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RANZCP trainee survey: Perspectives on rural psychiatry and rural experience

RANZCP report

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Introduction

The Australian Medical Association¹ and Health Workforce Advisory Committee² have identified a medical workforce shortage as a major health issue, in both Australia and New Zealand, respectively. In Australia, not only is there a nation-wide shortage of doctors, the overall distribution of doctors is skewed heavily towards major cities such that regional, rural, and remote areas hold a disproportionate workforce shortage burden.

In relation to specialists, workforce shortages are even more severe. There is a severe shortage of psychiatrists in rural Australia and in provincial areas of New Zealand, due to a strong preference to live and work in major cities. According to the most recent populations statistics and RANZCP Workforce Survey (RANZCP, unpubl. data, 2005), 12% of the population is located in outer regional and remote areas, approximately 3% of psychiatrists live and work in an outer regional or remote areas. A further 4% of psychiatrists provide part-time outreach to outer regional or remote areas from urban or inner regional centres.

A large proportion of psychiatrists who are located in rural areas are International Medical Graduates³. Further, trainee psychiatrists surveyed in 2004 about their future career plans⁴, reported strong preference to practice in a capitol city or urban centre (89%). A very small percentage (3%) planned to practice in a rural or remote centre with the remaining 8% having no preference.

In order to address this area of need in rural communities, RANZCP incorporated rural mental health experience as part of the training program. The aims of this experience are to provide trainees with the skills required to practice rural psychiatry (if they choose to in the future), provide trainees with a positive rural experience so as to promote rural psychiatry as a career option, and lastly, to provide rural communities with a stream of trainees to provide psychiatric care to the community (albeit only briefly). RANZCP has outlined a number of training objectives for the rural mental health experience.

In addition, RANZCP has received funding from the Department of Health and Ageing as part of the Rural Advanced Specialist Training Support Scheme (RASTS) to promote rural psychiatry and provide support and incentives to trainees based in rural areas (either on a short rotation or for those doing the majority of their training in a rural area). As part of the RASTS project, a survey of trainees was conducted to evaluate current levels of satisfaction with rural experiences, perspectives on rural psychiatry more generally, and future career plans. This is the first evaluation of the rural mental health experience. The results of the survey will be incorporated into future promotional materials, to provide information to trainees on the rural experience, and to provide direction for improving the rural experience.

Method

Participants

All trainees who had completed their rural mental health experience in the past 18 months, and sent their certificate of completion form to the RANZCP training unit, were invited to participate. A number of trainees who were completing a based in a rural area were also invited to participate in the survey. An invitation was sent out to 76 trainees by email and post. Thirty seven trainees participated in the survey giving a response rate of 49%.

Procedure

The survey was approved by the Committee for Training and consultation was also sought from ANZAPT. Two trainees piloted the questionnaire and a few minor changes were made. The survey took about 15 minutes to complete. Trainees were invited to participate either by completing the survey online or by posting back a completed hard copy of the survey. Trainees were assured that their responses would remain confidential. As an incentive, all participants who completed the survey were invited to be included in a draw to win 12 bottles of wine.

Questionnaire

The questionnaire included a range of questions, both open ended and structured. The questions covered:

- Demographic information
- Rural background
- Location and length of rural experience
- Satisfaction with aspects of the rural experience
- Overall benefit of the rural experience
- Ability to meet the training objectives
- Positive and negative experiences during the rural experience
- Future plans to work in a rural area
- Opinion on the inclusion of compulsory rural experience
- Perceived benefits and drawbacks of rural psychiatry
- Suggestions on how to promote rural psychiatry

Results

Demographics

Numbers of trainees participating from each state was generally proportional to the total number of trainees in each state or territories, with the exception of South Australia and Tasmania. However, no trainees from South Australia were invited to participate as there was no record of any trainee from South Australia completing a rural rotation.

Table 1. Trainees by state

	Invited		Participated	
	N=76	%	N=37	%
NSW	21	28%	12	32%
VIC	29	38%	12	32%
QLD	14	20%	6	16%
WA	5	5%	5	14%
NT	3	4%	1	3%
ACT	2	3%	1	3%
TAS	2	3%	0	0%
SA	0	0%	0	0%

The majority of trainees were basic trainees (81%). The majority also reported living in a capital city, inner suburbs (62%), with a further 11% living in outer suburbs. The remaining 27% of trainees live in a large regional town (11%) or a rural town (16%). In addition, 24% reported being from a rural background. Therefore, trainees who participated are slightly more likely to be from a rural background and slightly more likely to be located in a rural location than would be expected from the normal distribution of the population.

