The Royal Australian & New Zealand College of Psychiatrists

Your Health in Mind

Western Australian Branch

2027-2028 Pre-Budget Submission

RANZCP Western Australian Branch



Acknowledgement of Country

We acknowledge and respect Aboriginal peoples as the state's first peoples and nations and recognise them as traditional owners and occupants of land and waters in Western Australia.

We acknowledge that the spiritual, social, cultural and economic practices of Aboriginal peoples come from their traditional lands and waters, that they maintain their cultural and heritage beliefs, languages and laws which are of ongoing importance, and that they have made and continue to make a unique and irreplaceable contribution to the state.

We honour and respect their Elders past and present, who weave their wisdom into all realms of life – spiritual, cultural, social, emotional, and physical.

Acknowledgement of Lived and Living Experience

We recognise those with lived and living experience of mental health challenges and distress, their chosen families, moort, whanau, carers and kin. Their contributions, diverse perspectives, insight and courage keep us grounded and inclusive and focused on humanity, feeling and hope. We strive to work in genuine partnership in all that we do, honouring their voices by centring their experiences and expertise.

About the Royal Australian and New Zealand College of Psychiatrists

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) is a membership organisation responsible for training and maintaining professional standards of medical specialists in the field of psychiatry in Australia.

Our roles include support and enhancement of clinical practice, advocacy for people affected by mental illness, and a key advisory role to governments on mental healthcare.

The RANZCP is the peak body representing psychiatrists in Australia and New Zealand, and as a binational college, has strong ties with associations in the Asia and Pacific region. The RANZCP has over 9,600 members, including more than 820 psychiatrists and those training to qualify as psychiatrists in Western Australia.

The RANZCP Western Australia Branch Committee partners with people with lived experience, including through an active partnership on our Branch Committee.

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Chair's Foreword

People need care before crisis. WA needs to act now.

Behind the pressure on WA's hospitals are people who need help and cannot get it soon enough. For someone living with a complex mental illness, a gap in care can mean another crisis, another emergency department visit, or more time in hospital because the right support is not available. We cannot accept this as the best our system can offer.

The RANZCP WA Branch is asking the State Government to fund five practical initiatives over the forward estimates. The goal is straightforward: help people get treatment earlier, connect care around their needs and build the specialist workforce to make that possible. That is how we can begin to ease avoidable pressure on emergency departments and hospital beds, not by waiting for more people to reach crisis.

As the peak body representing psychiatrists in WA, we hear directly from members who see these consequences every day: patients returning to emergency departments, people staying in hospital because appropriate step-down care is unavailable, and opportunities for earlier treatment lost because services cannot respond. These are not simply problems of patient flow. They are missed chances to relieve distress and help people recover.

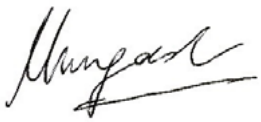
Government has already invested in services and workforce growth. We need to give those investments the best chance to succeed.

This submission sets out a focused way forward: protect psychiatry training, strengthen specialist advice across hospital and community treatment services, and close treatment gaps that leave people without support.

These five proposals build on what WA already has. They offer a practical opportunity to use existing capacity more effectively and reach people sooner, before their needs become harder to meet.

I urge our government to back these proposals in the next Budget. We are ready to work with you to put them into practice. People need more than a promise of care in the right place at the right time. They need us to make it happen.





Dr Murugesh Nidyananda
WA Branch Chair

Back smarter mental health investment – and relieve pressure on hospitals

This submission package combines workforce support with targeted service development to improve access to coordinated care and reduce avoidable pressure on emergency departments and hospital beds.

The Budget proposals focus on achieving the Government Priorities 2025-2029[1] for the care sector, chiefly:

- reducing avoidable emergency department presentations and the length of stay (Attachment 1);
- expanding specialist community mental health treatment;
- strengthening the public mental health workforce across WA; and
- connecting fragmented parts of the service system towards a more responsive system for people with complex and enduring mental illness (Attachment 2).

For budget assessment, each priority sets out the service gap, funding sought, intended policy contribution and rationale for using existing capacity more effectively. The proposals seek to protect existing investment and reduce avoidable demand. The forward estimates are indicative, with final-year costs for Priorities 3 and 5 pending further development of the proposed services beyond 2030.



Priority 1

Fund increased consultant supervision capacity for psychiatry trainees

Rationale and urgency of funding

The Branch welcomes the increased 2027 psychiatry trainee intake across both WA training zones. Funded supervision is essential to turn these additional places into qualified specialists. WA has the country's third largest psychiatric workforce gap, making this investment vital to filling vacancies and sustaining specialist capacity.

Clinical supervision is essential to training and assessing professional competence in psychiatry. The minimum five-year program requires protected non-clinical time for trainees and supervisors. Without funded capacity, supervision competes with clinical care, risking accreditation, trainee progression, supervisor sustainability and training quality. More training places will not resolve shortages if supervision constrains completion.

Funding request

The Branch seeks recurrent funding over the forward estimates for 1 FTE of additional protected consultant supervision time, increasing fractionally each year, across both training zones. Funding should support clinical supervision, assessment, feedback, trainee progression and coordination of high-quality accredited placements in metropolitan and regional services.

Delivery could use existing models, including fractional appointments for private psychiatrists to supervise public-sector trainees. This would help secure supervision capacity amid a global psychiatric workforce shortage.

