 4-year postgraduate degree). During this time, they may experience psychiatry rotations from their third year onwards.
Psychiatry Interest Forum (PIF)	Optional Stage: The Psychiatry Interest Forum offer a range of activities and opportunities though RANZCP including: ► Invitations to educational events, including lectures, workshops and conferences ► Career guidance in psychiatry and its sub-specialties through seminars and networking with RANZCP Fellows and trainees. ► Invitations to participate in RANZCP awards, prizes and grants around promotion, research or advocacy in mental health. ► Access to RANZCP e-learning resources. ► E-newsletters to keep up to date with RANZCP activities.
Junior Medical Officer/Intern (JMO)	The intern spends 2 years as a junior medical officer. Here they may have a clinical rotation of psychiatry, where they further experience the profession.
Resident Medical Officer (RMO)	Optional stage: After completing their medical internship, they typically spend 1-2 years as a resident medical officer (RMO) where they work under supervision in public hospitals to gain clinical experience, which may include psychiatry. Some doctors will enter training immediately after their 2-year internship.
The Adelaide Prevocational Psychiatry Program (TAPPP)	Optional stage: While in their RMO years, junior doctors are eligible to join the TAPPP program. This is a 12-month program consisting for two 6-month rotations. Areas of service include acute, rehabilitation, recovery, forensic and older persons mental health. These rotations vary between community, hospital, and residential settings.
Apply to RANZCP	The medical officer applies to the RANZCP for their specialist education.
Meet the eligibility criteria	The medical officer provides evidence of a medical degree and at least 24 months of general medical training. They must have general registration as a medical practitioner in Australia or New Zealand. They need to meet all other eligibility criteria.
Selection process that includes shortlisting and interviewing	After reviewing applicant information from CVs, written statements and written references, the 40-50 eligible applicants are shortlisted to approximately 28-34 interview places, to fill 22-26 positions each year. *Note: This is the first stage in the career journey in South Australia where congestion occurs. The training positions available are approximately 50-65% of the suitable applicants.*
Stage 1[70]	Stage 1 is the first year of psychiatry training. The focus is on gaining the knowledge and skills to practice in an adult clinical setting. 12 months' clinical work experience is required, 6 of which are in an acute setting. This is accompanied by a Formal Education Course (FEC). Training includes workplace-based assessments (WBAs), attainment of Entrustable Professional Activities (EPAs) and completion of mid-and end-of-rotation assessment forms (ITAs).
Stage 2	Stage 2 involves a 24-month period of six-month rotations in various areas of practice. It includes mandatory six-month rotations in child and adolescent psychiatry and consultation-liaison psychiatry. Trainees complete 12 further months in various elective areas of practice. The FEC, WBAs, EPAs and ITAs continue throughout stage 2. A centrally administered Multiple Choice Question (MCQ) Exam is usually completed during Stage 2. *Note: This is the second stage in the career journey where congestion occurs. The number of placements in the mandatory rotation are too few to enable greater intake of trainees. This is capped by the availability of supervisors and funding.*
Stage 3	Stage 3 is 24 months with the option to train in either general psychiatry or in various sub-specialty areas of practice. WBAs, EPAs and ITAs continue throughout Stage 3. An FEC is not compulsory, but one is made available to trainees. Some certificates of advanced training have a compulsory FEC. There are increased levels of responsibility. Generalist trainees complete four rotations from the following areas of practice: ► Addiction psychiatry ► Adult psychiatry ► Child and adolescent psychiatry ► Consultation-liaison psychiatry ► Forensic psychiatry

[69] Employee lifecycle, developed and validated in consultations and with training representative in the PCG.
[70] *Fellowship program* (2024) RANZCP. Available at: https://www.ranzcp.org/training-exams-and-assessments/fellowship-program (Accessed: 03 July 2024).