Most rural experiences were residential, at least 3-6 months in length, and were completed in a rural area (32%) or in a large regional area with outreach to rural areas (38%). Eight percent were completed in a large regional centre (with no outreach). A further 19% of trainees were located in a rural or regional area for a period longer than 12 months. Trainees from Queensland were more likely to have spent more than 12 months in a rural or regional area. Only one person responded to having a 15 day outreach from an urban centre experience.

Distance of rural experience location from location of residence was varied for trainees, from 2km to over 2000km. The data was grouped into three categories: 100km or less, 100-400km, 400km or more. Of the 33 trainees who responded to this question, 8 (24%) travelled 100km or less, 16 (48%) travelled 101-399km, and 9 (27%) travelled 400km or more. Trainees in Western Australia and the trainee in Northern Territory were more likely to travel long distances from home.

Quantitative analyses about the rural experience

Table 2 displays levels of satisfaction with various aspects of the rural experience. For each aspect of the experience, trainees were asked to rate their satisfaction on a 5 point likert scale, where "1" represented "very dissatisfied", "3" represented "neutral", and "5" represented "very satisfied". Therefore, the higher the average score, the more satisfied trainees were with this aspect of their rural experience. The table presents aspects of rural experience from the lowest scoring to the highest scoring. The percentage of total trainees who reported being dissatisfied or very dissatisfied is also shown in table 2. The average score per state is also shown in table 2 for states where there were more than 5 participants.

Table 2. Trainees level of satisfaction about aspects of their rural experience

	Total n=37		NSW n=12	VIC n=12	QLD n=6	WA n=5
	Avg.	% diss.	Avg.	Avg.	Avg.	Avg.
Prepare for exams	2.72	41%	2.55	2.56	3.17	3.25
Opportunity for PD	2.89	30%	2.90	2.92	2.83	3.20
Travel	3.11	19%	3.25	2.82	3.60	2.60
Access to internet	3.19	33%	3.17	2.67	3.83	3.80
Orientation	3.20	22%	3.25	3.18	2.80	3.80
Work load	3.22	33%	3.50	3.18	2.50	3.80
Social and leisure	3.29	28%	3.36	2.73	4.20	3.20
Financial	3.30	22%	3.25	3.42	3.67	2.60
Overall training	3.31	25%	3.33	3.18	3.33	3.60
Contact with family	3.46	22%	3.45	3.18	3.83	3.00
Supervision	3.53	27%	3.25	3.45	3.83	4.00
Work opp. / variety	3.61	23%	3.42	3.64	4.00	3.40
Accommodation	3.67	15%	3.64	3.60	4.25	3.25
Location	3.78	6%	4.00	3.45	4.33	3.20
Team / colleagues	3.89	17%	3.92	3.64	3.67	4.40

The aspects of the rural experience that trainees were most dissatisfied with included ability to prepare for clinical exams, opportunity for professional development, travel, access to the internet and resources, orientation, and work load. On the other hand, trainees were most satisfied with their team and colleagues, location, accommodation, work opportunities and variety, and supervision. However, it is also worth noting that while supervision scored well 27% of trainees were still dissatisfied

with their supervision. Another concern is that 33% of trainees report poor access to internet and resources which would have a significant effect on trainee's ability to keep up to date with their training, professional development, and contact with study groups, as well as difficulty remaining in contact with friends and family.

Average scores also varied significantly by state. Overall, trainees from Queensland were more satisfied with their rural experiences and scored higher on most aspects of the rural experience compared to other states. However, trainees from Queensland are more likely to do most or all of their training in a rural or regional area and therefore they are more satisfied with travel, location, overall training and ability to prepare for exams. Areas that could be improved for Queensland include orientation, work load, and team/colleagues.

Trainees from Western Australia were also satisfied with many aspects of the rural experience and scored particularly highly on supervision and team/colleagues. Areas that trainees were less satisfied with and could be improved included location, travel, contact with family, financial remuneration, accommodation, and work opportunities and variety.

Trainees from NSW scored highly on team and colleagues, location, and work load, compared to other states, and scored lower on work opportunities and variety, supervision, and ability to prepare for clinical exams than other states.

Trainees from Victoria scored higher on remuneration compared to other states and scored lower on ability to prepare for exams, travel, access to internet and resources, social and leisure opportunities. There is likely to be more variety in relation to specific rural rotation locations within states.

Figure 1 shows the overall level of reported benefit of the rural experience to overall training. Very few trainees found the rural experience of no benefit. Over half of trainees reported the experience to be very or extremely beneficial.

