The Royal Australian & New Zealand College of Psychiatrists

Your Health in Mind

Western Australian Branch

Royal Australian and New Zealand College of Psychiatrists
WA Branch
Submission to the WA Auditor-General, Audit of the Infant, Child and Adolescent Mental Health System Transformation Program, April 2026

Improve governance and planning of infant, child and adolescent mental healthcare

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.

This submission was developed on Noongar Whadjuk Boodja.

Acknowledgement of Lived Experience

We recognise those with lived and living experience of a mental health condition, including community members, RANZCP members and RANZCP staff.

We affirm their ongoing contribution to the improvement of mental healthcare for all people.

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 it plays 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 8500 members, including more than 800 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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Introduction

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) WA Branch welcomes the Auditor-General's audit of the Infant, Child and Adolescent System Transformation Program (or 'the ICA program'). The RANZCP Faculty of Child and Adolescent Psychiatry (FCAP) WA Subcommittee was consulted in the program development, while other Branch members had roles in the Expert Advisory Group and the Ministerial Taskforce into Public Mental Health Services for Infants, Children and Adolescents.

Psychiatrists are well placed to comment on the planning and implementation of the ICA program, as registrars and consultants who provide complex mental healthcare to children and adolescents, and as clinical leaders who are at the forefront of the practicalities of implementation.

Issues in ICA program planning

The Final Report of the Ministerial Taskforce, released in early 2022, made 32 wide-ranging and ambitious recommendations delivering on 8 key actions to effectively rebuild the child and adolescent mental health system.

The Taskforce Report contained a strategy and a system-wide implementation 'roadmap', prioritising the 32 recommendations into immediate, short-term, medium-term, and long-term objectives. The Report was to be followed by 'a more comprehensive, detailed Program Plan'[1] and a robust monitoring, reporting and evaluation process.

A Program Plan should have identified priorities in order of development, with more specific deadlines, and a reporting framework to track progress against the Taskforce Report recommendations. However, it appears that the Plan has never been developed.

Issues in workforce development

In 2022, the Branch welcomed and supported the Taskforce recommendations, but warned that the psychiatry workforce crisis and the convoluted mental health governance arrangements were barriers to their implementation.

While progress has been made in engaging Aboriginal mental health workers and peer workers in child and adolescent mental healthcare, it is not clear what system-wide planning on ICA mental health workforce has been completed, despite the Taskforce Report prioritising the development of the ICA workforce strategy and plan in the immediate term.

There are mental health challenges in which the contribution of a child and adolescent psychiatrist is essential, including psychosis, severe depression, eating disorders, comorbidities of psychiatric and neurodevelopmental conditions, personality disorders, self-harm, suicide, and responses to child abuse, neglect and trauma.[2]

Child and adolescent psychiatry is a key subspeciality shortage causing bottlenecks in training and service provision across WA public mental health services.[3] Expedited recruitment of psychiatrists with international qualifications is unlikely to ameliorate the crisis due to the large number required to meet demand: in 2026, WA requires an additional 154.6 FTE psychiatrists to meet unmet need above the baseline.[4]

This is a difficult target to achieve but opportunities to integrate services and use technology to support and extend the capacity of frontline clinicians should be explored in the ICA program context. These initiatives can be implemented immediately and should complement the development of a detailed mental healthcare workforce plan, which includes increasing training capacity in psychiatry.

It is important to note that the workforce recommendations of the ICA report mirror the national mental health and medical workforce strategies which identify psychiatry as an area of workforce shortage priority. In 2021 and 2022, Australian jurisdictions agreed to urgent actions, including increased training capacity in psychiatry and introducing innovative models of care in areas of acute shortage.[5]

Since 2024, the RANZCP has worked with the Department of Health to transform the training pathways in the public mental health system and improve the resourcing of psychiatric training. However, systemic lack of clarity and prioritisation of workforce objectives means that workforce sustainability remains the single most important challenge for the progress of the ICA program.

Issues in ICA program governance

Slow progress in ICA workforce development is partly a consequence of the complex mental health governance system in WA. While the Mental Health Commission is the main service commissioning and policy-setting agency, the Department of Health is identified as the system manager under the *Health Services Act 2016*, retaining the workforce planning function and oversight of the Health Service Providers (HSPs).

The Government's response to the Independent Governance Review in 2022, did not resolve the confusion over the role of the mental health system manager. First, the system governance arrangements which contextualise Taskforce Report recommendations, including its plan for further governance reform, ceased to exist. Second, the Mental Health Commission discontinued the position of the Chief Medical Officer – Mental Health, which had a key role on the Ministerial Taskforce and policy oversight over the HSPs. Third, bodies such as Implementation Steering Committee to oversee ICA program, was never established. The system governance changes have caused a gap in clinical safety and quality assurance and a disconnect between ICA program planning and implementation.

The distinct lack of clarity of the mental health system manager role in the current governance arrangements is a key barrier to system integration, especially impacting mental healthcare provision to children and adolescents with complex mental health challenges.

Issues in service integration across the ICA program

The Taskforce Report envisaged a connected ICA mental health system, with Community Infant, Child, and Adolescent Mental Health Service (ICAMHS) Hubs coordinating services for individual children, adolescents and their families as the first point of accessing mental healthcare.