	► Indigenous psychiatry ► Psychiatry of old age ► Psychotherapies ► Research/medical education/medical administration *Note: This is the third stage in the career journey where congestion occurs. The limited positions in these fields prevent greater numbers of trainees being able to receive training in the areas of practice they wish (for example, psychiatry of old age). However, this does not delay progression to fellowship, as trainees can be allocated to other rotations, although these may not be their first preference.*
Complete an Advanced Certificate	Psychiatrists can also complete an optional advanced certificate of training of 24 months duration during Stage 3, in one of the following fields: ► Addiction psychiatry ► Adult psychiatry ► Child and adolescent psychiatry ► Consultation-liaison psychiatry ► Forensic psychiatry ► Psychiatry of old age ► Psychotherapies *Note: This is the fourth stage in the career journey where congestion occurs. The limited funded training places can at times mean a greater number of applicants than positions, particularly in Child and adolescent psychiatry.*
Exams	During Stage 3 trainees complete most of their centrally administered Examinations in order to obtain Fellowship. These include the Clinical Competency Assessment (CCA), Modified Essay Questions (MEQ) Exam, Critical Essay Question (CEQ) Exam, Psychotherapy Written Case (PWC) and Scholarly Project (SP). All of these assessments must be passed in order to progress to fellowship. These exams have varying pass rates, from between 50-60% for the MEQ to 80-85% for the SP. Trainees can re-sit exams if they fail. *Note: This is the fifth stage in the career journey where congestion occurs. The majority of trainees do not complete all of these assessments within the timespan of the five-year training program, and take extra time to pass all exams (the average completion time for training across Australia and New Zealand is approximately 6 years, but with some trainees taking up to 8-10 years). This delays a significant proportion of trainees from achieving fellowship within and practicing as psychiatrists within the five years of the training program.*
Practice as a Psychiatrist	The psychiatrist then becomes a junior consultant, with opportunity for development throughout the course of their career.

Appendix C Implementation plan

A suggested high level implementation plan is set out below, with the priority actions highlighted in yellow.

		Short term (up to 2 years)	Medium term (2-5 years)	Long term (5-10 years)
Plan outcome 1: Address the projected short- to medium-term shortfall with a dedicated workforce surge strategy	Deliberately over-recruit now			
	Slow down retirements			
	Use adjacent workforces (such as GPs, clinical psychologists and nurse practitioners with a mental health specialty)			
	Extend access to telehealth which can be provided by interstate psychiatrists further in rural and remote area and metropolitan SA3 areas with limited supply.			
Plan outcome 2: Increase the projected growth of the South Australian psychiatry workforce over the next decade	Increase by 2 additional training positions each year			
	Recruit 10 psychiatrists internationally/interstate			
	Consider additions to psychiatry training rotations			
	Purposeful recruitment of First Nations and Culturally and Linguistically Diverse psychiatrists			
Plan outcome 3: Enable reskilling and redistribution to critical areas of need through systematic support	Implement systematic support for psychiatrists to reskill and redeploy in high-shortage areas			
	Upskill General Practitioners with a psychiatry-skills qualification			
	Increase focus on academic psychiatry by establishing professorial units in South Australia			
Plan outcome 4: Modernised working experiences for all psychiatrists, particularly administrative workflow and training	Review current psychiatrist activities, considering whether tasks can be reassigned to other medical/allied health professionals, administrative professionals, outsourced or stopped			
	Retain the current South Australian psychiatric workforce through part-time flexibility and mentorship programs. career pathways, succession planning and leadership development for psychiatry professionals			
	Provide continued medical educational and professional development opportunities for psychiatrists.			
	Understand the reasons behind patient no-shows. Implement interventions to reduce them such as follow-up assist			
	Modernise psychiatric training to give clinicians the skills to provide culturally safe care for diverse communities. Increase psychiatrist and registrar placements in Aboriginal Community Controlled Health Organisations.			
	Reforecast workforce supply and demand every two years to evaluate the progress made on closing the supply-demand gap in psychiatry, and to adjust the future direction of workforce strategies as required			
	Analyse current service model in private and public settings, including MBS codes, rights of private practice and NDIS.			
Plan outcome 5: Greater coverage of rural psychiatric demand	Implement relevant recommendations from the Review of Rural Mental Health Services in South Australia for psychiatric care.			
	Incentivise and fund 10-12 FTE permanent, locally-based psychiatry positions in country local health networks			
	Continue the Fly-In-Fly-Out model to maintain appropriate levels of psychiatric services in rural South Australia.			

