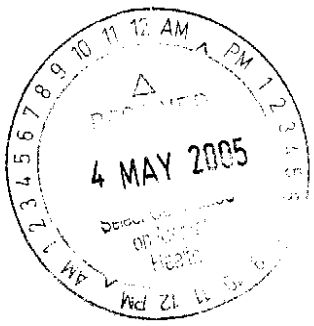


2nd May 2005.

From: Michael Witkowycz
[redacted]

To: Committee Secretary
Senate Select Committee on Mental Health
Department of the Senate
Parliament House
Canberra ACT 2600
Australia.

Dear Sir/Madam

I have no earth shattering information to give you only a general psychiatric nursing perspective over a 29 year long career. I hope these points are insightful, helpful and contribute to a speedy change for the improvement of services.

(A) THE MENTAL HEALTH STRATEGY, RESOURCES, RESPONSIBILITIES AND FUNDING.

I can only speak for the hospital I work in now, although I have worked in 4 different area health services in NSW. For a very long time I have been subjected to the government, the Health Departmental and management rhetoric "you must do better with less" or "work smarter not harder" as the "fat was trimmed off" the mental health budget. Today the accountants remain in control and continue with similar rhetoric but there no more fat, there is no more meat and the bone is the only thing left. Still the rationalization of services continues with the result that the population is provided with only a skeleton or token basic service.

This country relinquished its full responsibility for the total cared of (its Australian citizens) the psychiatric patients about twenty five years ago. Psychiatric services in the past were seen as unprofessional, but the patients at that time received more individual service time, were faced with more skills options and a fuller, more complete service. Psychiatric patients in the mental health service were in the majority better off and more fully cared for than they are today.

The Richmond and Shipp's reports appeared and NSW Health forced patients to comply with the NSW Health policy of "freeing" patients from psychiatric institutions, without mentally ill people having a voice or choice. Since the implementation of the Richmond and the Shipp's policies by NSW Health the patients were moved out of mental health facilities into the communities, I mean the psychiatrically ill people were assimilated into the community, whether the community or the patient agreed with this move or not.

In Orange, NSW the fresh water tanks of one of the Shipp's houses was deliberately poisoned with sheep dip. This act was the indicator of the level of emotion and hostility some community members felt with the health policy direction. The Mental Health service arranged community meetings to allay individual fears but the community did not agree and condemned this course of action. NSW Health continued with its cost cutting psychiatric patient management plan.

The implementation of this policy direction in the past, has resulted today with the mentally ill person prominent represented in the numbers across social classification such as street people, poor, no hopers, etc and in our prison. In the governments haste to reduce service cost by cutting back their full responsibilities and support to care for mentally ill people the current treatment and service levels is clearly evident at the hospital bedside in our society today. This cost cutting exercise reduced the Mental Health budget but proportionally increased the costs and care burden to other public services facilities such as Corrective services, Police, General hospitals, etc, and community services such as charity organizations.

The indicator of the level of importance/value the governments have places on mental health services can be appreciated in the ongoing devaluation of this service ie the present funding level. The funding provided to mental health services presently reported in the newspaper is 3% of the total health budget. Additionally the dollar numbers may have increased as skited by many health spokesperson's but the value (purchasing power) of the dollars have been continually falling as long as I can remember.

When people were treated in mental institutions they were offered many different services during their stay. They participated in training programs such as cooking, socialization, gardening, a shopping program, all aiming to building individual skills to a level for independent living. They also had social programs organized such as picnic and outings, there were picture nights, games nights to participate in; socialalisation and mixing skills aimed again at normalisation. The government service was people focused not profit oriented continually ruled by the entrepreneurial bottom line.

The mentally ill person did not have a choice in having a major mental illness and there seem to be a lack in support for them and their careers. Yet it appears that corrective services expanded, where individuals have a choice in their individual behaviour are better funded to address the needs of their clients than mental health services are funded to address the needs of their clientele. The disparity in the levels of human services is impossible to understand and keep quiet about.