Forward estimates

2027-2028	2028-2029	2029-2030	2030-2031
Metropolitan training			
$450,000	$ 650,000	$750,000	$750,000
Rural training			
$250,000	$300,000	$450,000	$550,000

Estimate based on average salary costs including on-costs

Alignment with Government priorities

This investment would support the Government's expanded psychiatry intake and strengthen specialist capacity in hospital and community services. Intended longer-term benefits include earlier assessment and treatment, less deterioration to crisis and fewer avoidable emergency department presentations.

The proposal is consistent with the workforce objectives described in this submission and the National Medical Workforce Strategy 2021–2031. It would:

- reduce reliance on emergency and acute care;
- protect the quality, safety and accreditation of psychiatry training across both training zones;
- support timely trainee progression and Fellowship completion;
- improve recruitment and retention in an area of acute shortage through a supported training environment; and
- increase psychiatric capacity across metropolitan and regional services.

Cost-effectiveness and system integration

The value-for-money case is to protect investment in additional trainee positions. Existing consultant expertise and accredited infrastructure would support trainees through to Fellowship and strengthen the specialist workforce. Workforce investment returns outweigh expenditure at a 4:1 ratio, as shown in Attachment 3.

Funded supervision addresses bottlenecks that constrain accredited posts, delay completion or contribute to attrition. It would immediately support training capacity and progression, with specialist service capacity increasing as trainees qualify and enter the consultant workforce.



Priority 2

Fund the Director of Advanced Training in Consultation-Liaison Psychiatry

Rationale and urgency of funding

Consultation-Liaison psychiatry supports people with co-occurring mental and complex physical illness in hospitals and other health settings. A sustainable advanced training pathway is essential to build the specialist workforce advising emergency, medical, surgical and community teams.

The Director of Advanced Training (DoAT) leads, coordinates and oversees training quality and supervision. Inconsistent remuneration leaves consultants absorbing these responsibilities alongside clinical workloads. The Metropolitan Training Program accreditation process recommended remuneration. Protected, funded time would address this recommendation and safeguard trainee support, placement coordination and training continuity.

The risk extends beyond training administration. Limited consultation-liaison capacity restricts specialist advice for complex presentations and planned care. Funding this leadership role would protect the workforce pipeline serving hospitals and communities, rather than leave it reliant on unfunded time.

Funding request

The Branch seeks recurrent funding over the forward estimates for 0.2 FTE of protected, remunerated time for the Director of Advanced Training in Consultation-Liaison Psychiatry to oversee statewide advanced training.

Forward estimates

2027-2028	2028-2029	2029-2030	2030-2031
$100,000	$100,000	$100,000	$100,000

Estimate based on average salary costs including on-costs

Alignment with Government priorities

This proposal links workforce sustainability with coordinated mental and physical healthcare. Stronger training leadership and specialist capability would support more timely advice and coordinated hospital and community care. It would:

- advance the Government priorities for an appropriately skilled workforce and integrated care that unblocks hospital access;
- strengthen the pipeline of psychiatrists equipped to work across mental and physical healthcare;
- support workforce capability, clinical leadership and high-quality supervision;
- improve coordination between mental health, emergency, medical, surgical and community services.

Cost-effectiveness and system integration

The request funds 0.2 FTE of an existing specialist leadership role within established training and service infrastructure, rather than a separate program. It makes statewide oversight resourcing explicit and protects time for this responsibility.

Protected leadership time would support consistent supervision, coordinated placements and better use of specialist expertise. Over time, a stronger consultation-liaison workforce would help general health, primary care and community teams access specialist advice and manage complex presentations through planned care where clinically appropriate.

The immediate investment is in workforce infrastructure. Intended downstream benefits include better coordinated treatment, fewer fragmented referrals and reduced discharge delays.



Priority 3

Fund a YouthLink pilot and statewide neuropsychiatric liaison service

Rationale and urgency of funding

Between 30% and 50% of people with intellectual and developmental disabilities experience severe and enduring mental health challenges, yet WA remains the only Australian state without a specialised public community treatment service for this cohort.

Psychiatrists see this gap across WA. People with intellectual disability, cognitive impairment, acquired brain injury and neurodevelopmental conditions too often navigate services not designed, resourced or clinically supported to meet their complex needs.[2]

Without a specialist pathway, people can deteriorate while families, carers and clinicians seek help, leaving emergency departments as the default. The proposal links a statewide consultation and referral service across public, private, hospital and community settings with a YouthLink treatment pilot for young people with co-occurring mental ill-health and disability, particularly ADHD and autism. Together, they would support earlier intervention and coordinated care.[3]

Funding request

The Branch seeks staged funding over the forward estimates to establish:

- a YouthLink pilot for young people with co-occurring mental health and neurodevelopmental conditions; and
- a statewide public neuropsychiatric liaison service.

Members' clinical experience highlights the need for specialist support before crisis. This investment would begin a statewide hub-and-spoke model based on the WA Eating Disorders Outreach and Consultation Service (WAIDOCS, see Attachment 4). Staging would allow the YouthLink pathway to be tested before expansion.

Alignment with Government priorities

This proposal would support the WA Government's commitment to the right care, in the right place, at the right time. It would:

- advance the Strategic Pillar 4 of the WA Mental Health and Alcohol and Other Drugs Strategy 2026–2031 for accessible, easy-to-navigate services, community-based alternatives and specialist support;[4]
- respond to the Recommendation 6.33 of the Disability Royal Commission's call for equitable access to appropriate mental healthcare.[5]
- support Sustainable Health Review Recommendations 6 and 7 by shifting care toward early intervention and community settings; and
- connect services and strengthen accountability for integrated planning and delivery.