Appointment of a Steering Committee

It will be important that a Steering Committee is appointed with appropriate minister oversight/accountability to oversee the implementation of these recommendations, where these are approved and funded to be implemented. We suggest that a clear timeline is developed as the first priority of this Steering Committee, alongside a prioritisation process for the provided recommendations. We suggest that every recommendation is assigned to a specific owner who has clear accountability for its implementation. The Steering Committee should establish a regular cadence of meetings to aid this process of accountability and increase the likelihood of the successful implementation of recommendations. The Steering Committee should include, but not be limited to, representatives from child and adolescent psychiatry, rural psychiatry, private psychiatry, psychology, nursing, doctors and lived experience.

Appendix D Detailed recommendations

Plan Outcome	Recommendation	Finding(s) addressed	Description	Expected impact
Plan outcome 1: Address the projected short- to medium-term shortfall with a dedicated workforce surge strategy	Deliberately over-recruit	3.1.3 3.5	Deliberately over-recruit now (international/interstate), particularly in shortage areas such as child and adolescent psychiatry. Consider the new mental health units to be opened, average turnover, parental leave, retirements over the 10 years to determine size of recruitment.	Reduce the expected workforce shortage projected for 2027-2030
	Slow retirements	3.1.3	Slow down retirements to extend more of the existing workforce over the 2027-2030 period. Engage individual psychiatrists close to retirement for case-by-case negotiations.	
	Use adjacent workforces	3.1.3	Use adjacent workforces (such as GPs, clinical psychologists and nurse practitioners with a mental health specialty) to support psychiatry where possible.	
	Extend telehealth services	3.1.3 3.2	Extend access to telehealth which can be provided by interstate psychiatrists further in rural and remote area and metropolitan SA3 areas with limited supply.	
Plan outcome 2: Increase the projected growth of the South Australian psychiatry workforce over the next decade	Expanded training positions	3.1.3 3.3	Increase training positions by 2 each year in the training program in over the next 10 years. Provide the necessary resources like supervisors. Conduct reviews at the 5- and 10-year marks to assess the viability of continuing to increase training places. Promote psychiatry as a desirable career option to feed into additional training places. Collaborate with universities and teaching hospitals.	Sustainably increase the South Australian psychiatry workforce of the future.
			Consider introducing optional rotations in private, rural, disability, AoD psychiatry as part of the Psychiatry Training Program.	Training focused on areas of need
	International recruitment	3.1.3 3.5	Recruit at least 10 FTE internationally (in alignment with Kruk review recommendations) and/or interstate, with a focus on: ► Child and adolescent psychiatry (2 each year for next 3 years) ► Psychiatry academics ► Older persons psychiatry Align recruitment with shortage areas and timing, particularly the projected peak in shortages expected in 2027.	Increase number of experienced psychiatrists within the workforce, particularly to address short-term shortage areas
	Expand Aboriginal and Torres Strait Islander and CALD psychiatrist workforce	3.4	Purposeful recruitment of First Nations and Culturally and Linguistically Diverse psychiatrists.	Diversity and representation in the workforce
Plan outcome 3: Enable reskilling and redistribution to critical areas of need through systematic support	Reskilling in sub-specialties	3.1.3.2 3.2 3.6	Implement systematic support for psychiatrists to reskill and redeploy in high-shortage areas. These include child and adolescent, older persons, and potentially alcohol and other drugs, disability, and forensic psychiatry. Reskilling and redistribution planning needs to align to projected peak shortages from 2027 onwards. Prioritise redeployment to areas with the greatest expected return on investment, particularly Child and Adolescent psychiatry	Support areas of greatest shortage to be appropriately resourced to meet patient demand.
	GP credentialling	3.1.3 3.8	Upskill GPs with a psychiatry-skills qualification. (Noting RANZCP's Certificate of Postgraduate Training in Clinical Psychiatry has been designed for this purpose, planned to take initial enrollees from 2025.)	Reduce lower acuity demand for psychiatrists
	Increased focus on academia.	3.9.3	Promote a greater focus on academia, including establishing professorial units in SA.	Improve posture of academic psychiatry in South Australia. Use to attract and retain psychiatrists in SA.