My current assessment of services provided is that presently I would not refer any of my family and/or relatives to mental health services unless I was totally desperate. In my opinion the quality of the services provided to patients is of a lower standard today, despite the any modern advancements and technological improvements. I am sure that some government or health representative could completely contradict my point of view with the old, well used rhetoric that any deficiencies in the current service provided are explained away in beautifully written and superbly expressed and verbalised statements.

The success of the Mental Health Strategies is obvious and evident on the current front line of services provided and not in some verbose blueprint explanation of intended future commitment. The patients are overcrowded now in our hospitals or can't get a bed, lack of nursing staff, inappropriate admissions, decrease in community services, increasing number of complaints, doctors shortage, etc, are all symptoms of a decaying health system.

I work in an eight bed Psychiatric Intensive Care Unit or PICU. The unit budget does not allow for patients to have a second serving of food. The portions given are adequate for patients who are physically incapacitated as in general hospitals. The portions are often insufficient and are not designed for mostly young people who have healthy appetites and given the fact that the majority of medications given to them increase their hunger. Just days ago, another cost cutting exercises, the cheese portions allocated to this unit has been decreased.

The beds our patients sleep on are stamped 1976 year of manufacture. Simple requests to the management (or what seem simple) to improve the quality of beds hence the comfort and safety of the patients and decrease the chance a nurse back injuries. The replacement program budget of the beds can only address replacing one bed every six months in this hospital. The one bed we received for trail almost 12 – 18 months ago is the only new bed in our eight bed unit today.

The current NSW Health Departments expectations of service provisions, the present staffing levels, the NSW nurses award, facilities provided, managerial views and the reality of every day working conditions are all incongruent with each other. The fact remains that prospective qualified workers have recognized this fact and do leave this service. The condition that nurse's work under, generally are very difficult and the service treats nurses poorly.

NSW Health talks about time sharing, working from home, flexi time, etc but this usually applies to executives level (accountants, policy makers and managers) not the nurses at the coalface who are currently hard pressed to get study or conference leave. The older staff have been so conditioned to negative responses that they do not apply today for courses. Generally working day to day looking forward to days off and payday.

Getting a full time seclusion room took many years of negotiation and still I would not consider this seclusion room to be state of the arts. This room lacking in basic safety features, such as safer walls, limited air supply, lack of air conditioning in this locked room (think about this room in the summer months). Services manager protect their budget for more important matters and refusing to purchase and install an air conditioner. The original principles, responsibly, values and substance for mental health care (before Richmond) watered down to accommodate the bottom line today resulting in the present band aid system that regularly needs local, state and federal enquires into services provision.

In my job there is an expectation in the level of my professional performance in providing a quality treatment and service. This same principal does not appear to apply to the policy makers, managers and the accountants. The policy makers, accountants and managers appear to operate at a different level of responsibility for patient care, with their decisions having enormous consequence on the entire service provision to the individual, but are at an almost untouchable levels of accountability for services provided.

Patient complaints about me are scrutinized and may or can result in job loss or in the worst case goal. The same does not apply up the chain of command, where controversial service provision decision made by accountants, policy makers and managers. Their decisions can impinges negatively on the entire population groups, yet are not scrutinized nor lead to the same consequences as for workers on the ground implementing their policies.

Layers of managers are far removed from personal or face to face contact with the patient and relatives. Their information is based on statistics and cost information. These workers are instructed from above to reduce costs and seem unaware of the power they wield in the stroke of a pen on quality of services provision down the line to mentally ill people.

The independent thinking and actions of the accountants, policy makers and managers needs to be clearly focused on patient service which presently does not seem to exist. Perhaps due to the fact that from the top, the Minister chooses like minded, politically orientated, cooperative, accountants, policy makers and managers to assist in a smooth implementation and administration of their (the Ministers) ideas of standards for service delivered to the population. This system seems to produces countless numbers of individual looses i.e. the recipient of these service and immeasurable emotional and personal suffering for all in touch with the mentally ill in our population.

