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The RANZCP Workforce Report: Action is needed, now

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Abstract
Objective: The RANZCP conducted an anonymous survey of 7200 members (trainees and psychiatrists) in December 2023, receiving 1269 responses, representing the views of roughly 1 in 6 members, and of the respondents, three quarters reported experiencing burnout in the last 3 years. We provide a commentary, citing evidence from relevant previous research, discussing the implications and proposing potential interventions.
Conclusions: Members of the RANZCP reported worsening workforce shortages, with 9 in 10 respondents stating that these negatively impacted patient care, and 7 in 10 experiencing symptoms of burnout. Eighty per cent identified workforce shortages as the top contributing factor to such burnout. The aetiology of workforce shortages and burnout is likely due to operational and structural shortfalls in psychiatric services. However, public and private sector employment information was not included in the report. There are a range of strategic, evidence-based interventions to address the psychiatrist and trainee workforce challenges, comprising general healthcare service as well as specific initiatives. Based on the findings of the report, such interventions are needed, now.

Keywords: psychiatrist, trainee, burnout, moral injury, workforce

Findings of the RANZCP Workforce Report

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) released a Workforce Report in 2024 entitled *Burnout and moral injury: Australian Psychiatry at its limits.*[1] This was based on an anonymous survey of 7200 members (trainees and psychiatrists) in December 2023, that received 1269 responses, representing the views of approximately 18% of members. The RANZCP analysis found worsening workforce shortages with over 90% reporting workforce shortages adversely impacted patient care. Approximately three quarters experienced

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symptoms of burnout, and of these 82% cited workforce shortages as the top contributing factor to burnout. These findings are perhaps somewhat surprising, and certainly alarming.[1]

These findings may be an underestimate given that people with burnout may have been less likely to respond to such a survey. Alternatively, other members with higher job satisfaction might have elected not to respond, resulting in overestimation.

Concerningly, 73% of trainees also reported experiencing symptoms of burnout. Furthermore, with serious implications for ongoing retention of medical staff and service delivery, 33% of all psychiatrists, 13% of trainees, and 14% of early career psychiatrists considered leaving the profession in the next 3 years.[1]

Psychiatry is demanding work, involving the provision of empathetic care to patients experiencing heightened emotional distress, which requires high levels of professional and organisational support for a psychosocially safe workplace. These Australian findings therefore mirror international research on burnout in psychiatry, indicating high levels of symptoms such as emotional exhaustion.[2] For instance, a broad-ranging systematic review and meta-analysis found high levels of psychiatrist burnout, ranging from 25.9% using the Maslach Burnout Inventory to 50.3% using the Copenhagen Burnout Inventory.[3,4] Furthermore, international research on burnout in healthcare has found that it negatively impacts the care provided,[5] as endorsed by 93% of RANZCP members in the survey.[1] The levels of burnout self-reported in the survey exceed the findings from research using validated measures of burnout, and this may be due to methodological as well as ecological issues arising from the respondents' work circumstances. Future research should include validated burnout measures and collect data on work characteristics, such as public and/or private sector employment, in outpatient, telehealth or acute hospital and community settings.

The RANZCP survey also asked about factors that might contribute to burnout, and the five highest ranked were: workforce shortage (82%); under-resourced system (lack of community mental health clinical and support services, not enough capacity in the public and private system due to long wait times, lack of inpatient beds, etc., 81%); workload and type, (increasing patient load and increasing complexity of presentations, 73%); moral injury/feeling disempowered (59%); and unsafe workplace environment (including poor management or service design, 51%) (p. 8).[1]

These levels of burnout may represent the symptoms of a healthcare system facing enduring healthcare worker shortages, leading to unsafe workplaces.[1,6,7] In this context, the report has highlighted enduring experiential, structural and operational challenges that psychiatrists and trainees face on a daily basis, and which militate against the ability to provide optimal care to patients. The high levels of burnout in psychiatry may also influence both recruitment and retention. For example, the RANZCP Workforce Report is sobering reading for medical graduates considering a career in the profession.

Accordingly, it is necessary to consider how the workforce challenges that psychiatrists and trainees in Australia currently face can be addressed. The top five factors endorsed as likely to improve job satisfaction are: adequate staffing levels (79%); having enough resources and time to genuinely help patients (78%); adequate support with administration (69%); good work–life balance (68%); and working collaboratively with other health professionals including primary care providers and skilled multidisciplinary teams (67%).[1] The RANZCP report did not publish results comparing public sector and private sector, which might have revealed differences in the incidence of burnout which would be useful to understand and address.

The RANZCP report is not an isolated example. The National Mental Health Workforce Strategy promulgated by the Australian federal government Department of Health and Aged Care offers a high-level approach not specific to the psychiatric workforce.[8] Like the RANZCP Workforce Report, the Workforce Strategy acknowledges problems with workforce shortages and an increased demand for services. It states 'Increasing workloads, rapidly changing work environments, geographical and social isolation, insufficient practical support, inadequate operational guidance and lack of management conditions are some of the commonly cited reasons for workplace burnout, particularly among first responders and frontline workers'.[8] Two of the four 'Strategic Pillars' in the Workforce Strategy for growing and retaining the health workforce are to 'Attract and Train' as well as 'Support and Retain' staff; however, details as to how to do this are limited.[8] In response to the findings in the RANZCP Workforce Report, we suggest the elements of a strategic approach to addressing psychiatric workforce issues, outlined below.