Plan Outcome	Recommendation	Finding(s) addressed	Description	Expected impact
Plan outcome 4: Modernised working experiences for all psychiatrists, particularly administrative workflow and training	Review and adjust psychiatrist activities	3.1.3 3.8 3.9	Scope of practice: Review the current responsibilities of psychiatrists, considering whether activities could be reassigned to other medical/allied health professionals. This allows psychiatrists to work at 'top of scope'.	Support psychiatrists to effectively spend more time on 'top of scope' activities. Reduce administrative burden on psychiatrists.
			Automation opportunities: Review the current responsibilities of psychiatrists, considering whether activities could be enabled through use of technology such as automation or AI or voice-to-text notetaking software.	
			Administrative and other support: Review the current responsibilities of psychiatrists, considering whether activities could be reassigned to administrative professionals, outsourced, or stopped, particularly in CAMHS.	
	Mentorship	3.9.4	Strengthen and improve accessibility of existing mentorship program. Re-baseline mentoring needs of members and how well these are being met. Implement required actions based on findings. Develop a clear capability framework and outcomes for mentoring.	Provide psychiatrists additional mentoring to support professional development and improve retention
	Part-time flexibility	3.9.1	Create greater flexibility for part-time working arrangements, particularly within the public system, including flexible working hours (e.g., 40 hours in 4/4.5 days)	Reduce likelihood of psychiatrist burnout and increase attraction to the public system.
	Career pathways	3.9	SA Health to implement clear and accessible career pathways.	Better understanding and ability to plan long-term careers
	Succession planning	3.1.3 3.9	SA Health to support psychiatrists working in different disciplines/job settings to succession plan.	Support consistent pipeline of psychiatrists in various specialty areas of psychiatry, particularly for leadership positions
	Leadership development	3.9	SA Health provides a leadership development program for senior psychiatry positions. The program focuses on clinical and operational leadership skills. Create a clear capability framework and outcomes for the program that define specific development initiatives.	Support psychiatrists working in leadership positions obtain the skills necessary to effectively lead within their scope of practice.
	Continued medical education and professional development	3.8.2 3.9.3	SA Health to put measures in place to protect dedicated time for non-clinical activities, as specified and endorsed in the EBA, J&P's and workplans. This includes but is not limited to clinical research, quality- and safety-related tasks, audits, professional commitments, and teaching.	Support high-quality of care provided in line with most up to date evidence of best practice, and support psychiatrists' requirements for registration to be met.
	Addressing patient no-shows	3.1.3 3.8.2.1	Understand the reasons behind patient no-shows. Implement interventions to reduce them such as follow-up assist	Reduce 'lost time' due to no-shows
	Equitable and culturally safe Aboriginal and Torres Strait Islander care	3.4	Increase psychiatry time and registrar opportunities in Aboriginal Community Controlled Health Organisations	Support psychiatrist services to people from Aboriginal and Torres Strait Islander backgrounds
	Equitable and culturally safe CALD care	3.4	Increase psychiatry time and registrar opportunities working with people from culturally and linguistically diverse backgrounds	Support psychiatrist services to people from CALD backgrounds
	Regular workforce forecasting	3.10	Reforecast workforce supply and demand every two years to evaluate the progress made on closing the supply-demand gap in psychiatry, and to adjust the future direction of workforce strategies as required	Review effectiveness of changes and adjust workforce strategy as needed
	Review existing model of care	3.1 3.2 3.4 3.6 3.7 3.8 3.11	Models of care operationalise how best practice care can be delivered at the individual person, service, or systems level and should be developed to improve clinical and process outcomes, translate evidence into practice, and be clear about the efficient use of resources. A contemporary model of care should describe the way in which the mental health workforce provides evidence-based interventions, including how psychiatrist time is planned.	Model of care more appropriately facilitates optimal patient and psychiatrist outcomes.

Plan Outcome	Recommendation	Finding(s) addressed	Description	Expected impact
			Review existing model of care (including how public and private interact and the roles of each; MBS codes available for use for psychiatrists; encouraging private psychiatrists to admit to private hospitals, where appropriate).	
	Review Rights of Private Practice	3.11.2	Review the Rights of Private Practice – considering effects on the supply of public psychiatrists and accessibility of patient care. Consider an optional loading to be provided to psychiatrists in lieu of taking up RoPP.	Increase psychiatrist time with public health patients
	NDIS	3.11.3	Consult with the NDIS to adjust requirements from psychiatrists.	Reduce demand of psychiatrists' time for NDIS requirements.
Plan outcome 5: Greater coverage of rural psychiatric demand	Recommendations from the Review of Rural Mental Health Services in South Australia	3.7	Implement recommendations from the Review of Rural Mental Health Services in South Australia as they relate to psychiatry	Address aspects of the systemic and demographic challenges which prevent equitable access to psychiatry services.
	Fund 10-12 Country LHN positions	3.7	Incentivise (through tailored working arrangements) and fund 10-12 FTE permanent and locally based psychiatry positions in Country LHNs over the next 10 years, with a view to increasing beyond 2033.	Increased level of in-community psychiatric care
	Continue FIFO model	3.7	Continue FIFO model to provide appropriate levels of psychiatry services to rural SA.	Continued support through FIFO model

Appendix E Modelling approach – Supplementary information

This section contains further detail on the modelling approach as outlined in section 1.3.4 and an overview of the modelling assumptions and limitations.