The Community ICAMHS Hubs Model of Care, developed in December 2022, positions the Hubs as 'the central point of contact for all children, families and carers requiring mental health support, and the most critical service of the future infant, child and adolescent mental health system. That is, children will receive the majority, if not all, of their care through Community ICAMHS – from access through to transition.'[6]

To date, only one ICAMHS Hub has been announced and funded, servicing the WA's South-West region from Bunbury. The hub and spoke model for Community ICAMHS was due for completion in all regions by June 2025, according to the timeline in the Taskforce Report. Ideally, ICAMHS Hubs should have been established as the first step in integration of child and adolescent mental health services towards a system where access is not a barrier to treatment and support.

General practitioners, paediatricians, and primary care providers play a critical role in the mental health of young people, yet the integration between primary care and specialist services remains underdeveloped and has been a constant concern for private psychiatric practitioners. Shared-care models are required, especially in the context of ADHD reform and involvement of GPs in diagnosis, assessment and management of ADHD.

International evidence supports stepped care and collaborative care models where specialist psychiatrists provide consultation, supervision, and support to primary care providers, extending the reach of scarce specialist resources, including workforce.[7]

The UK's Primary Care Mental Health Service model, New Zealand's Integrated Primary Mental Health and Addiction Services, and Australia's own Primary Health Network initiatives demonstrate effective approaches to shared care that the ICA Program could learn from and adapt for WA's unique geographic challenges.

Critical gaps in the ICA service system

Many children and adolescents, particularly those with complex mental health challenges, are unable to access mental health services when and where they need them. In 2024, 18.5% of WA children 1-15 years of age reported having 'quite a lot' and 'very much' trouble with emotions and treatment. But 16.5% of all children, including those with 'only a little' trouble, received treatment for an emotional or mental health condition.[8]

Critical gaps remain in the service system, which have otherwise been prioritised by the Taskforce for completion by June 2025. Still awaiting implementation, the following service gaps present further barriers to access and service integration:

- A stepped care model for children with an intellectual disability and neurodevelopmental or neuropsychiatric conditions and co-occurring mental health issues
- A personality disorders model of care that supports children in the community, and where required, in hospitals
- A stepped-care model for infants and children 0-4 years of age.

Private psychiatric practitioners see an increasing number of patients with neurodevelopmental conditions, particularly ADHD and autism spectrum disorders. Many public mental health services exclude neurodiverse children and adolescents from their services and are reluctant to engage in shared-care models. The ICA program requires mechanisms to integrate all resources and supports into care pathways.

In the area of technology and digital health, Action 7 has received comparatively little attention, and implementation is limited to telehealth services only, but it should be expanded to fall in step with international progress in digital mental health. Specifically, the use of AI in mental healthcare should be seen as an opportunity to support psychiatrists to deliver high quality and safe mental health services.[9] Internationally, mental health services are increasingly deploying AI-assisted triage and screening tools, clinical decision support systems, digital therapeutic interventions, and predictive analytics for risk assessment.[10] These technologies are not designed to replace clinicians but to augment their capacity – a critical distinction.

Transparency and outcomes measurement in the ICA program

The ICA website and a progress report dated October 2024, are the only public documents showing progress on the ICA program implementation. While we understand that the Outcomes Framework for Mental Health and Alcohol and Other Drugs Sector is in final stages, the evaluation and monitoring framework for the ICA program has not been developed. External stakeholders are unable to determine if the substantial investment in the ICA program translates into improved care for young West Australians. The Branch notes that program and service evaluations should have occurred every three years, but it is likely that delays in establishment automatically overrode those timelines.

A critical finding from the original ICA Taskforce consultation was that fewer than one-in-five children aged 0–12 years referred to services were accepted for treatment, leading some health professionals to stop referring to public mental health services entirely. The RANZCP FCAP Subcommittee are concerned that current waitlist data for child and adolescent mental health services is not publicly available. Neither current numbers, wait times by urgency category, nor trends over time are publicly reported for metropolitan or regional services.

This transparency deficit makes independent assessment challenging. It is also not clear how, in absence of the required data and an evaluation framework, either the system manager or clinicians can assess whether the Service Guarantee developed for the ICA program is being met.

Conclusion

The ICA Program is an important part of the Government's system transformation agenda and a meaningful response to systemic failures exposed by Kate Savage's tragic death. Significant progress has

been made addressing crisis care services for children and adolescents, opening new forensic psychiatric services, and investing in preventative community services such as Ngala's parenting service.

However, the rising youth mental distress, chronic workforce shortages, and evolving clinical needs demand an integrated response. To date, the program has been planned and implemented in a seemingly haphazard, reactive manner, without the sense of urgency which current challenges demand. Investing in workforce, thinking beyond traditional service models, and integrating private practice and primary care, remain unfulfilled goals requiring improved governance, planning and investment.

References

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[5] Department of Health and Aged Care, National Mental Health Workforce Strategy 2022-2032, Canberra, 2023; National Medical Workforce Strategy, 2022.
[6] Infant, Child and Adolescent (ICA) Taskforce Implementation Program, Community Infant Child and Adolescent Mental Health Service (ICAMHS): A model of care, December 2022.
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[8] Department of Health, Epidemiology Directorate, Health and wellbeing of children in Western Australia 2024, 2025.
[9] For RANZCP's position on AI in mental healthcare please see RANZCP's submission to the Department of Health and Aged Care, Safe and Responsible Artificial Intelligence in Health Care – Legislation and Regulation Review, October 2024.
[10] Graham, A.K. et al, Experimental therapeutics for digital mental health. *JAMA Psychiatry*, 76(12), 1223–1224.