Forward estimates

2027-2028	2028-2029	2029-2030	2030-2031
$350,000	$350,000	$350,000	-

Estimate based on average cost of WAIDOCS, plus CPI

Cost-effectiveness and system integration

The value-for-money case is to concentrate expertise in a hub supporting metropolitan and regional services, rather than duplicate specialist services locally. The pilot would test a targeted treatment pathway alongside statewide consultation. Funding assumes consultation support begins in year two and runs concurrently with the pilot.

The model would:

- help local clinicians provide appropriate care in the community;
- prevent deterioration that leads to ambulance callouts, emergency department presentations, prolonged admissions and repeated referrals;
- release consultation-liaison and acute-bed capacity for people who require hospital care; and
- use existing infrastructure, referral networks and telehealth capability, reducing implementation risk.

Community treatment for people with complex mental health conditions returns 3:1 on expenditure, as illustrated in Attachment 3.



Priority 4

Enhance ADHD diagnostic and treatment capability across public mental health services

Rationale and urgency of funding

The Branch supports the Government's $1.3 million GP shared-care training program. Its success requires a public specialist pathway for severe co-occurring conditions, diagnostic uncertainty and complex clinical risk. Public adult mental health services have historically had limited capacity for ADHD referrals. Without dedicated capability, improved primary care access may expose a bottleneck in complex assessment and treatment.

Funding would close the gap between referral and specialist care. People with complex trauma, mood or personality disorders, substance use or treatment-resistant neurodevelopmental presentations may otherwise face repeated referrals, interrupted treatment or lost continuity at transition to adult services. A clear public pathway would support planned care before an emergency.

People on low incomes and in regional WA face particular disadvantage from insufficiently subsidised private assessment and limited specialist access. A statewide public pathway would deliver on the Government's timely-access commitment for those with the most complex needs.

Funding request

The Branch seeks staged funding over the forward estimates for a program to:

- train and support psychiatrists, mental health nurses and multidisciplinary public mental health teams;
- strengthen assessment, diagnosis and treatment of complex ADHD;
- operate across metropolitan services and the WA Country Health Service; and
- create clear public specialist pathways for people whose needs cannot be safely managed through GP shared care.

Forward estimates

2027-2028	2028-2029	2029-2030	2030-2031
$250,000	$250,000	$150,000	$150,000

Estimate based on the cost of GP Specialist ADHD training program

Alignment with Government priorities

This proposal would complement GP shared-care investment by strengthening public specialist services for complex referrals. It would:

- complete the pathway created by the GP shared-care program;
- advance the WA Mental Health and Alcohol and Other Drugs Strategy 2026–2031 priorities for specialist support, equitable access and integrated care; and
- support Sustainable Health Review Recommendations 6, 7, 10 and 12 through earlier intervention and stronger primary, specialist, metropolitan and regional links.

Cost-effectiveness and system integration

The value-for-money case is to protect existing GP training investment. Public paediatric and psychiatric services need capacity to accept complex referrals, advise clinicians and return suitable patients to primary care with a treatment plan. Shared care depends on these links; primary care training alone cannot provide specialist assessment and treatment.

A statewide support function would:

- use scarce psychiatric expertise to build capability across multidisciplinary and regional teams;
- reduce duplicated assessments, failed referrals, diagnostic delay and treatment interruption;
- improve continuity between primary care, child and adolescent services, adult mental health services, alcohol and other drug services and the WA Country Health Service; and
- reduce escalation to crisis, emergency department and inpatient care.



Priority 5

Improve women's access to mental healthcare across the lifespan

Rationale and urgency of funding

WA has made important investments in perinatal and infant mental health care, sexual assault services and the Women's Mental Health Unit at Cockburn. Our members nevertheless continue to see women whose gender-specific mental health needs fall outside existing service boundaries. Recent research found that women with post-partum psychosis experience a fragmented service system when attempting to get support despite contacting health services repeatedly.[6]

Funding would extend an established statewide program to close gaps between life stages, strengthen frontline capability and provide a clear source of specialist advice. Existing expertise and relationships would improve timely access and coordination, rather than create a separate service.

Funding request

The Branch seeks staged funding over the forward estimates to expand the Statewide Perinatal and Infant Mental Health Program through the Women and Newborn Health Service.

The investment would:

- build specialist workforce capacity;
- establish a statewide women's mental health hub;
- support primary care, public mental health services and the non-government sector; and
- improve responses to the mental health needs of women and girls across the lifespan.

Forward estimates

2027-2028	2028-2029	2029-2030	2030-2031
$350,000	$350,000	$350,000	-

Estimate based on average cost of WAEDOCS, plus CPI

Alignment with Government priorities

This proposal would help the Government deliver accessible, responsive care when and where women need it. It would:

- implement the life-course approach in the Western Australian Women's Health and Wellbeing Policy;
- advance equity, prevention, early intervention, workforce development, collaboration and women-centred care;
- support the Mental Health and Alcohol and Other Drugs Strategy 2026–2031 priorities for accessible, integrated and person-centred services; and
- connect the Statewide Perinatal and Infant Mental Health Program with primary care, public mental health and non-government services.

This would create a visible statewide pathway rather than another organisational boundary.

Cost-effectiveness and system integration

The value-for-money case is to concentrate expertise in a hub supporting metropolitan and regional services, rather than duplicate specialist services locally. The pilot would test a targeted treatment pathway alongside statewide consultation. Funding assumes consultation support begins in year two and runs concurrently with the pilot.

The model would:

- help local clinicians provide appropriate care in the community;
- prevent deterioration that leads to ambulance callouts, emergency department presentations, prolonged admissions and repeated referrals;
- release consultation-liaison and acute-bed capacity for people who require hospital care; and
- use existing infrastructure, referral networks and telehealth capability, reducing implementation risk.