Overarching assumptions and limitations

There are several limitations to this analysis, stemming from assumptions on the models of care and some limitations of the data. The modelling utilised case specific deidentified activity data as well as assumptions, where the available data did not provide the required information. The modelling assumptions were based on qualitative information collected in this project. The workforce modelling results should be considered with these limitations in mind, noting that they could change the results in a material way.

The following table provides an overview of the data issues, key assumptions and limitations associated with the workforce modelling.

Table 5: Data issues, key assumptions and limitations

Item no.	Issue	Assumption	Implication / Limitation
1	Lack of access to unit record data on the psychiatrist workforce in South Australia.	Multiple sources of information were utilised to synthesise the characteristics of the current psychiatrist workforce, including data from RANZCP, the National Health Workforce Dataset and SA Health. Psychiatrists were assigned characteristics based on this data, including age, location of work, and primary health care setting of work.	The actual characteristics of the psychiatrist workforce may differ from the synthesised workforce, impacting reporting of the characteristics of the current workforce.
2	Lack of detailed NMHSPF data on the number of people requiring mental health services from a psychiatrist.	While the NMHSPF provides estimates of demand for mental health services, it does not provide detailed data on the number of people requiring psychiatry services specifically. Instead, this was estimated based on NMHSPF data on services that would require psychiatrist involvement in relevant care profiles.	The actual number of people requiring access to a psychiatrist may be more or less than these values, impacting the projected workforce shortages / surpluses. See section below for further detail.
3	Lack of data on the types of services and health care settings that people with unmet need would require.	The unmet need cohort was assumed to utilise psychiatry services in each health care setting to the same extent as the cohort that did access care from a psychiatrist.	Those representing unmet need may have different conditions and requirements from those that can access care, meaning the required demand for psychiatrists would differ.
4	Some disorders are excluded in NMHSPF data that are relevant to psychiatry (including autism spectrum disorders and substance use disorders).	No assumption applied.	As such, the number of people requiring care from a psychiatrist is a lower bound, and therefore the estimated unmet demand would also represent a lower bound. In addition, the growth rate of services by health care setting may differ. Information from stakeholder consultations indicated there is a high prevalence of these disorders in child and adolescent populations, so projected shortages of child and adolescent psychiatrists may be underestimated.
5	Data was provided on patients accessing psychiatry services in both the public and private systems. - Within the public system, patient data was obtained from SA Health and allowed for the removal of duplicate patients – for example, where the same	No assumption applied.	There are several instances where patients access services in both the public and private sector (see examples to the left). This means the total number of patients accessing psychiatry services may be lower than estimated by this report. The report