I am in contact with people every day that are extremely worried, extremely anxious and in a very emotionally disturbed state leaving mental ill relatives in the care of the mental health services. The decision makers would only personally experience these conditions from a far, unless their family, relatives or friends had experienced being admitted into the public mental health system. I am aware that one reason the old "Drug Directorate" was establishment related to the fact that Mr Bob Hawk daughter had a drug addiction when he was the Prime Ministry of Australia.

Do all the people in Australia need to wait for a politician to experience personally family mental illness before changes are implemented. Do they need to experience their young persons hopes, dreams and future disappear, the hopes of the family devastated because of mental illness, a young mentally ill patient suicide, a relatives or friends of a mentally ill person be killed by the mentally ill person, etc. Just like the recent needless and preventable death of the innocent 5 year old little girl recently murder by a mental ill patient smoking drugs. Does the experience need to be personal before perspectives and attitudes towards evaluating the present the mental health services provision occurs.

Research Funding.

I accept that research is necessary as part of continually testing, improving treatments and service provided. Since NSW pushed for the amalgamations between health services and the universities there seems to be a reduced amount of resources spent directly on patient care and treatment, accommodation and support services. NSW Health did not provide an increased budget (in real money value terms) to mental health services in this merger (take over), but professors in universities who took control of the health budgets.

Professors running facilities in universities and health services resulted in service rationalision, to encompass their personal views on the priorities needed for service improvements. Research facilities expanded, the individual empires grows.

How does/will the current Newcastle university funding crisis impinge on all health services including mental health services provided to the people of the Hunter? The University is 25 million in the red.

The addition of research to services such as mental health without an increase in funding meant that research is funded from existing health resource provided. I am presently unaware of any major or significant research contribution or influenced that has changed nursing practice (patient care and treatments) in mental health service, at the grass root level. There has not been any change in mental health service provision implemented (at the face to face level) as a result of the research contribution for the improvement of nursing practices that I am aware of.

There has been research conducted in the mental health system by doctors in their area of interest that have confirmed existing knowledge. Their research results has catapulted their careers but has all the resources consumed by the research been of value to mentally ill person, their families and the population.

I have no **hard proof** I cannot send you any supporting evidence to sustain what I have described. I have only my history of observations, my personal standards to rely on, but with a simple visit and check I believe my statements would be supported re present conditions. General service standard need to be changed to be measured against the simple answer to the question "would I like my love ones my wife, son, daughter, parents or relatives to be accommodated and treated in the present mental health service/system?

(D) ROLE OF PRIVATE AND NON GOVERNMENT SERVICES.

The Non Government Organisations (NGO's) contract to service like the mentally ill and Developmentally handicapped people (our most vulnerable group of people) have lead to a general decline in this groups living standards since intuitional care ceased. Common sense tells you and me that the full amount of government capital paid to NGO's for service provision to this group would not be entirely spent on patient's services, but be proportionally reduced by a percentage (%) factor for profit that the NGO's felt entitled to. This is evidenced by todays continual out cry from community services and charity

agencies in NSW for more governmental assistance and support to increased funding for services to care the disadvantaged population.

NGO's services may have been able to offer privacy to patients in some cases but in many cases ***"dosse"*** housing accommodation was only affordable. Ex-patient's offered a room to sleep in, otherwise left to their own limited reality initiative, management and devices. Some NGO's employers offering full care, employed cheaper, inexperienced young labor just out of school, unskilled staff, untrained staff, hired for cost reason not service provisions reasons. The level of individual skills offered within NGO's (I have been in contact with) by employees is often lacking for workers to handle every day events arising in psychiatric services or somewhere to somebody in life.