Community treatment for people with complex mental health conditions returns 3:1 on expenditure, as illustrated in Attachment 3.



Attachment 1

Accessing mental healthcare through emergency departments: current risks and solutions to the ED revolving door

Emergency departments are a necessary component of the mental health crisis response. However, repeated presentations, extended stays, and barriers to inpatient and community care indicate a broader system-design issue. Currently, WA EDs are increasingly functioning as the default access point when earlier intervention, psychiatric assessment, and specialised community treatment alternatives are unavailable or difficult to navigate. The number of presentations with over 24 hours stay have increased significantly over the past year:

Table 1: Number and length of stay of mental health emergency presentations that were admitted to WA hospitals[7]

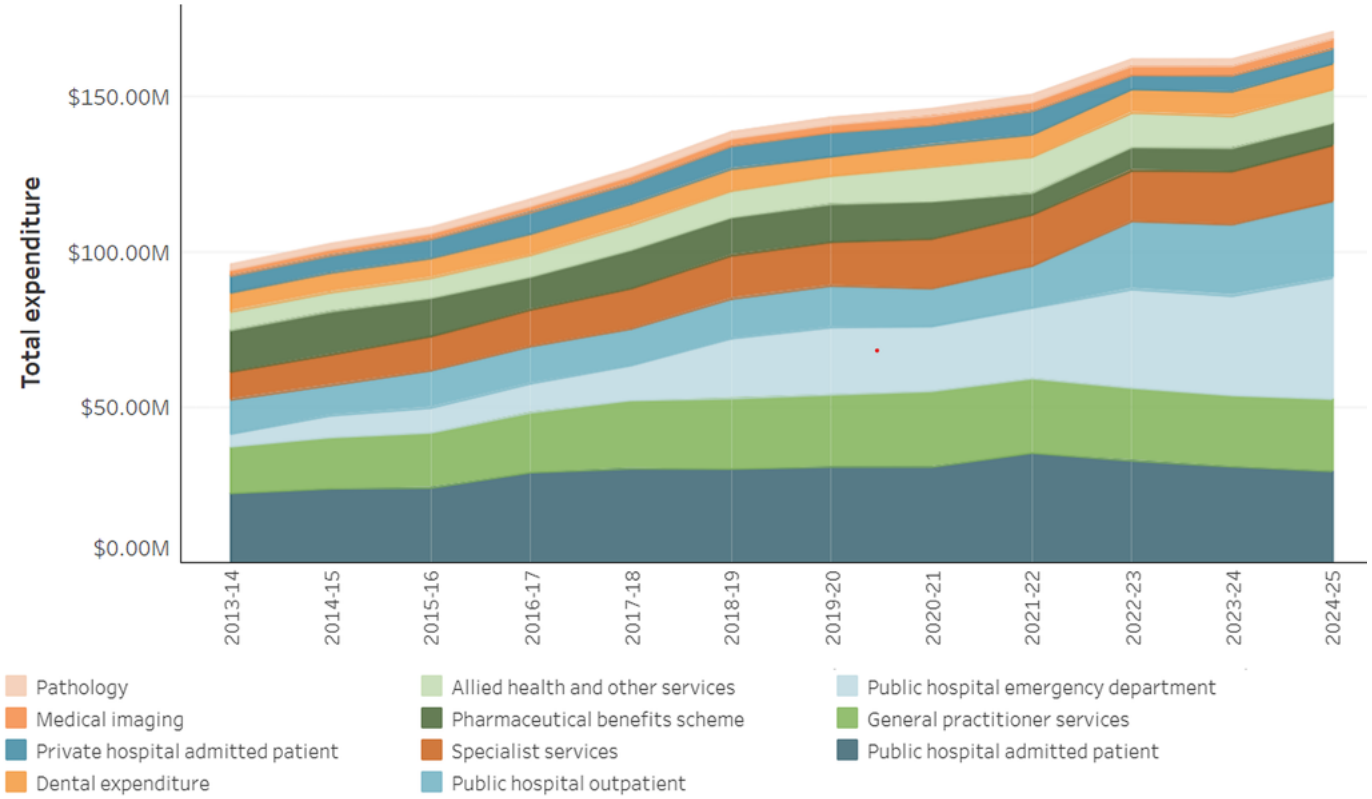
Length of stay	January 2025-August 2025	January 2026-August 2026
>24 hrs and <=48 hrs	1,194	1,394
>48 hrs and <=72 hrs	206	329
>72 hrs and <=96 hrs	41	100
>96 hrs and <=144 hrs	20	63
>144 hrs	5>	5>

In 2019, 5% of WA mental health patients accounted for about 20% of mental health ED attendances, averaging 8.8 attendances each year.[8] And in 2020, the State Auditor-General reported that 10% of adults with acute mental health needs used 90% of inpatient care and 50% of emergency and community treatment.[9] These figures are dated and should be interpreted cautiously.

However, more recent data confirms **long-term, sustained pressure** on WA EDs: in 2025, the Australasian College for Emergency Medicine tracked the rising trend in the length of stay for mental health presentations and an increase in presentations requiring hospital admission since 2016–17.[10] Independent AIHW data shows ballooning expenditure on ED presentations for select mental and substance use disorders over the past decade, recording the biggest rise across the board, as shown in figure 1:[11]



Figure 1: Total expenditure on Other mental and substance use disorders by detailed are of expenditure (Total Person, all ages, Western Australia), 2013-14 to 2024-25



The policy challenge is therefore not simply to improve ED performance, but to strengthen capacity and continuity across the full mental health service system.