Item no.	Issue	Assumption	Implication / Limitation
	patient accessed care across multiple health care settings, e.g., a public hospital and a public community setting, this patient was only counted once. - Within the private system, patient data was obtained from Ramsay Health & AIHW, and allowed for the removal of duplicate patients – for example, where the same patient accessed care from a psychiatrist in a private hospital and a private clinic, this patient was only counted once. However, data was not available to account for duplicate patients where a patient accessed care across both public and private health care settings – therefore there is potentially an element of overcounting patients. Some qualitative examples of public-private crossover were noted by several psychiatrists through consultations, including: private outpatients who do not have health insurance can be admitted as public patients; public inpatients can be referred post-discharge to a private psychiatrist for follow-up; rural patients can access care from a private psychiatrist and have their case managed by a community mental health team.		therefore is more indicative of the upper bound. However, there is no impact on the total number of people estimated to require a psychiatry service – it simply means the actual usage of services is lower, and the level of unmet demand for services is higher (given unmet demand is the difference between those needing services and those accessing services). While there is some double counting, in the context of the overall demand for psychiatry care, any overestimation of demand due to this factor is likely to be small.
6	Lack of unit record data on admitted patients that required specialised psychiatric care.	As such, a combination of SA Health admitted patient data and publicly available AIHW data were utilised, to estimate the number of patients accessing care in this health care setting as well as their age and location characteristics. A psychiatrist was assumed to see each patient.	The actual demographic characteristics of the patient cohort in question may differ slightly from the characteristics obtained from the SA Health data.
7	While there was data available on the number of patients accessing mental health-related care in an emergency department, there was not data on the number treated by a psychiatrist specifically, nor on the time spent by psychiatrists treating patients in emergency departments.	In the absence of data, psychiatrists were assumed to provide input to each patient presenting at an emergency department for mental health related care (while they may not provide direct care to all patients, they are expected to provide some input to the medical professional that is providing care).	This approach could overestimate the number of people that historically accessed care from a psychiatrist, meaning unmet demand and projected psychiatrist shortages are understated and would be greater.
8	Lack of data on the number of patients seen in a private psychiatric hospital (only the number of admissions were reported).	The number of admissions were converted to a number of patients, based on the readmission rate advised by Ramsay Health.	The actual number of patients treated in a private psychiatric hospital may be more or less, but the impact should not be significant given there were a relatively small number of admissions, compared to the total number of psychiatry services in SA.
9	The estimation of FTE by health care setting utilised data from the NHWDS, on clinical hours worked in public / private settings, in the absence of data on total hours worked in public / private settings (which would include time spent on research, teaching or administration).	The clinical share of time is taken as a proxy for the relative distribution of total time.	Where the public / private share of total time differs materially from the public / private share of clinical time, the estimated FTE in public/private settings will differ.
10	While psychiatrist data was available by FTE in rural areas from SA Health, there was a lack of headcount data. As such, other sources (incl. NHWDS) were relied upon for the headcount data.	As such, other sources (incl. NHWDS) were relied upon for the headcount data.	Actual data may be higher or lower. Note that FTE is higher than headcount in regional / remote areas, which may reflect that some psychiatrists are based primarily in urban areas (headcount) but undertake some travel to regional / remote areas to provide psychiatry services (FTE).

Need for psychiatrists - Further detail on the use of NMHSPF data

The estimated need to see a psychiatrist in 2021-22 was based on data from the NMHSPF and considers the various need groups (care profiles), based on age, severity of condition and Indigenous status. Underlying population projections were updated with the latest Plan SA data. The estimation of need included consideration of:

- Services that require a psychiatrist specifically: The total number of people requiring care from a psychiatrist was estimated by multiplying the highest share of the population requiring a psychiatry service within a NMHSPF 'care profile', by the number of people needing services in that cohort. A relevant share of the *Medical Unspecified* category was also considered.[71]
- Services provided by a team that includes psychiatrists: The total number of people requiring care from a psychiatrist operating within a team was estimated by multiplying the highest share of the population requiring a team-based service by half of the people needing services in that cohort (and adjusted for the average staff ratio), in order to take a conservative approach to reflect that psychiatrists may not necessarily be involved in every case.

There are several reasons why the true number of people requiring access to a psychiatrist could be higher or lower than the estimated value. There may be some people not included within this cohort that require care from a psychiatrist, and there may be others within this cohort that do not require care from a psychiatrist. Notably, there are several disorders that can be treated by a psychiatrist (autism spectrum disorder and substance use) that are out of scope in the NMHSPF, which will result in an underestimation of demand. Similarly, the NMHSPF does not separately model people requiring ED services (see section below). Also, some care profiles had multiple services requiring a psychiatrist, and if different patients access all service types, the actual need value could be higher. In addition, the estimate of need does not consider the role psychiatrists undertake in providing Bed-based services. In contrast, some care profiles had lower shares of the population requiring access to a psychiatrist, meaning the actual need value could be lower.

In 2022, the estimated need for psychiatry services exceeded access to services, at the state level. However, there are some instances at a greater level of detail (considering specific health care settings, ages and locations) where access to services exceeded the projected need for services. This may reflect limitations of the data at this level of detail, as well as instances of individuals that require care from a psychiatrist but were not included within the estimated need cohort (if they have a mild or moderate condition for example). Again, the precision of the estimated number of people with need for psychiatric care is limited by the data available.