Factors affecting the psychiatrist and trainee workforce

The psychiatric workforce exists as part of a healthcare ecosystem which includes mental healthcare, and an important context is that there are general challenges in maintaining healthcare workforce supply, especially in the context of COVID-19 pandemic healthcare and societal changes.[6]

Therefore, the following discussion proceeds from the general healthcare to specific mental healthcare and psychiatrist workforce capacity factors, towards potential interventions.

General healthcare factors

1. There was an existing shortfall of healthcare workers before the COVID-19 pandemic in most high-income countries.[6]

2. All health professions have suffered attrition, as well as intentions towards accelerated retirement of workers during and post-pandemic.[9]

3. There have been access[10] and exit block[11] challenges facing public hospitals, caused by structural lack of bed capacity as well as functional loss of community supports to facilitate discharge of care to the community.[6]

4. There is also competitive demand for healthcare workers from the residential Aged Care and Community sector,[12] that may reduce the pool of multidisciplinary healthcare workers in the acute hospital and community sector.

Specific mental healthcare factors affecting psychiatrists and trainees

5. As a result of the general factors above, the workload for psychiatrists and trainees has been observed to be increased in quantity and complexity, increasing the emotional demands and work strains on psychiatrists.[1]

6. There are specific concerns about under-resourcing and unsafe work environments due to poor management or suboptimal service design.[1]

7. Factors 5 and 6 above lead to unsafe and unsatisfying work experiences, and feelings that psychiatrists and trainees are unable to provide optimal, and at times even standard, care.[1,13]

8. It is then inevitable that psychiatrists and trainees describe moral injury/disempowerment and burnout.[1]

Interventions to address psychiatrist and trainee workforce challenges

General healthcare-based interventions

1. Specific training and selection for expert physician leadership in frontline care.[14] Expert medical leaders understand the core business of healthcare and can therefore develop and implement well-considered and well-designed, safe work environments.[15] This can enhance worker autonomy, which is a key factor in avoiding worker burnout.[4]

2. Work role clarification, safe work environments and duty-hour limitations reduce overload, risk and worker fatigue.[4,16]

3. Work–life balance[1] may also be enhanced by the new industrial initiatives on the right to disconnect. Mental healthcare involves uniquely individualised care for patients, which is labour-intensive and requires direct involvement from psychiatrists and trainees. Therefore, work–life balance is necessary to best deal with the emotional and psychological demands of the work.

4. Enforcing worker wellbeing as a key performance indicator for medical administrators and health service administrative boards has been proposed to effect action to reduce bullying, intimidation and harassment.[17]

Specific mental healthcare interventions

5. Adequate staffing levels[1] are predicated upon efficient design of services and expert leadership that understands the workflow and can marshal resources to employ sufficient staff.[15,16]

6. Reduce the burden of work-related documentation for psychiatrists and trainees such as through customised, fit-for-purpose Electronic Medical Record systems.[16,18]

7. Psychiatrists and trainees prefer to work in collaborative care with skilled multidisciplinary teams.[1] When such teams are either under-staffed and/or under-skilled, their workload increases. Improving multidisciplinary team staffing and skill levels is essential.

8. Adequate resources and time to provide care[1] depend on interventions 5 through 7, as well as support from leaders/managers that enhances the administrative support[1] needed to effect care (e.g. correspondence via transcription and efficient pharmacy systems).[16]

9. Enable opportunities to foster better team and social integration to reduce social and professional isolation.[19]

Other issues of relevance

While the focus of the RANZCP Workforce Report is not primarily on bullying and harassment, it remains a substantive issue in medical practice in general, including psychiatry, as indicated in the results of the Australian Medical Board's Medical Training Survey (https://medicaltrainingsurvey.gov.au/). This issue warrants a further separate discussion.

There are other workforce challenges that arise due to the relative concentration of the psychiatric workforce in primarily metropolitan coastal Australia, shortage of rural and remote specialists, and predominant patterns of part-time work.[20] As the focus of this discussion is upon the views expressed by psychiatrists and trainees to the RANZCP regarding their experience of the workplace, we acknowledge that these issues warrant further discussion.

Conclusions

The RANZCP Workforce Report has revealed the symptoms of an at least partially ailing and fragmented psychiatry workforce, which directly impact patient care. These symptoms require strategic intervention to

improve workplace conditions, and psychiatrist and trainee wellbeing. There may be synergies from adapting general healthcare interventions on leadership, work safety and duty-hour limitations, as well as implementing specific interventions in relation to design, multidisciplinary care, operational management and work–life balance. Action is needed, now.

Author contributions

All authors have satisfied substantial contributions to the conception or design of the work; or the acquisition, analysis or interpretation of data for the work; and drafting the work or revising it critically for important intellectual content; and final approval of the version to be published; and agreement to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

Conflict of Interest

The author(s) declared the following potential conflicts of interest with respect to the research, authorship, and/or publication of this article: JL, SA, TB, SK, PM and FW are editorial team members for the journal – they were not involved in the independent peer review process.

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