SENATE ENQUIRY INTO MENTAL HEALTH

STATEMENT BY TONY JOSEPH BLANCO

1. My Name is Tony Joseph Blanco. I am a Registered Psychiatric Nurse (RPN). I qualified in 1991 and have been practicing as a Psychiatric Nurse for 15 years. I hold a Post Graduate Diploma in Advanced Clinical Psychiatric Nursing. I have experience working in in-patient and community based services. I am employed as an RPN 4 (currently acting RPN 5) within the Inner West Area Mental Health Service - a community based mental health program of North Western Mental Health, Melbourne Health, in Victoria. My current position is titled Senior Clinical Development Nurse. Unless otherwise stated I make this statement based on my own knowledge and to the best of my knowledge it is true and correct in every respect.

2. In addition to various projects that arise from time to time, my three main portfolios and areas of responsibility in my current position are: community psychiatric nurse in which I carry a case load of approximately 30 mental health clients (in addition to all other portfolios) with varying degrees of acuity and complexity; Senior Clinical Development Nurse in which I am primarily responsible for the education and professional development of nurses within the community teams of Inner West Area Mental Health Service, and coordinating and supporting undergraduate students and their placements from various universities; and trans-cultural psychiatry portfolio responsible for provision and coordination of training of all clinicians in the areas of trans-cultural psychiatry and to develop and promote policy and processes for effective use of interpreters.

3. I wish to focus on four main areas:

1. excess case loads of clinicians;
2. lack of available beds;
3. the lack of discharge options; and
4. workforce/undergraduate preparation of psychiatric nurses.

Excess case loads.

4. It is my experience that community clinicians, including myself, carry case loads that are unmanageable and unrealistic. It is not uncommon for clinicians to have case loads in excess of 30, and up to 40. In these circumstances clinicians find it very difficult to dedicate enough time to their clients so as to effectively work on relapse prevention, family education and to be able to respond to periodic crises.

5. The consequences of this for clinicians is physical exhaustion, high levels of personal stress and anxiety and frustration at not being able to provide the level of care needed, coupled with an increased requirement for documentation, leading to increased absences, sick leave etc.

6. The consequence of excessive caseloads for patients is reduced responsiveness to their personal crises and/or needs. Patients can be

discharged without adequate supports and relapse prevention plans leading to re-presentation to the service, including re-admission to in-patient services.

7. I believe that a reasonable and more appropriate case load requirement, taking into account the mix of illness and the degrees of difficulty and complexity, should be not more than 25 per clinician, noting that these days most if not all clinicians have additional portfolios.

Lack of available beds.

8. It is my experience that there are not enough acute in-patient mental health beds to meet demand. I cannot plan an admission for therapeutic reasons when I know someone is becoming unwell because there are no available beds. Consequently, I often have to wait until the person becomes so unwell that the admission is traumatic. This could involve police transports, involuntary admissions and forced treatment, all of which is distressful and traumatic for the person and their families as well as clinicians.
This occurred recently with a client that would have benefited from a facilitated admission to deal with increased symptoms and deteriorating personal care. Unfortunately the admission was delayed for two weeks to avoid a lengthy wait in the local hospital's accident and emergency dept.

9. It is not uncommon now for people to be discharged after only a couple of days while still unwell and/or experiencing symptoms. This puts increased pressure on the person and their families. The reason for this is to facilitate vacancies for even more seriously unwell clients. In other words the least unwell person is discharged unwell to admit some else in greater crisis.

Lack of Community Discharge Options

10. Part of the reason contributing to the excessive caseloads clinicians are expected to carry is the lack of community discharge options, either into supported accommodation, including non government provided services or to GP's or other ongoing community based treatment and monitoring providers. Often people are discharged to the care of their families who may not be equipped to provide the level of care necessary or into substandard accommodation without any support services.

11. A consequence of the lack of discharge options is increased homelessness of people with mental illness. This transfers their treatment to mental health homeless teams, increases their exposure to the criminal justice system or leads to re-presentations either to community or inpatient services.

12. Drugs and alcohol have become increasingly more prevalent in recent years, increasing the complexity and severity of mental illness. This reduces discharge options and increases the risk of relapse for this cohort.
A particular client I work with who has both a chronic mental illness and substance abuse difficulties, requires very intensive support to assist him with access to long term drug and alcohol counseling .Even with a relatively stable mental illness, the client is unable to organize and commit to the drug use support without case management input. His substance abuse has also

increased the incidents of acute presentations to Accident and Emergency departments.

Workforce/undergraduate preparation of psychiatric nurses

13. Mental health is experiencing a workforce crisis characterised by a lack of recruitment and retention. The shortages are most pronounced in psychiatric nursing and mental health professionals such as social workers, occupational therapists and psychologists. This also contributes to the high case loads carried by community based clinicians.

14. The area of greatest crisis is in psychiatric nursing. There are not enough nurses being trained to practice in mental health. The experience level of existing nurses is reducing as experienced nurses retire or otherwise leave the profession.

15. In the mid 1990's in Victoria the state government ceased the provision of specialist trained psychiatric nurses. These were nurses specifically trained over three years to be specialist psychiatric nurses. This was replaced by a comprehensive model of nurse education that was/is based singularly on the then general nurse training program.

16. The level of undergraduate preparation and training at university is inadequate, both in theoretical and practical aspects, leaving graduates poorly prepared to practice in mental health or for them to want to pursue a career in mental health. There are significant variations between universities in the quality and quantity of mental health content provided to undergraduates, eg clinical placements, theory etc.

17. The lack of specialist psychiatric nurse training discourages undergraduates from taking up psychiatric nursing. This is because of the overwhelming general nursing theory, content and training and undergraduates are actively discouraged from doing psychiatric nursing.

18. The consequences on patient care are staff shortages and a lack of comprehensive mental health care. This creates unsafe environments for both nurses and clients.

19. The responsibility for preparing graduates for mental health practice has fallen onto service providers through graduate programs. These programs are still a long way from being able to replace the current level of attrition and the lack of recruitment of nurses into mental health.

20. If we are unable to address these workforce issues the quality of care will be compromised as well as worker and client safety as is the community/families generally. Demand on services, including any new initiatives, will not be able to be met.

21. In my opinion, to address these issues, we need to give people the beginnings of a clear career pathway, provide better preparation for clinical practice, and to increase clinician satisfaction specialist psychiatric nurse training should be

introduced at the undergraduate level. By increasing an undergraduate's exposure to mental health, prospective students are more likely to be motivated to pursue mental health as a career.