Improving estimates of psychiatry demand in emergency departments

The National Mental Health Service Planning Framework (NMHSPF) does not separately model people requiring emergency department (ED) services. As this report leverages data from the NMHSPF, this means the estimated need for psychiatrists is likely lower than the actual need, and projected shortages could be greater.

ED usage in the NHMSPF is based on service use rather than population prevalence. Therefore, people requiring ED services are included in existing need groups (those with severe, moderate, or mild mental health conditions) that utilise other mental health services. However, according to data from SA Health, many patients use ED services but no other public psychiatry services. It was not possible to identify the severity of the conditions of these patients, nor the extent to which each NMHSPF need group ED users belonged to.

The workforce modelling estimates psychiatric need based on South Australians estimated to have severe or moderate mental health conditions (see sections 1.3.4 and 3.1.2 for further detail). Accordingly, patients accessing mental health ED services are assumed to have severe or moderate need, but may actually have lower levels of need (for example, they may have a mild condition). This would mean total need for psychiatrists is underestimated, as only severe and moderate need populations are included. If lower-need groups that use mental health ED services are included, the projected psychiatric demand would be higher and shortages greater.

Supply modelling – Limitations of the microsimulation approach

A fundamental characteristic of a microsimulation model is its inherent variability and randomness, reflecting the unpredictable nature of individual behaviours and thereby capturing a range of possible outcomes. Each simulation yields different results under the same initial conditions due to the stochastic processes involved.

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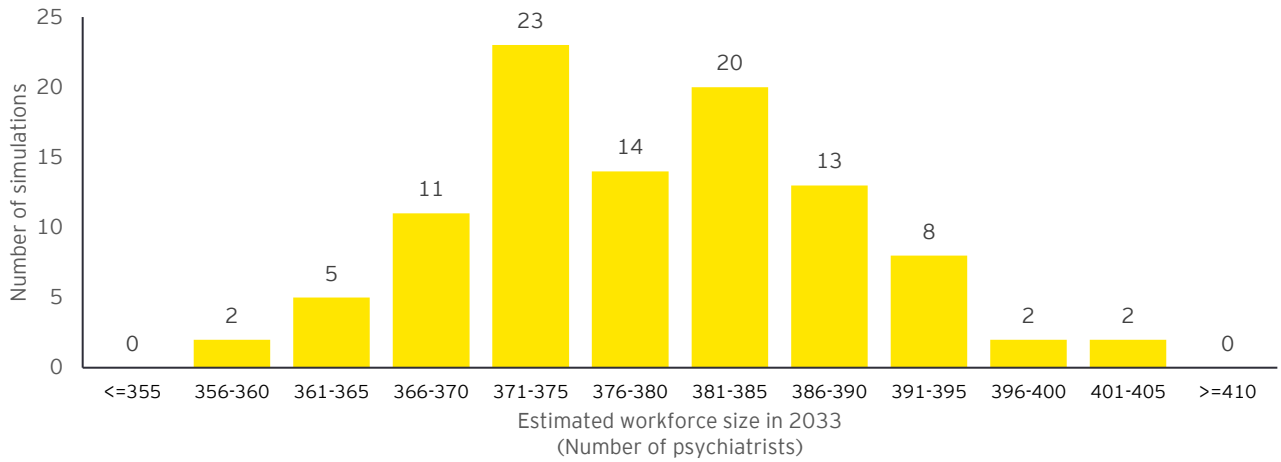
[71] Services that would be treated by the *Medical Unspecified* workforce type could be seen by a psychiatrist, general practitioner, junior medical officer or registrar. The share of this workforce type estimated to be seen by a psychiatrist was based on workforce FTE data.

For example, a simulation may show multiple psychiatrists retiring in a given year, but in reality, fewer may retire if, for example, there are workforce shortages at the time and psychiatrists choose to extend their careers (as reflected in the number of individuals continue to work in the older age groups beyond typical retirement age).

The charts below show the distribution of 100 simulation results as of 2033 and the average workforce supply in each year. The simulation results indicate that the estimated workforce size of 380 (headcount) by the year 2033 is positioned at the 50th percentile, meaning it is the median value of all outcomes. The average predicted workforce size in 2033 from 100 simulations is approximately 379 psychiatrists.

Figure 42: Distribution of estimates of workforce size, 2033



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