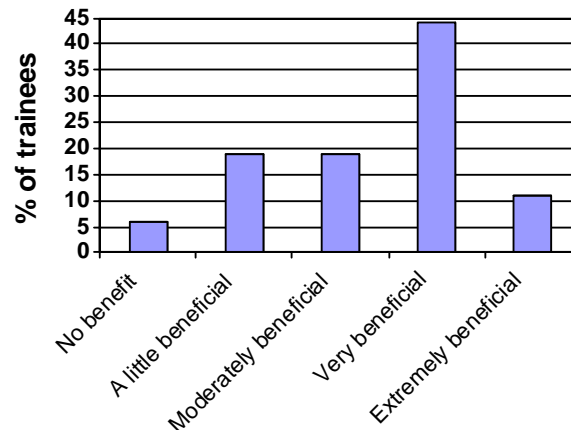


Figure 1. Benefit of rural experience.

The average benefit rating for the rural experience was 3.37 (where “1” represents “no benefit” and “5” represents “extremely beneficial”). The average benefit rating varied little by state, NSW (3.33), Victoria (3.36), Queensland (3.50), and Western Australia (3.40).

Trainees were also asked about their ability to meet the rural training objectives while on their rural experience. Of the eight rural training objectives, the percentage of trainees who reported achieving each objective was very high (89-97%) for six of the objectives. The remaining two objectives, focused on developing skills to use videoconferencing (achieved by 64% of trainees) and to become familiar with the special needs of minority groups (achieved by 83%), were more difficult to achieve for trainees.

Since 2003, rural experience has been a compulsory part of the training program. Table 3 shows the results of trainees' perspectives on whether the rural experience should be a compulsory part of psychiatry training. The results show that 75% of trainees believe in some form of rural experience and are not opposed to the experience being compulsory. A further 11% believe in rural experience but not compulsory experience. A small group either do not believe rural experience is necessary, have a similar negative viewpoint, or are uncertain.

Table 3. Views on rural mental health experience in psychiatry training

Yes, definitely (residential)	16%
Yes, definitely (residential or outreach)	16%
Yes, mostly (as long as special circumstances options)	32%
Yes, but(would like more choice, better supervision etc.)	11%
I believe in rural experience but not compulsory	11%
I do not believe rural experience is necessary	5%
Other – negative view	3%
Uncertain	3%

Thirty-one percent of trainees also reported that they were more interested in rural psychiatry as a result of their rural experience. A quarter of trainees were less interested in rural psychiatry as a result of their rural experience and the remaining 44% reported the experience had no impact on their interest in rural psychiatry.

Distance as a factor

Grouping respondents into how far their rural experience was from their place of residence provided a few differences in the results. Overall, the average score for the benefit of the rural experience was lower for trainees who had travelled greater than 400km for their rural experience (mean = 2.91) compared to trainees who travelled 100km or less (mean = 3.44) or travelled 101-399km (mean = 3.38). Examining the aspects of the rural experience showed that trainees who had to travel the greatest distances were less satisfied with work opportunities, orientation, access to internet, and opportunities for CPD, compared with trainees who were travelling small to moderate distances.

Qualitative analyses of the rural experience

Two open-ended questions about the positive and negative experiences trainees had while on their rural experience were also included in the questionnaire. Trainees provided a range of responses. Responses were analysed for main themes as shown in Tables 4 and 5. The most frequently reported positive experiences related to being a part of a small, committed and friendly team of professionals. Work related factors such as the variety of patients, having more autonomy, and having new work opportunities were considered to also be positive experiences on the rural rotation.

Table 4. Positive experiences and benefits of the rural experience

	<u>% (n=34)</u>
Staff / team – committed, friendly, and supportive team	56%
Breadth and depth of patients	18%
Good supervision	15%
More autonomy	12%
Opportunity to travel	12%
Work opportunities – working with indigenous, remote communities, Videoconferencing etc.	12%
Patient management with poor resources (challenging)	9%
Lifestyle / environment of rural area	6%
Being part of a small community	3%
Work load not too heavy	3%
<u>Total Positive comments (n=48)</u>	

On the other hand, higher work loads and on-call responsibilities was considered a negative aspect of the rural experience. Being away from study groups and ongoing training as well as being away from family were also frequently mentioned as negative parts of the experience.

Supervision and support were frequently mentioned as a positive part of the experience and as a negative aspect of the experience by many trainees.

Table 5. Negative experiences and drawbacks of the rural experience

	<u>% (n=34)</u>
Work load / on-call	32%
Poor supervision and support	29%
Away from study groups / training	26%
Location / distance from family	21%
Staff	18%
Driving	15%
Accommodation	12%
Resources	9%
No internet	6%
Lack of interesting cases	6%
Equity – location of places / payment	6%
Financial costs incurred	3%
<u>Total Negative comments (n=62)</u>	

Two open-ended questions about positive and negative perceptions of rural psychiatry, were also included in the questionnaire. Trainees provided a range of responses. Responses were analysed for main themes as shown in Tables 6 and 7.