Risks, their implications, and recommended policy response

Risk 1: delayed access to assessment and treatment.

Access block, ambulance ramping and ED crowding can delay clinical assessment, specialist review and transfer. This is not acceptable because people presenting in crisis require timely, safe treatment, and delays can increase distress, clinical deterioration and pressure on patients, families and staff.

Policy response: establish whole-of-system patient-flow targets and accountability across ambulance, ED, mental health inpatient and specialised community treatment services, supported by real-time escalation arrangements.

Risk 2: care determined by service availability rather than clinical need.

Insufficient acute, subacute and step-down capacity can constrain admission, delay transfer or result in care being delivered in a setting not designed for ongoing treatment. This is not acceptable because access and discharge decisions should be clinically led and consistent with safety, recovery and least-restrictive-care principles.

Policy response: undertake needs-based capacity planning across acute beds, subacute care, rehabilitation and supported transition services, with transparent reporting against demand and acuity.

Risk 3: fragmented responses to complex need.

People using EDs frequently may also experience substance use, physical illness, homelessness or insecure housing and acute psychosis. Separate eligibility criteria and disconnected services can leave key needs untreated. This is not acceptable because fragmentation shifts risk between services and contributes to avoidable deterioration and re-presentation.

Policy response: commission integrated multidisciplinary models across mental health, alcohol and other drugs, primary care, specialist treatment, housing and social services, with shared care planning and clear lead responsibility.

Risk 4: unsafe gaps at discharge and transition.

Delayed follow-up, weak handover, medication disruption and limited access to housing or psychosocial support can undermine recovery after ED or hospital discharge. Safe and stable accommodation does not remain so if a person relapses and cannot access treatment when the community treatment services are stretched. This is not acceptable because foreseeable transition failures expose people to relapse, harm and avoidable return to crisis care

Policy response: ensure timely post-discharge contact, documented safety and care plans, assertive clinical follow-up, medication continuity, and direct referral pathways to practical supports.

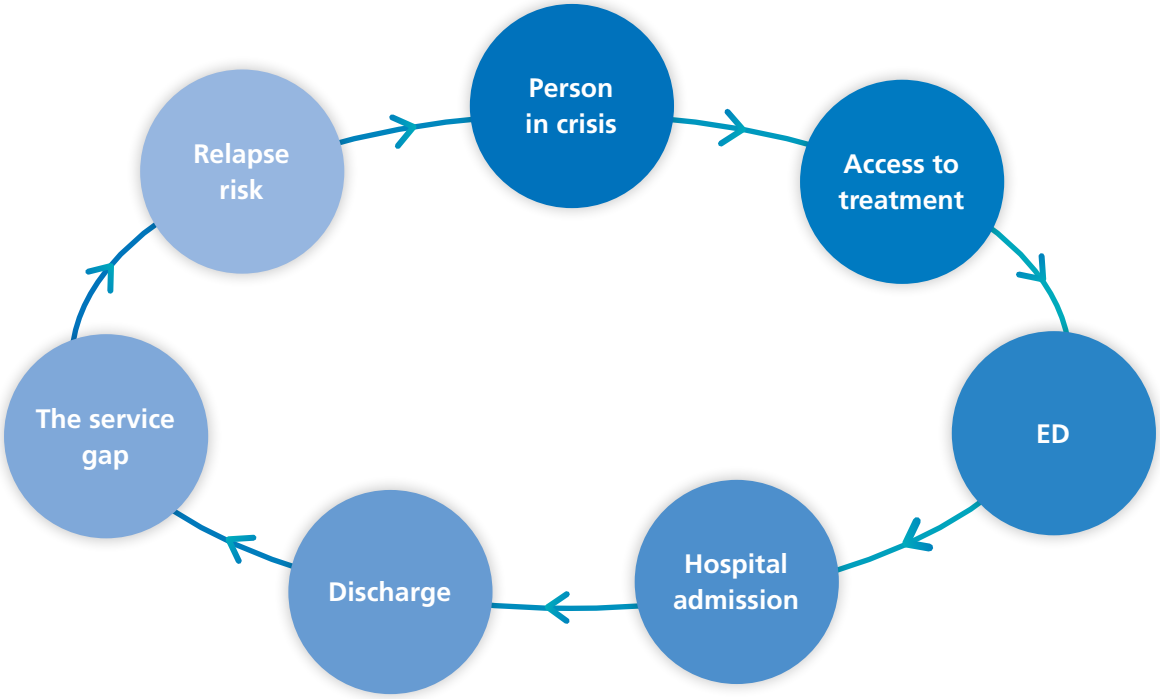
Risk 5: accountability focused on episodes rather than outcomes.

ED timeliness measures alone do not show whether a person receives continuous and effective treatment and care after leaving the department. This is not acceptable because the system can meet an episodic target while failing to prevent repeated crisis presentations.

Policy response: include treatment continuity and follow-up, clinical outcomes, patient experience, housing stability and re-presentation in performance frameworks, with public reporting across the full pathway.

Pathway 1: Service pathway and policy pressure points in ED presentations requiring psychiatric admission

Pathway 1 illustrates where Risks 1–5 can arise when a person requires psychiatric admission. The central policy concern is that timely, clinically appropriate treatment may be constrained by patient-flow pressures, bed availability and discontinuity at transition points.



