RANZCP WA Branch Briefing Note

Meeting with the Minister for Health; Mental Health

17 July 2025

The Royal Australian & New Zealand College of Psychiatrists

Your Health in Mind

Western Australian Branch

ADHD care reform

Background

- In response to the WA Government's announcement of pathways for GPs to diagnose and prescribe stimulants for ADHD, the Royal Australian and New Zealand College of Psychiatrists (RANZCP) WA Branch Committee wishes to work collaboratively with the Department of Health and the specialist colleges in the development of care pathways that ensure safety and quality of service to the community.
- The RANZCP position on ADHD care is also articulated in the following documents:
    - Position statement #55: ADHD across the lifespan
    - The President's Statement on diagnosis and treatment of ADHD by GPs.
- The Branch welcomes the announcement to improve access to services for ADHD. However, increasing calls to expand the role of GPs in ADHD management require clearer standards and stronger support systems. There is a pressing need for high-quality, standardised training for all professionals involved in ADHD diagnosis and treatment.
- The RANZCP has developed two sets of principles in response to growing demand, regulatory reform, and health system pressures related to the diagnosis and treatment of ADHD.
- These principles address the major concerns of RANZCP members:
    - System-level reform to improve access, equity and service integration in ADHD care
    - Standards for the training of medical professionals, particularly in relation to diagnostic accuracy, clinical rigour, and ethical care delivery.

Key Branch objectives

- The RANZCP WA Branch and the WA Faculty of Child and Adolescent Psychiatry (FCAP) Subcommittee are well positioned to contribute to the training and development program for GPs and co-design the care pathways for different age groups and care needs with the Department of Health.
- The Branch aims to collaborate with the RACGP to upskill their members and provide high quality education to ensure they are appropriately skilled in diagnosing ADHD and prescribing stimulants.
- The RANZCP will work to improve the education of our members in ADHD care pre and post fellowship.

Principles for ADHD service reform

The WA public mental health sector lacks capacity and expertise of ADHD care, but psychiatrists who work in the sector hold great interest in providing adequate care. The government should consider an increase in capacity and capability in public sector psychiatry for ADHD and neurodiversity more generally. The Branch is ready to provide expertise and support to the creation and implementation of the GP ADHD Model of Care.

The RANZCP has developed the following principles for ADHD service reform and the GP Model of Care.

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Principle One: Recognise ADHD as a lifelong, evolving condition

ADHD is a lifelong neurodevelopmental condition that presents differently across various stages of an individual's life.

However, care for children and adolescents is different from the care required by adults, and different care pathways are required for people in each age bracket. The FCAP WA sub-committee and the Royal Australasian College of Physicians are in the best position to contribute to the development of care pathways for children and adolescents.

Principle 2: Prioritise timely diagnosis and early intervention

Timely diagnosis and early intervention can significantly improve long-term outcomes for individuals with ADHD. Despite this, many people struggle to access care due to a lack of psychiatric workforce capacity and healthcare models that often overlook the critical role of general GPs.

Diagnosis and medication should be accessible and timely, but there is concern that people who fall through the service gaps – particularly patients in public mental health services and the justice system – will continue to miss out. These patients often have complex comorbidities and a range of unmet needs and are best looked after in a share-care model with both GPs and non-GP specialists.

Principle Three: Specialise GPs appropriately

While medication is often the first line of treatment, it comes with risks. Side effects and dependence are important considerations which can be regulated through dose and product restrictions. Ongoing monitoring of care is essential, and the Department of Health should consider increasing the capacity of the Medicine and Poison Regulations Branch for reporting and monitoring.

The following actions should guide the expansion of the role of GPs in diagnosing and managing ADHD:

1. Ongoing development of care models that enable comprehensive assessment, diagnosis and treatment, tailored to the needs of patients.
2. ADHD-related policy should be informed by the most current and robust clinical guidance from relevant medical colleges.
3. National consistency in prescribing rules, achieved through harmonised state and territory regulations around ADHD medications.
4. Creation of joint clinical guidelines and competency frameworks by professional colleges to support GPs in an enhanced role, integrating both pharmacological and non-pharmacological treatment strategies.
5. GPs should have access to specialist advice and support when needed to ensure patients receive comprehensive care.
6. Encouragement of team-based approaches, promoting collaboration between GPs, psychiatrists, and other mental health professionals.
7. Expansion of accredited training programs for GPs to build confidence and capability in ADHD care, including safe and effective use of medications and alternative interventions.

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Principles underpinning training in assessment, diagnosis, and treatment of ADHD

The College has developed five principles to underpin the training requirements relating to ADHD. Each principle outlines a facet required in any affective training for a medical practitioner to deliver ADHD services.

Principle One: Clinical depth and diagnostic rigour

Professionals must possess and continuously refine a deep, evidence-based understanding of ADHD and its complex interplay with other psychiatric and neurodevelopmental conditions. A rigorous diagnostic process is essential, one that thoroughly distinguishes ADHD from its many differential and comorbid presentations.

To mitigate risks in service provision, the Department of Health should consider mechanisms that prevent the emergence of services focused on high turnover but low in quality, as demonstrated by the recent case in Queensland of medicinal cannabis overprescribing.

Principle Two: Structured and multisource assessment

Assessment must be comprehensive, structured, and informed by multiple data sources. This includes standardised tools, developmental history, collateral information, and multidisciplinary input, ensuring a longitudinal and holistic understanding of the individual's presentation.

Principle Three: Integrated, individualised, and evidence-based intervention

Treatment must be personalised, multimodal, and evidence-based. This includes pharmacological and non-pharmacological interventions that address both core ADHD symptoms and comorbid conditions, while carefully monitoring benefits, risks, and functional outcomes.

The Department of Health could consider developing a supervision/consultation framework and clear pathway for patients with complex ADHD presentations.

Principle Four: Ethical, collaborative, and culturally responsive practice

Care must be delivered ethically, in partnership with the person and their support network, and with sensitivity to cultural, social, and systemic influences. Practitioners must actively mitigate bias and ensure equitable, respectful, and inclusive care.

Principle Five: Lifelong learning and professional accountability

Professionals must engage in ongoing education, reflective practice, and supervision. Commitment to continual skill development and scholarly inquiry is essential to uphold clinical excellence and respond to evolving knowledge, policies, and community needs.