



IN ACTION CONFERENCE

Sharing workforce to grow capacity and improve outcomes

Dr Shuichi Suetani

Alana Turnbull

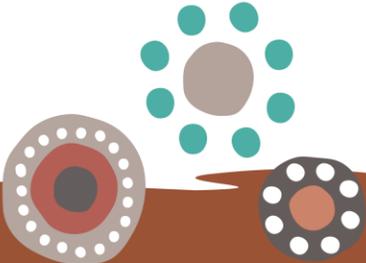
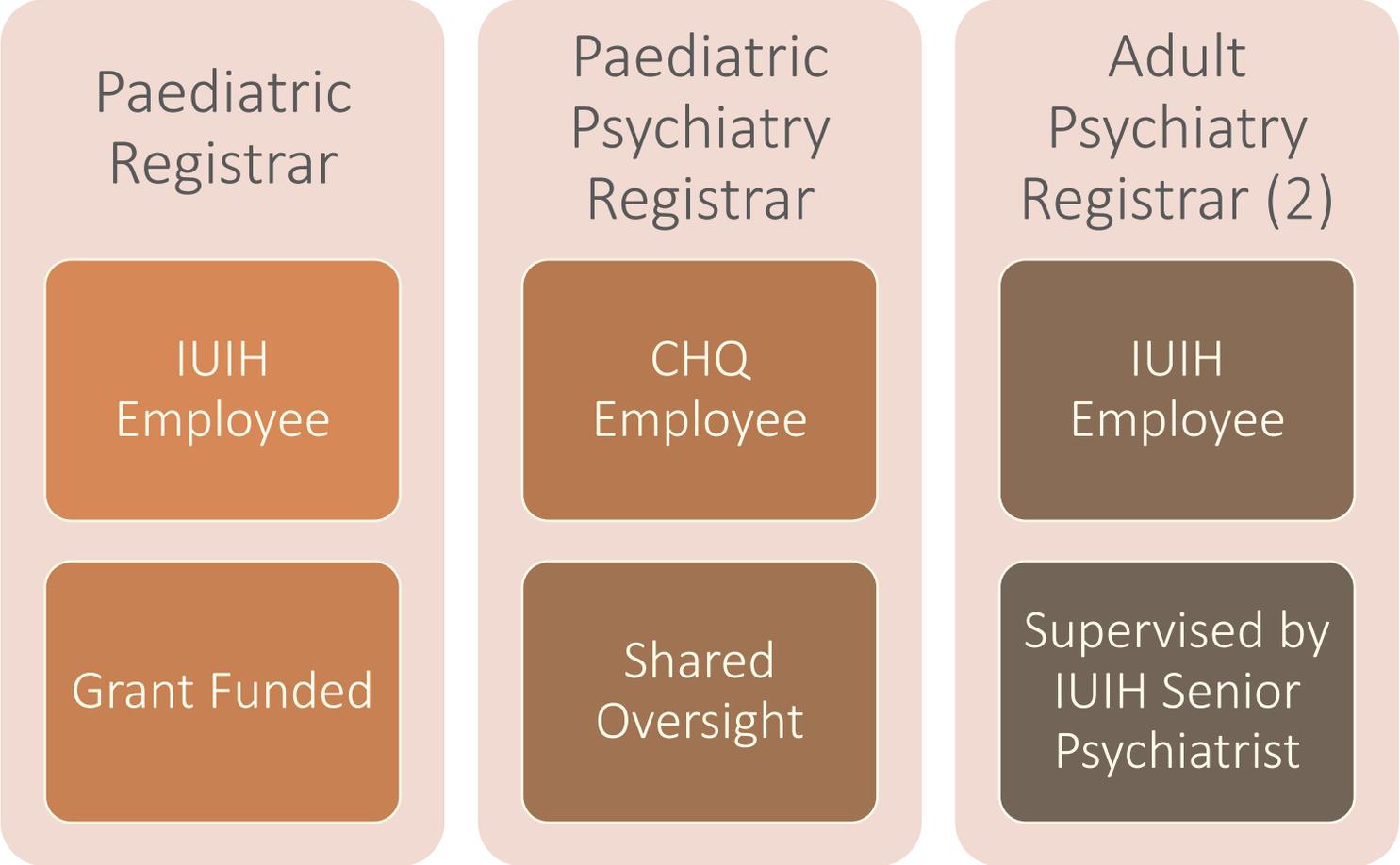
Key Priority Areas

