North West CAMHS - our story about budget cuts 23-11-2011

DHHS, Statewide and Mental Health Services, Child and Adolescent Mental Health Service CAMHS Burnie comprises of:

- 1x part time consultant psychiatrist
- 1x team leader
- 4x social workers (1x part time)
- 2x nurses (1x part time)
- 2x part time psychologists
- 1x intern psychologist
- 2x admin staff

These 13 staff fill 10.4 FTE (Full Time Equivalent) positions, CAMHS HR establishment is 17.24 FTE but is to have another doctor added = 18.24 FTE positions. The 8.4 FTE clinical staff directly provides treatment to 150 children across the 64 telephone district from Elizabeth Town to Zeehan and includes King Island.

Through "consultation" a budget proposal of reducing 3x FTE was evolved. This proposal and a management proposal have been rejected by combined health unions' membership. An alternative proposal from members asked for a NW service-wide audit to inform any budget proposal. This has been rejected and a combined "consultation" / management proposal has eventuated. This equates to the loss to CAMHS NW of a senior psychologist, occupational therapist and admin assistant. This reduces the establishment to 15.71 FTE and is primarily based on vacancy control. These clinical positions have been unable to be permanently filled due to international shortages of psychiatric clinicians. Some mainland states, and many overseas countries, offer relocation bonuses and loyalty payments to clinicians willing to travel.

Currently we have 3 staff on maternity leave; they are backfilled by 3 clinicians on contract seconded from youth or psychiatry services. There has been recent agreement that their contracts will be renewed for 6 months. However another staff member who fills a permanent vacant position on contact is not being renewed = 14.71 FTE. Our intern psychologist has not at this time had her contract renewed despite her being in a training role and her professional career in the balance = 13.71.

The 4 contract staff and 4 others have been studying Developmental Psychiatry through *Mindful* a centre for child and adolescent psychiatry formed by Monash University and University of Melbourne. This expensive and elite post graduate training was funded by Statewide and Mental Health Services, Workforce Development Unit. A costly exercise for Tasmanian taxpayers if the greatly needed and highly trained staff are "let go".

Our concern is that at a time when early intervention is being recognised internationally as a very cost effective and clinically efficacious practice; Tasmania is reducing service capacity. The ongoing budget reductions will inevitably cause us the loss of our hard fought for contractor colleagues next year. The issue of forced redundancies has been mentioned at NW Industrial Consultative Committees. The area manager believes they are inevitable to meet the predicted budgetary requirements. 2 NW clinicians have already

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resigned and moved to interstate in response to the mental health service cuts.

NW CAMHS is already struggling to meet demand, any service reduction will predictably increase demand on other government and community sector organisations. The CSO's and other departments are also going through budgetary restrictions and will be unable to meet the specialist paediatric demand. General practice and emergency departments will remain the first responders but tertiary care will no longer be available in a timely manner. The future stress on education services, youth justice and children's services is unavoidable. The primary issue will be the damage to community caused by untreated mental illness. The evidence of Dr Pat McGorry (and others) proves the case for early intervention – it radically reduces the burden of disability on community. Early intervention can be shown to reduce lifetime mental illness by 75%. However the longer most psychiatric conditions are left untreated the worse the prognosis.

If cost was the only measure to be used, then early intervention is a champion. The costs of disability from serious mental illness and treating adults are massive by comparison to early intervention and recovery. CAMHS operates from recovery based model of care; the state has been unable to date to resource the same in adult services. Adults with impaired cognitions have difficulty learning new concepts and ways of thinking however for children it is a natural process. Further, by any social or moral measure early intervention is mandated. The population demographic of the NW encompasses 1 in 2 families receiving payments from Centrelink. Low socioeconomic status is a risk precursor for mental illness. NW Tasmania has a higher than average incidence (per capita) of mental illness; indicating a genetic antecedent. Heredity is another prime risk factor in prevalence of psychopathology further demonstrating the need for early intervention with NW children. A dollar spent in CAMHS saves tens of thousands of dollars in adult psychiatry and associated care.

NW CAMHS is a small service by community mental health standards and has consistently been responsibly managed and returned financial surpluses. 8.4 (FTE) clinicians currently service a catchment of 107,000; 22% of Tasmanian families; with 2 cars and 4 mobile phones. Our unit is being asked to accept financial restraint for events beyond our control that will severely impact on service delivery in the future. Ongoing budget reductions can only lead to further staff reductions and reduced care for the children of North West Tasmania.

In Summary - currently CAMHS NW is to be reduced by 3 clinical positions and 1 admin assistant for 2011. The future of our intern psychologist is unknown. What 2012 brings is also unknown but unless public policy follows a more ethical path we expect more cuts and service reduction. The low morale and soaring work load of our service mirrors that of the broader health service. The future direction of Tasmanian society with respect to meeting the mental health needs of our children is at a crossroad.

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