The diversity of services offered in the past by governmental institutions now limited by NGO's to basic humane service in order to make a profit. There was no government department nominated with the responsible to police the quality of service provided by NGO's to the mentally ill or developmental delayed person. The service providers made up their own standards and policies re service provision to our ex-patients.

An interesting aspect worthy of note here is the fact that when people usually cared for by DOC's or their contracted NGO's, are admitted to this mental health services funding continues to go to the agency, although the cost of treatment is carried by the public system. To me this is double dipping into tax payers moneys for the care of the patient while in hospital and the NGO continues to be paid.

(F) SPECIAL NEEDS GROUPS – ADOLESCENTS.

There is a specialty adolescent unit here but as per normal there is not enough beds to admit everyone or the treatment program is long term. This unit is attached to the general hospital and is under the clinical control of a university professor. Any adolescents that that are difficult to manage in this unit are transferred to the James Fletcher Hospital, Psychiatric Intensive Care Unit (PICU) for care, treatment and control.

We have treated numerous **young** patients as **young as twelve years old in our locked PICU**. Neither DOCS nor their agencies careers nor any other services could or would take on the management of these disturbed individuals at that time. This mental health service is not equip to treat these young people and they generally remain locked up in the intensive care unit mixing and learning from the most ill or most ill mannered, poorly behaved, disruptive and manipulative people in this mental health system . This is not the decent thing to do to these young dysfunctional, mostly low functioning and vulnerable young people.

Several reasons why these situations arise may be:

- Lack of appropriate service facilities for disturbed young people.
- The hands on careers seem to lack basic knowledge and skills in managing difficult adolescents contracted under their care.

- The agencies do not have the powers under the Mental Health Act to care, treat and control as does the mental health system.
- Its easer to flick difficult to manage adolescents to mental health services, at no cost, funding continues to come in, staff and management have respite for a few days or a few weeks or longer.
- Workers remain uneducated even after numerous suggestions by PICU staff and over many admissions.

An interesting aspect worthy of note here also is that when people cared for by NGO's or contracted services are admitted to mental health services that persons funding continues to accepted by the NGO or the contracted service although the cost of treatment is carried by the public system, i.e. double dipping into tax payers moneys for the care of the patient.

(G) ROLE AND ADEQUACY OF SUPPORT FOR PRIMARY CARERS.

The evidence of the mental health service level of treatment and quality provision is unmistakable apparent at the coal face for all that want to see to see. I include the community mental health team in the total mental health service. The readmission rates of discharged patients back into hospital and in the decreasing number of parents, relatives and friends that fully support the mentally ill person.

In the faces of parents, relatives or support person there are many questions that need explanations on the initial admission and future interaction with this service. Many patients now live alone in public housing, some times due to the fact that private renters have concerns re people presenting, some with obvious mental health conditions. Family, relative and other career's support is often given from afar and only at desperate times perhaps due to the fact of limited service support for them that can be provided.

Today the Mental Health services touch a limited number of people i.e. the most acutely behaviorally disturbed (self harming, suicidal, violent or homicidal) person or the most acutely psychiatrically ill persons, the '**squeaky wheel' theory**. The current level of treatment provided is limited in my view and we do wrong by to the Australian population, their careers and supporters. This group needs more of our input in order to be equipped to provide more individulised and cultural specific care. This is an area of untapped potential in service cost cutting, prevention of admissions to hospitals.

Once referred to the depleted and basic community health service these patients are **prioritised** for services visits, than again the '**squeaky wheel**' theory applies. The community service is under staffed and cannot provide the full service expected during the day and a very limited service especially after hours. With huge case loads and workloads the workers can only do their best under present budgetary constraints, distributions and managerial priorities.

There are never enough beds in the hospital and we regularly go over allocated hospital bed numbers, accommodating patients on fold out beds till a real bed is available. The 'best of the bunch' patients are placed on leave or discharge (usually Monday mornings or Friday afternoons) to make room for more unwell people This operating system is a through put system (only counting the number of persons in contact with the system) and has limited measurements of individual areas of health improvements after contact with the mental health system.