SEQ First Nations Health Equity Strategy Key Priority Areas

- KPA1 Cultural Safety: Actively eliminating racial discrimination and institutional racism within services.
- KPA2 Access: Increasing access to healthcare services.
- KPA3 Determinants: Influencing the social, cultural, and economic determinants of health.
- KPA4 Delivering Quality Healthcare: Delivering sustainable, culturally safe, and responsive healthcare services.
- KPA5 Service Delivery Partnerships: Working with First Nations people, communities, and organisations to design, deliver, monitor, and review health services.
- KPA6 A Strong and Capable Workforce: Strengthening the First Nations health workforce.



Models of 'shared' workforce

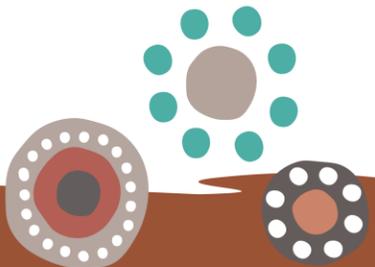


Barriers

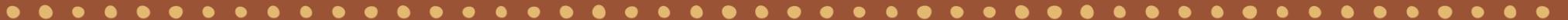
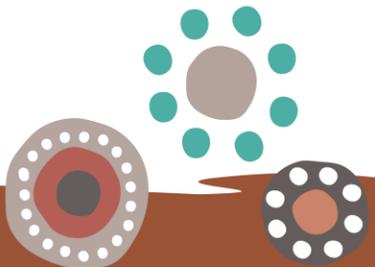
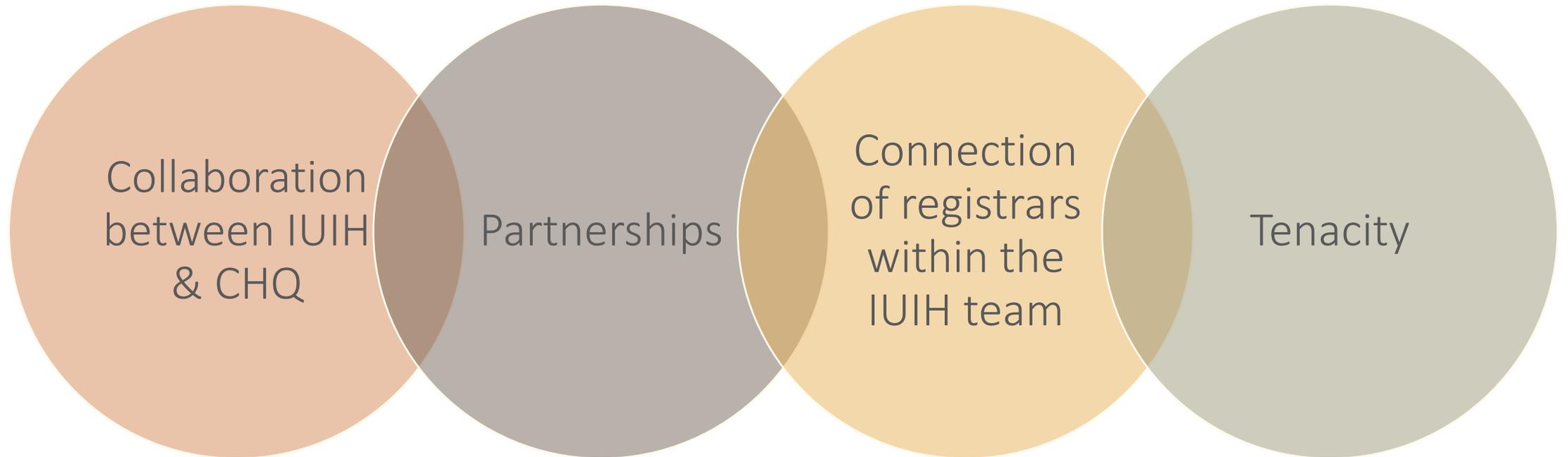
Funding