Before presentation: Risk 3: fragmented responses to complex need. Fragmented clinical, housing, and social supports can allow needs to escalate into crisis. It is a cycle: in crisis, people can jeopardise secure housing or access to supports, which escalates the crisis. **Policy alignment:** better access to specialist treatment services, integrated commissioning, shared care planning, and a clearly identified lead service.

Entry to care: Risk 1: delayed access to treatment. Ambulance transfer delays and waits for assessment can prolong an acute crisis. September 2026 set an all-time monthly record in ramping hours, showing persistent structural challenges that were not solved with the Government's 'Winter Strategy 2026'. **Policy alignment:** whole-of-system flow targets, escalation protocols, and shared accountability across ambulance and hospital services.

Emergency department: Risks 1 and 2: delay and capacity-constrained care. Crowding, delayed specialist review, and waits for an inpatient bed can extend time in an environment designed for emergency assessment rather than ongoing psychiatric treatment. **Policy alignment:** needs-based inpatient capacity, rapid specialist assessment, and transparent access-block reporting.

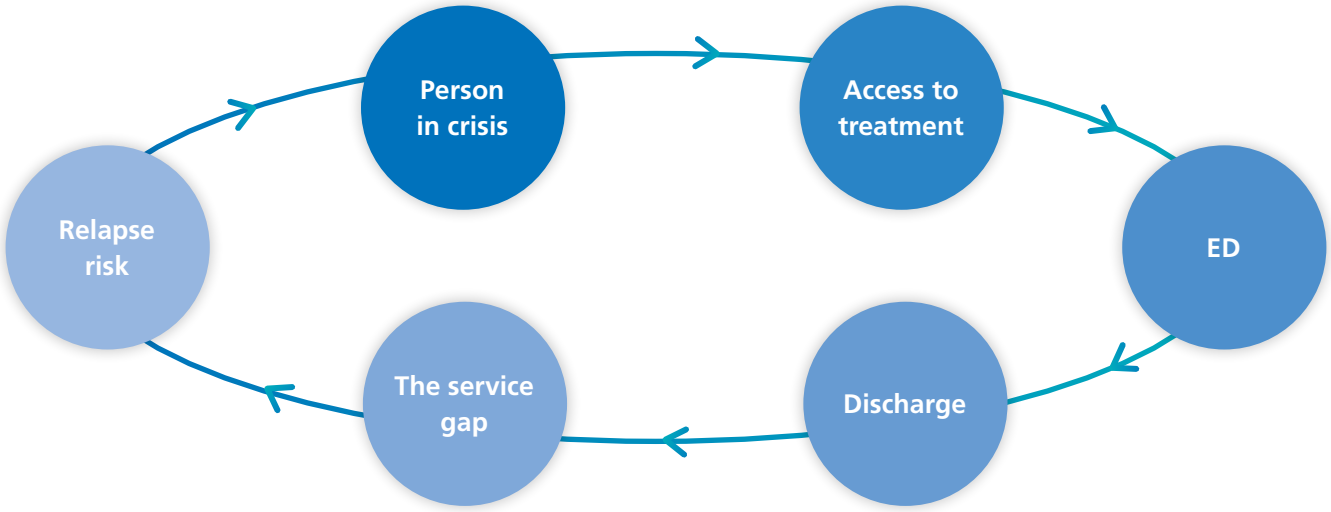
Admission and inpatient care: Risk 2: treatment constrained by capacity. Admission provides safety and treatment, but insufficient therapeutic, rehabilitation or step-down capacity can delay recovery and discharge. **Policy alignment:** coordinated planning for acute, subacute, rehabilitation, and supported transition capacity.

Discharge and transition: Risk 4: unsafe gaps in treatment continuity. Weak handover, delayed specialist follow-up, medication disruption, and inadequate housing or psychosocial support can erode gains made in hospital. This is not acceptable because these are foreseeable transition risks. **Policy alignment:** funded specialist assertive follow-up, medication continuity, documented care plans and direct referral to practical supports.

Re-presentation: Risk 5: episodic accountability. A return to ED may indicate that treatment and support were not sustained across the pathway. Re-presentation is not always preventable, but repeated crisis use linked to known service gaps is not acceptable. **Policy alignment:** measure continuity, patient outcomes and re-presentation, and require cross-service review of recurrent access failures.

Pathway 2: Service pathway and policy pressure points in ED presentations not requiring psychiatric admission

Pathway 2 illustrates where Risks 1, 3, 4 and 5 can arise when psychiatric admission is not clinically required. The policy objective is to ensure that discharge is supported by prompt, accessible specialist community treatment and care rather than becoming a return point to crisis services.



Before presentation: Risk 3: fragmented responses to complex need. Fragmented clinical, housing, and social supports can allow needs to escalate until ED becomes the only readily accessible option. It is a cycle: in crisis, people can jeopardise secure housing or access to supports, which escalates the crisis. **Policy alignment:** better access to specialist treatment services, integrated commissioning, shared care planning, accessible community alternatives and a clearly identified lead service.

Entry to care: Risk 1: delayed access to treatment. Ambulance transfer delays and waits for assessment can prolong distress and defer treatment. **Policy alignment:** whole-of-system flow targets, escalation protocols, and shared accountability across ambulance and hospital services.

Emergency department: Risks 1 and 3: delay and limited alternatives. ED teams can assess and stabilise immediate risk, but emergency care cannot substitute for sustained access to specialised treatment, safe housing, and social support. **Policy alignment:** rapid specialist assessment, crisis alternatives, improved specialist treatment services, and direct referral pathways to integrated community services.

