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12th May 2005

Committee Secretary
Senate Select Committee on Mental Health
Department of the Senate
Parliament House
Canberra ACT 2600

Dear Sir/Madame

Re: Submission to Senate Select Committee on Mental Health

I am writing to you to express my concerns regarding a current practice in New South Wales Health Services which I believe goes against the major principles of the National Mental Health Plan 2003-2008.

The practice to which I am referring to is the transfer of funding for community based child youth and family counselling services to Adult Mental Health Services.

I am a social worker and manager of a Child Youth and Family Counselling Service in Sutherland NSW . The Service provides counselling and groupwork programs to families, young people and children 0-18 years.

I have had 25 years experience working in community-based child youth and family services. I have a Bachelor of Social Work and a Masters in Administration and Social Policy. Many of work my colleagues, also trained social workers and psychologists, have 20 years plus experience working in this field.

Child and Family Services based in community health offer a range of programs developed to address broad social issues that are important to the mental health of the community. For example, the program which I currently manage provided 96 groups and seminars to families young people and children over the past year. These programs were in addition to the generalist child youth and family counselling and therapy services provided.

The Service has been instrumental in developing and offering programs that have a focus on assisting parents to “parent for the emotional and mental well being of their children”. We have provided these programs with the insight and assistance of the parents/consumers involved. Our Service is also pro-active in working to prevent child abuse and will assertively follow-up families to engage them in programs.

Our concerns with the transfer of child and family services to Adult Mental Health Services is the limitations imposed by the prescriptive Medical Model and Diagnostic Treatment Models used which are not suitable for early intervention and prevention work with families. The Proposal submitted by the local Director of Mental Health states that he wants to be able to direct staff in our Service to collect data that is directly related to the diagnosis of children and young people. If we do not address the issues raised our work in early intervention and prevention will cease. A model of service which is reactive and creates a vicious cycle of diagnosis and treatment will limit the Service.

Yours faithfully

Gloria Arentz. BSW MA (Soc.Admin)
Service Manager
Child Youth and Family Counselling Service

Submission to the Senate Select Committee on Mental Health

Terms of Reference: A, B, F, H

The key issues in this submission relate to the increasing practice in New South Wales Health Services of Directors of Adult Mental Health Services (AMHS) taking budgetary control of the community based Child Youth and Family Counselling Services (CYFCS) and redefining them as Child and Adolescent Mental Health Services (CAMHS). Essentially this is a movement of resources from early intervention and prevention to a focus on providing treatment to those with a moderate to severe diagnosable mental illness. This practice is in conflict with the National Mental Health Plan 2003-2008.

It is vital that CYCFServices and CAMHServices remain distinct services working in partnership with each other to fulfill the aims of the National Mental Health Plan 2003-2008. .

A case in hand is the current proposal by the Director AMHS of the Sutherland Hospital and Community Health Service in Southern Area Health Service to transfer the Child, Youth and Family Counselling Team to Mental Health and redefine it as a CAMHS. The expressed reason for the takeover is to streamline budget and management. The proposal outlines a commitment that nothing else will change in the short term. However the effects of such a takeover are more far-reaching that outlined in the proposal.

CAMHS are an acute service for children and adolescents with a moderate to severe mental illness. In contrast services provided by the CYFCS aim to prevent and promote mental well being. The danger in combining the two is that prevention and promotion of mental well being will give way to the treatment of mental illness. (This has already occurred for similar services of St George Hospital in the same region.) Further evidence for this lies within the proposal itself. It suggests that while the functioning of the CYFT will go on unchanged in the short term, long term, intake procedures will need to be reviewed with the current practice of having a non-clinician taking referrals giving way to a clinician taking referrals. This would permit referrals be triaged/screened at point of contact and only those referrals with a moderate to severe mental illness could be accepted.
Presumably clients presenting with other concerns would be told their problems are not serious enough for the service and referred elsewhere.

Furthermore a service dealing with the promotion and prevention of mental health for children and adolescents needs to be mindful of the stigma and connotations that unfortunately still exist within the term “mental health”. A change in name from Counselling service to Mental Health service runs the risk of deterring fragile, young people from using the service. Even services providing acute care need to be mindful of the specific needs of children and adolescents and need to be flexible. Young people will shy away from the rigid application of the models used for the assessment of adults.

2.

The CYFT places emphasis on early intervention and prevention. Current Federal and State Government policy health and welfare initiatives are strongly focussed on providing a model of service for families and children that fits well with the Child Youth and Family model of service. The new reforms are based on evidence and research and advocate early intervention and prevention. Promoting closer community and consumer involvement and establishing local service networks are cornerstones of these new initiatives. Southern Area Health is already implementing and guiding the development of these Programs, for example Families First, Better Futures Programs. The transfer of services already involved in this area of work into a diagnostic medical model is in conflict with current Federal and State policy initiatives.

Unfortunately the National Mental Health Plan is not clear on how it is to be implemented at a local level. It provides no clear direction as to how primary health services and acute services are to be developed. Without clear direction there is a risk that early intervention and prevention services will be absorbed into acute services. A case in point is the current proposal at Southland Shire for the CYFCT to be transferred to the Division of Mental Health.

The broad aims of the National Mental Health Strategy have remained consistent with an increasing emphasis on mental health promotion and mental illness prevention. The Strategy recognizes that “mental healthcare should be responsive to needs as they vary across the life span, recognizing that the needs of children and adolescents differ from those of adults”. The current moves to transfer services that offer these approaches to Adult Mental Health Services are in direct conflict with the aims of the Strategy.

Terms of Reference O

Data collection can be prescriptive of the treatment model used and therefore can limit the range of treatments available and the flexibility of services provided. Treatment models should be varied and able to accommodate the broad range of needs in the community. The Adult Mental Health Service in NSW currently uses MHOAT and SCI-MHOAT for their data collection.
These formats were used by the CYFCT over a six month period and found to be unsuitable for the case management needs of clients seen by the CYFC Service. Eighty percent of clients seen did not fit the criteria for diagnosis. This was also the experience of child and family workers in the Illawarra region, where use of MH-OAT was so time consuming less clientele were seen.

The importance of data collection in the planning and delivery of health services is readily acknowledged. What remains questionable is when the time involved impacts on clinical service time and services to the community are diminished.

3.

The integrity of statistical data needs to be maintained in a simple and relevant fashion so that it is not obscured or buried within attempts to promote singular treatment models. It is important to recognize that there can be many social, family and environmental factors to be considered when identifying data and interpreting it. Data collection is one component in a broad range of considerations that can be useful in guiding decisions and directions in the provision of Health Services.