Workforce

Integration



Enablers



A solution?: Bringing psychiatry into Indigenous Health

In Brief

ANZJP

The Institute for Urban Indigenous Health: The role of psychiatry in reducing health inequality

**Shuichi Suetani^{1,2,3,4} , Leshay Chong¹, Randall Frazer¹,
Carmel Nelson^{1,3}, Lyle Turner¹, Marianna Serghi¹,
Adrian Carson¹ and Harvey Whiteford^{2,3}**

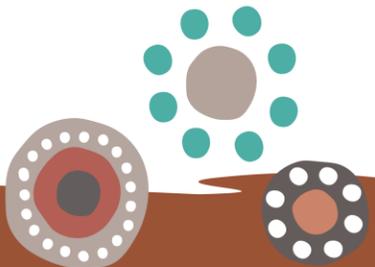
Australian & New Zealand Journal of Psychiatry
2022, Vol. 56(11) 1376–1377
DOI: 10.1177/00048674221103481

© The Royal Australian and
New Zealand College of Psychiatrists 2022
Article reuse guidelines:
sagepub.com/journals-permissions
journals.sagepub.com/home/anp

 SAGE

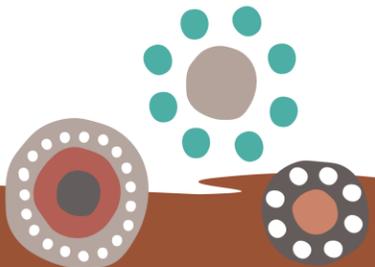
“Of particular significance, the UIH senior psychiatrist position *brings psychiatry to Indigenous health* – to the system of care with proven effectiveness for Indigenous people”

A fulltime role – I have no other job



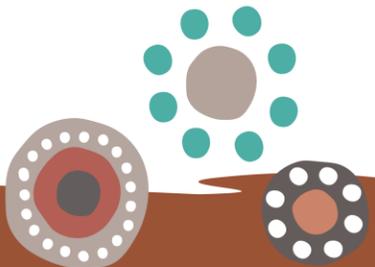
Could we reduce some of the barriers by bringing *registrars* in to IUIH?

- Psychiatry workforce shortage... everywhere
- Short rotation time (six months)
- Unknown quality of registrars
- Limited input (0.1 - 0.4FTE clinical time – often very little non-clinical time)
- People changing jobs all the time (on both ends)
- Leave, nights, exams, PDL, ECT, and other training stuff
- Different documentation systems: MMEX v CIMHA + IEMR
- Different ways of doing psychiatry (acute mental health v. community psychiatry)



Could we reduce some of the barriers by bringing *registrars* in to IUIH?

- Psychiatry workforce shortage... everywhere
 - Short rotation time (six months)
 - Unknown quality of registrars
 - Limited input (0.1 - 0.4FTE clinical time – often very little non-clinical time)
 - People changing jobs all the time (on both ends)
 - Leave, nights, exams, PDL, ECT, and other training stuff
 - Different documentation systems: MMEX v CIMHA + IEMR
 - Different ways of doing psychiatry (acute mental health v. community psychiatry)
- 12 months rotation for Stage 3 (advanced) registrars
 - We interview and choose the candidates
 - Full time with us (incl. Non-clinical time)
 - Employed by IUIH rather than Q Health
 - Supervised by IUIH senior psychiatrist



Two registrar jobs: One – Psychiatry Workforce Program

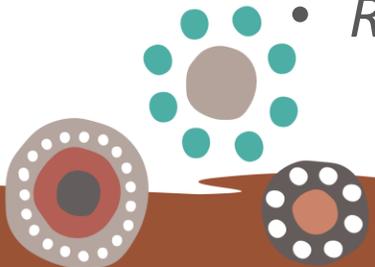
Improving access to psychiatry

The Australian Government is investing \$27.5 million to expand the psychiatry workforce, ensuring all Australians regardless of where they live have better access to quality mental health care.