Decision not to admit: clinical decision with a system safeguard. Where inpatient treatment is not indicated, community specialist treatment may be the most appropriate response. The decision becomes unsafe if required follow-up is unavailable. **Policy alignment:** discharge decisions supported by confirmed service acceptance, timely appointments, shared care planning, access to StepUp treatment, and a documented safety and care plan.

Discharge from ED: Risk 4: unsafe treatment transition. Risk increases when handover, safety planning, medication support, or practical assistance is delayed or uncertain. **Policy alignment:** funded specialist follow-up, warm referral, medication continuity, and direct access to housing and psychosocial supports.

Community follow-up: Risks 3 and 4: fragmented or delayed treatment. Long waitlists, narrow eligibility criteria and disconnected services can leave complex needs unaddressed. **Policy alignment:** timely post-discharge contact, assertive specialist outreach, and integrated specialist mental health, alcohol and other drugs treatment services, primary care, housing and social support.

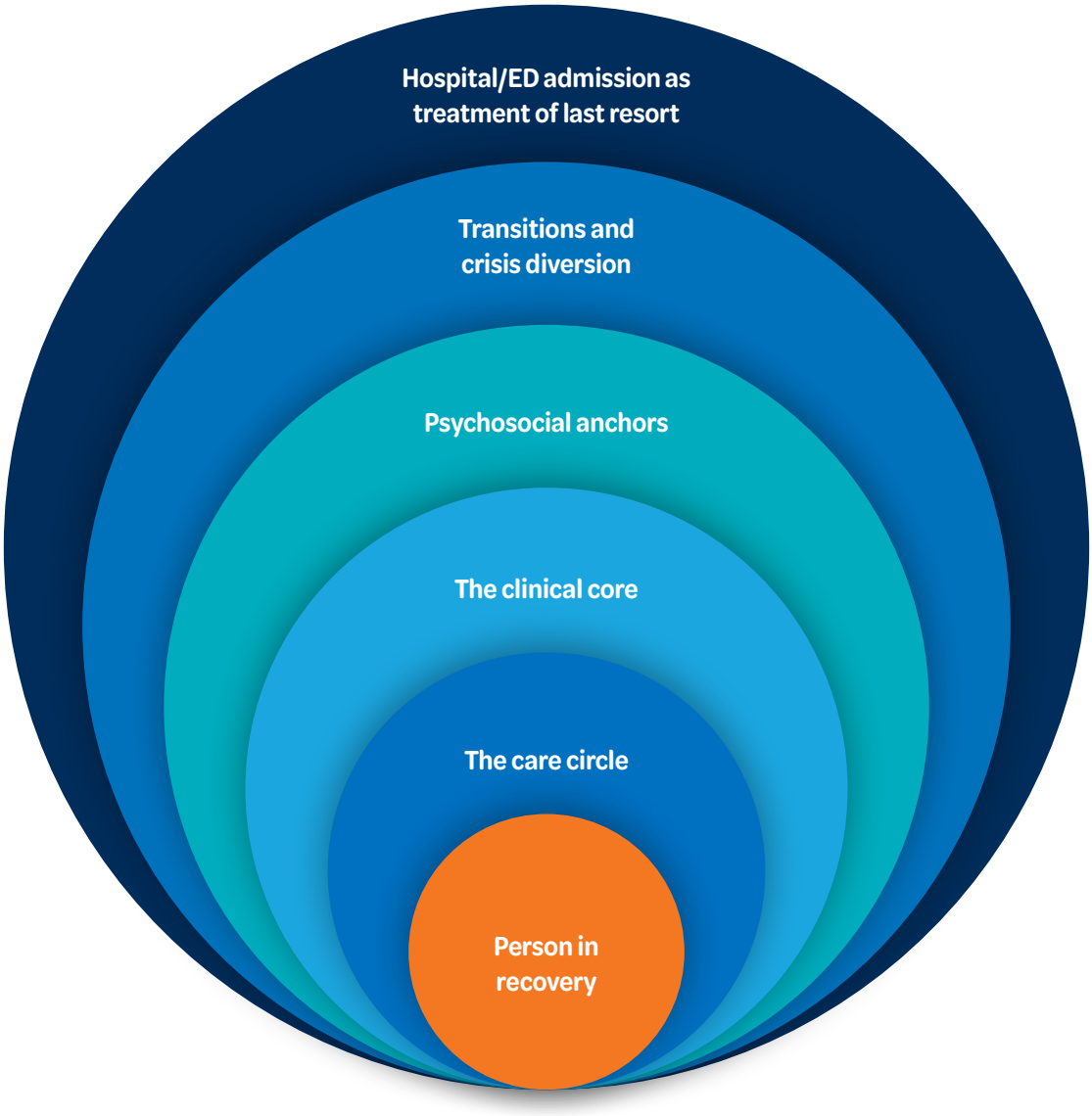
Re-presentation: Risk 5: episodic accountability. A return to ED may reflect renewed clinical need, but repeated presentations associated with unresolved service gaps indicate a failure of continuity. **Policy alignment:** track outcomes and re-presentation across services and require multidisciplinary review and a revised care plan after recurrent crises.

Attachment 2

Connecting treatment, care and support for people with severe and enduring mental illness: a system map

This figure maps an integrated approach to mental healthcare for people with severe and enduring mental illness. It aligns with the system map used in the Mental Health Commission's Mental Health, Alcohol and Other Drugs Strategy 2026–2031.

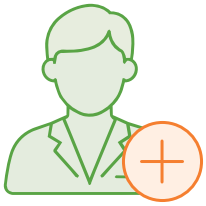
The model places the person at the centre, connecting the treatment, care and support they need through a coordinated, wrap-around approach. It presents integration as a whole-of-system responsibility, rather than a collection of disconnected services.