The present funding system is orientated to through put and not the measurement of improved functioning, living standards, fullness of individuals and family life. The present shotgun approach has proved ineffective services for many years yet we continue supporting this approach continually adding numerous band aids to stop the obvious lack in service. The Australian population deserves a full and effective mental health treatment service and a potent prevention approach in mental health services to complete the package.

Mental health presently appears to be less valued by all levels of government and the general population. The contrasting value come from those people touched by mental illness or in continual contact with these services requesting support and input. At the initial point of contact with mental health services, the service limitations become a reality to patients and relatives.

A view of the admission process.

It's not hard to recognize, assess and admit a floridly psychotic, manic or depressed person. The challenge starts when the cognitive and intelligence levels are functioning at higher levels i.e. the addition of manipulation and street wise survival skills. A majority of people who presented for assessment have experienced the standard admission process. Some have been quick to taken advantage of this mental health system many times receiving refuge rather than facing the music and responsibility for their action in the criminal system.

There are an increasing number of foreign doctors that continue to receive their training in the mental health system but have little awareness of the colloquial language and the meanings of the Australian terms and culture. People have been admitted to mental hospitals because of these misunderstandings. One that comes to mind is the term "kick the bucket". The medical officer was unable to distinguish between the descriptive local language and his interpretation of this inappropriate, nonsensical statements made by a person being assessed for admission.

I have been around long enough to participate in many admission processes with a huge variety of different admitting doctors. Let me make the point clear here, that I do not have any prejudice against foreigners. Just one look at my name surname should alert you to the fact that Witkowycz is a good old **Australian** name but I do have concerns re this admission practice.

Each inappropriate admission costs the mental health service dearly financially and the bed taken up by the inappropriate admission denies a mentally ill patient a bed. Then if an extra patient is admitted the hospital and the hospital goes over numbers (overcrowding). The patients are slept in make shift beds, an extra place created in the already small dinning room, fire lists doctored, etc, which increases nurse's workloads. At times it's not uncommon for the hospital to be 3 - 4 over official hospital patient carrying capacity.

Patients have repeatedly told nursing staff of incidences where police, ambulance and other hospital personal have given potential patients tips, misleading (sure fired way advice for admission) information in order to gain admission to the mental health services. People have been misinformed re the services and conditions available in mental health and reacted when their expectations were not met.

The personal high level of prudence exercised by the medical officers to avoid personal court suits and criminal proceedings that may be brought about by patients and there relatives. The most glaring example of this occurrence is the admission of Personality Disordered persons to hospital regardless of the latest best practice clinical recommendations. The threats of self harm or aggression to others if not admitted, must be assessed by the admitting medical officer at that time in their reality terms.

The admission to hospitals of Personality Disordered people is generally counter productive in their treatment, except when the person is in serious crisis. The majority of new training doctors (and trained experienced doctors) in the admission process admit this group of people due to the doctors uncertainty and fear of the persons potential threats of self harm or harm to others rather than real risk of the person. This group consumes very precious and limited resources due to generally long term stays in hospital often manipulated by continued threat of self harm or harm to others if discharged from hospital.

People present for assessment for numerous reasons and present by themselves, arriving with family and friends, transferred from other hospitals escorted by police, etc. A number of people presenting for admission have secondary gains for presenting e.g. pending criminal charges and/or future imprisonment. The admitting medical officer does not often use opened questions or other counseling techniques in the assessment process, but uses a list of admitting question the answers needed to complete a forms.

The process starts with i.e. personal information eg your name, address, etc, than leading to questions why are you here?, to questions like:

- Do you hear voices?

Answer Yes or No. Yes means a stay in hospital, No means you go to goal.

- How long have you heard these voices?

Answer anything you like time to use your creative skills now.