- Partnership with City Specialists Clinic
- Funded through the PWP funding
- 0.5FTE at IUIH and 0.5FTE at CSC
- Exposure to private psychiatry and Indigenous mental health
- Fully employed by IUIH
- *Rotation allocation by Metro North*

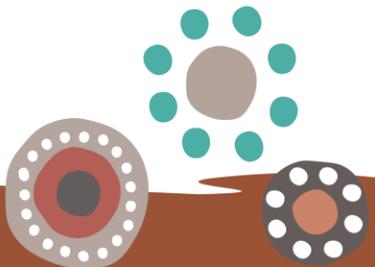


[Home](#) [Our Team](#) [About Psychiatry](#) [Appointments](#) [CSC Star Program](#)



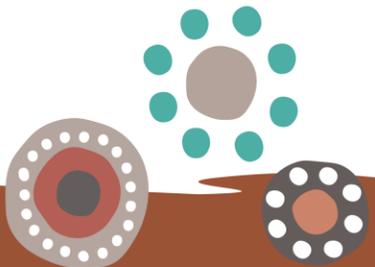
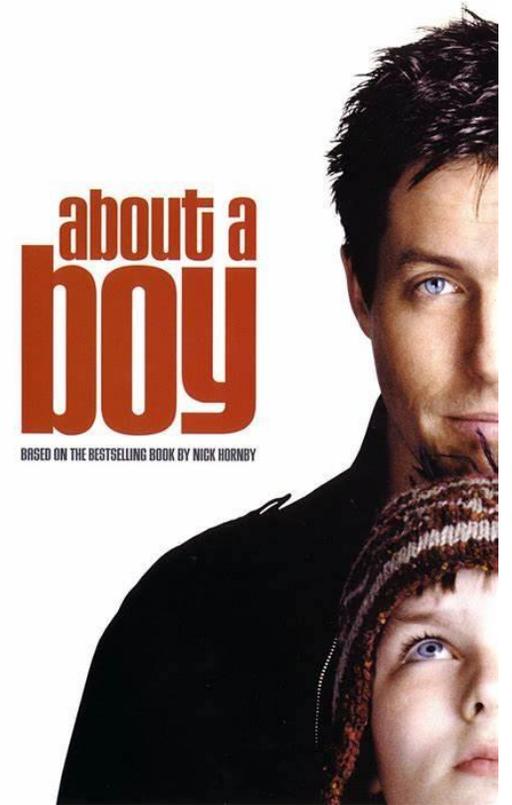
Two registrar jobs: Two – In-house IUIH job

- Funded by IUIH
- *“Registrars are so much cheaper than consultants”*
- Matches Q Health reward rate
- GP liaison psychiatry – exposure to common mental disorders (e.g. anxiety, depression, PTSD, ADHD)
- Working in 3 different IUIH clinics where the supervisor goes



“No man is an island” – *Jon Bon Jovi*

- IUIH Clinics covered: Margate, Goodna and Wynnum
- Regular catch ups with Acute Care Teams (The Prince Charles, Caboolture/Redcliff, and Bayside)
- Shared registrar with Caboolture Hospital (0.1FTE)
- West Moreton – the Ipswich Staying Deadly Hub link
- Working with Metro North for IUIH/CSC rotation allocation
- Regular teaching/training/in-service with various community and inpatient mental health teams
- Journal peer reviewed paper publications and conference preser
- Formal education lecture (Stage 3, leadership and management)

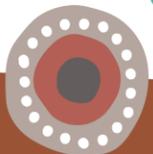


Where to from here...

- I want to build an empire – but *no man is an island*
- Recruitment and retainment:
 - Hopefully, some of the registrars will stay as consultants
 - Even if they don't – they will take Indigenous mental health back to psychiatry...
- Ongoing collaboration and improved relationships with Q Health



"We can't do this alone – we need to work together"





IN ACTION CONFERENCE

Panel Yarn

Dr Christopher Gandar

Dr Jacqueline Fleetwood

Dr Nadia Leonidou

Workshop Questions

How can we replicate this to other disciplines and services?

- *What models would work best?*
- *What other specialty areas could we explore?*

What systems changes could we make in order to expand across SEQ?