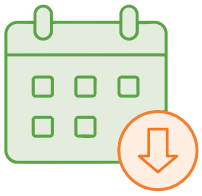
Attachment 3

Growing the workforce pipeline saves money

An excellent example of a return on investment is the Rural Psychiatry Training Pathway WA (RPTPWA). Since 2023, when the RPTPWA began, the WA Country Health Service has seen the following benefits:[13]



an increase of 4.3 FTE
in permanent psychiatric consultants.



reduced dependence on locum staff by 36%:
prior to the roll-out of the RPTPWA, 44% of all psychiatric staff were locums, down to 8% in 2024.



decreased salary bill, by approximately $360,000 a year,
while growing a permanent and self-sufficient rural workforce.

It is cost effective to treat more people with mental ill-health

The cost effectiveness of community treatment services for people with severe, complex or enduring mental ill-health can be measured:



Early intervention services for people with acute mental health challenges reduce the costs of care and rates of suicide and self-harm, while improving social participation.

For every $1 invested, the resultant saving is $15.[14]



The collaborative care models built around the patient show a return on investment of

$3 for every $1 invested.

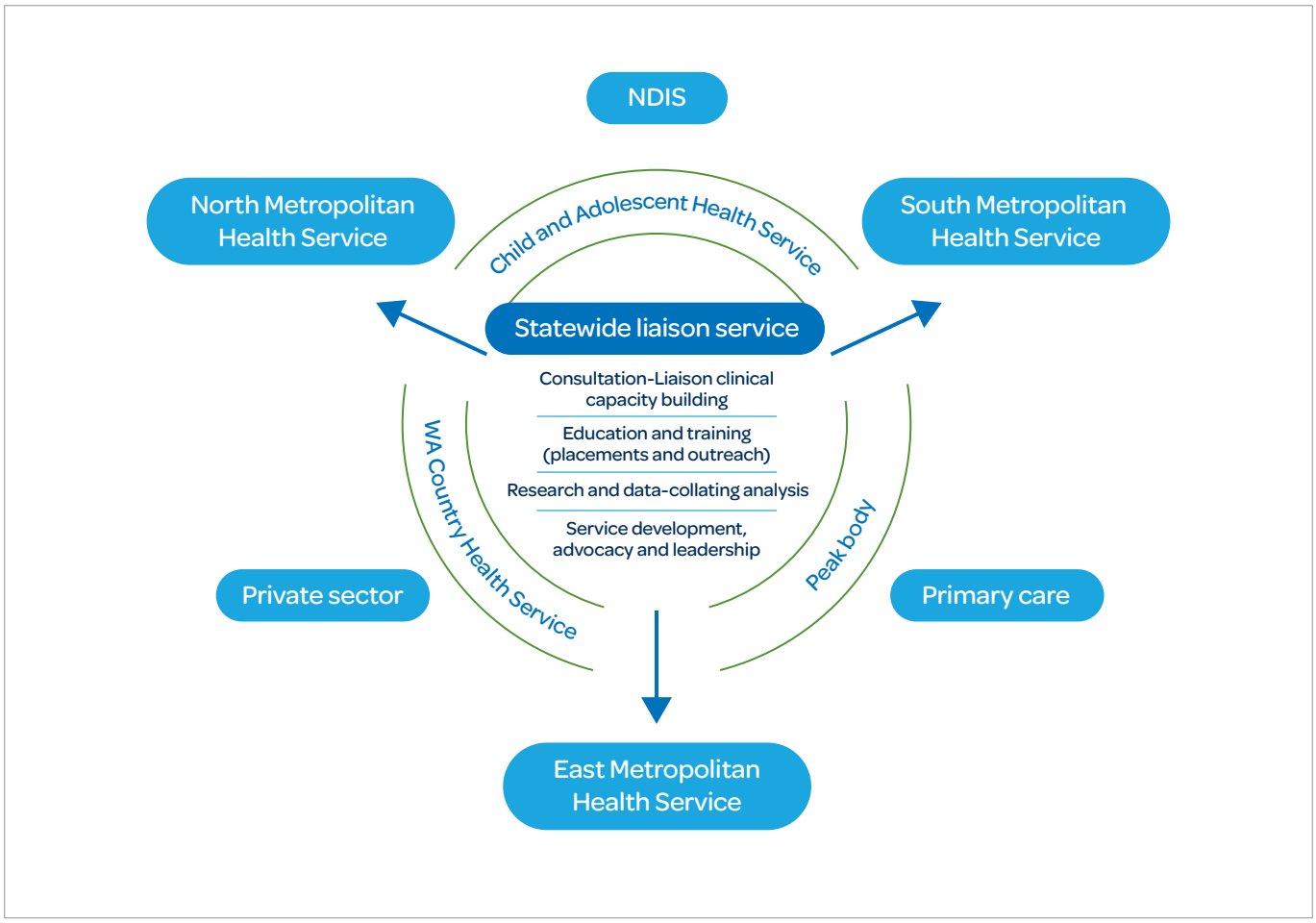


Multidisciplinary treatment services for people with complex mental health issues result in savings amounting to millions of dollars across the economy and

reduce the costs of future health service provision by 30%.[15]

Attachment 4

Proposed model for the statewide liaison service for people with dual diagnosis (intellectual and cognitive disabilities, ADHD, autism, mental illness), based on WA Eating Disorder Outreach and Consultation Service (WAEDOCS).



References

1 Government of Western Australia, Our Priorities for Government 2025-2029.

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