- Are the voices inside your head or outside your head?

Again multiple choice any answer and you are in

- Is it a male or female voice you hear?

Multiple choice, any answer will do.

- Is the voice of a young or older person?

Any answer will do.

- Is it a friendly voice or is the voice saying derogatory thing's about you?

Multiple choice, I have see uneducated people on their 2nd presentation for assessment for admission use the word derogatory, still not knowing what it means.

- Do you feel like hurting others or hurting yourself?

Either answer gets you in.

- How would you hurt your self?

Let your imagination run wild here.

In going through this format the form is completely filled in and the necessary funding statistics collected.

I would hope that you understand the point behind the above small written illustration. The present admission process needs review in order to increase its sensitivity and accurately to better detect the genuine mentally ill person. A better screening tool is long over due to assist new admitting officers in the mental health service.

A survey to demonstrate conditions that my fellow nurses and I work in on a daily basis (perhaps offering an insight into difficulties in recruiting nurses).

I wish to submit my 2002 Aggression survey for you to have a brief overview or a sneak peek into the conditions and staffing levels that psychiatric nurses face daily. I do not know of any other 'professional service' providers that work under the same conditions, may be corrective services would be most similar in some aspects.

I have submitted this survey to management in late 2002 but as yet have not received any feedback and the only change implemented is a prevention of violence and aggression course for the nurses. This prevention of aggression course places the onus of any aggression experienced by workers back on the individual. Management of this service seem to consider themselves to be absolved from having contributed to any aggression in the system.

Having inexperienced and insecure medical officers admitting people guided by unclear, vague and unsupportive policies does not reduce inappropriate symptomatic (intoxicated, assaulting, aggressive and violence behaving else where in the community) people presented for admissions with 2 cars loads of police. People believing there is nothing wrong with them being presented to a "loony bin" for assessment and possible admission can escalate in behavior to anger, aggressiveness, hostility and violence, needing restraint and medication in the admission unit.

Since this survey, the admission of inappropriate patients has not change. The reality is that mental health services have traditionally been perceived and considered to be the 'end of the line" or "the end of the line"service. The old community perception continues

of referring people to mental health services because they do not fit well anywhere else in the society.

The prescribed medication levels are unchanged from the survey levels, the nurses are investigated for "wrong doings" when unhappy, unsatisfied patients make complaints about their treatment by the system operations. The nurses remain in the front line on three shifts in a twenty four hour period – around the clock and become the focus of the patient's wrath caused by others or the system. Nurses are dealt with (rightly or wrongly) but the management of this imperfect system and the system itself that caused the problems remain unchanged.

One interesting point is that no psychiatrists, doctors, psychologist, social workers, office workers, etc (all members of a multidisciplinary team) attend "Code Blacks" (staff members in physical danger). Any worker in the hospital can call a code black but only the nurse's in the responses team responds to the crisis, usually to aggressive violent patients. The system discriminate against nurses and this implies a class difference in valuing of individual professionals within the mental health service.

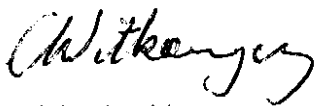
Management insists that the individual nurse unite (no matter their age, state of health, beliefs) whether male or female are considered of equal value on the response team. I believe that the majority of females have feminine trait's, physical violence does not come naturally to them. In my experience female don't cope well in a physical take down of a swearing, threatening, aggressive and violent patient.

Yet managements view is they receive the same amount of pay, they are expected to do the same job as the males. This aspect is incongruent and in equable, just because you are a female nurse you respond to code blacks but female doctors, office workers, social workers, etc, do not have to participate in the restraint of patients. To my knowledge all staff are required to be trained in a Prevention of Aggression Course or some similar titled course.

I hope some one does read this effort. If these points are relevant maybe these ravings will help set the background picture for other peoples factual presentations.

What do you think of the survey results?

Many thanks for your time.



Michael Witkowycz