The most frequently mentioned positive aspects of rural psychiatry were the lifestyle and environment associated with a rural area, the variety and challenge of clinical work, and overall job satisfaction of working in a rural area. Having a sense of community and being a part of a smaller, supportive team were also considered positive.

Table 6. Positive perceptions of rural psychiatry

	% (n=33)
Lifestyle / environment of rural area	48%
Variety and challenge of clinical work	36%
Job satisfaction – being needed and appreciated	36%
Sense of community	21%
Smaller, supportive team	18%
Financial rewards	12%
Good environment for young families	9%
Cost of living	9%
Working with indigenous communities	6%
Patients – more receptive	6%
More job opportunities available	6%
Less bureaucracy	3%
Total Positive comments (n=70)	

On the other hand, trainees did perceive that personal and professional isolation were significant drawbacks to a career in rural psychiatry. Furthermore, both a lack of resources of rural mental health services and a lack of access to continuing professional training and good supervision were considered real drawbacks by about a third of trainees. Additional practical concerns about rural practice included lack of culture or entertainment opportunities, access to education for children, and employment opportunities for spouses.

Table 7. Negative perceptions of rural psychiatry

	% (n=33)
Personal isolation from friends and family	48%
Lack of resources – Rural mental health services	39%
Professional isolation	33%
Lack of training / CPD / supervision	33%
Lack of culture / entertainment	27%
Education / good school for children	24%
Lack of privacy / anonymity from patients	18%
Work load / on-call	15%
Poor career path / job opportunities	12%
Employment for spouse	12%
Integrating with community	6%
Stigma of mental illness in community	6%
Total Negative comments (n=90)	

The final open-ended question related to ideas to increase recruitment of rural psychiatrists. Trainees reported a number of ideas which are summarised in Table 8. The most frequently mentioned incentive to promote a career in rural psychiatry related to some kind of financial remuneration whether through tax benefits, Medicare reimbursements, or increased salaries. Non-financial incentives included supervision, improved access to CPD opportunities, promotion of the rural lifestyle, flights home, and extra exam preparation.

Table 7. Incentives to promote rural psychiatry

	% (n=31)
Financial reward	45%
More / improved supervision	16%
CPD opportunities (subsidised travel)	16%
Publicise the positive - lifestyle	16%
More flexibility in rural training locations	13%
Flights home	10%
Extra exam preparation / training	10%
Social opportunities / orientation	6%
Additional annual leave (for every year in rural area)	6%
Improve rural mental health services	6%
Provide positive rural training experiences	6%
Total comments (n=47)	

Conclusions

As part of the RASTS project, a survey of psychiatry trainees was conducted to evaluate current levels of satisfaction with rural experiences, perspectives on rural psychiatry more generally, and future career plans. Thirty seven trainees who had completed their rural mental health experience in the past 18 months or who were currently based in a rural area participated in the survey. The survey was approved by the Committee for Training and consultation was also sought from ANZAPT.

Participants represented the majority of states and territories (with the exception of South Australia and Tasmania). The majority of participants reported finding the rural experience of some benefit to their overall training experience. Over half reported the experience was very or extremely beneficial. Additionally, three-quarters of participants agree with the rural experience being part of the training program. A further 11% believe it is important but should not be compulsory. Furthermore, close to a third are more interested in rural psychiatry as a direct result of their rural experience.

The three main benefits of the rural experience reported by trainees include:

1. the variety of clinical work, increased autonomy, and unique opportunities;
2. good work relationships and team support;
3. an opportunity to experience a rural environment and community.

The main drawbacks of their rural experience include:

1. higher work load and on-call responsibilities;
2. lack of support and good supervision;
3. distance from family / young children;
4. difficulty to maintain study.

In order to promote rural psychiatry as a career path, it is vital that trainees have a positive rural experience. The results of this survey provide information on areas that are currently perceived as negative and could be improved. In addition to these aspects of the experience already mentioned, areas that can be more easily targeted for improvement include:

1. ability to prepare for clinical exams;
2. opportunity for PD;
3. access to internet and resources;
4. workload;
5. orientation.

Additionally, ensuring quality accommodation, supervision, and reasonable remuneration (including expenses relating to travel and accommodation) are all bottom line expectations for any training experience that are particularly important when the experience involves the inconvenience of living in temporary residence and being away from home.

The results of the survey will be incorporated into future promotional materials, to provide information to trainees on the rural experience, and to provide direction for improving the rural experience. The RASTS project also has funded the development of an online resource which will provide orientation information for trainees on their rural experience, promotional information about rural psychiatry, and opportunities to use the forum for educational purposes.

References

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