2019 Submission - Royal Commission into Victoria's Mental Health System

Name
Ms Lynne Baudinet-Johnson

What are your suggestions to improve the Victorian communitys understanding of mental illness and reduce stigma and discrimination?
"Mental illness is a real problem affecting individuals from all walks of life. Mental illness should be presented in this way, so that people are aware that it can affect anyone at any time and often have catastrophic consequences if appropriate competent clinical support is not provided. "

What is already working well and what can be done better to prevent mental illness and to support people to get early treatment and support?
The Government currently provides a great deal of funding for individuals suffering with mental health issues. People can access clinical counselling and support through their GP which has been a move in the right direction. The Government have done this well and continues to do this well. No-one in this country should miss out on quality mental health care.

What is already working well and what can be done better to prevent suicide?
"I am not sure that anything is working well apart from the Government's commitment to mental health and the funding provided thus far. I have never had faith in triage or Government mental health clinicians and have watched over the years the systematic failure of these people to correctly assess, diagnosis and section individuals who have presented with suicidal intent and had a plan to end their life. "

What makes it hard for people to experience good mental health and what can be done to improve this? This may include how people find, access and experience mental health treatment and support and how services link with each other.
People sometimes don't know how to access counselling/treatment from services unless told. Competent mental health clinicians and good experiences are sadly lacking. A campaign at GP clinics would certainly help. PHN networks are very involved in promoting their service and linking services and GP's. They do a great job.

What are the drivers behind some communities in Victoria experiencing poorer mental health outcomes and what needs to be done to address this?
"Lack of qualified clinicians in rural and remote areas. Lack of employment, housing, social and family support, and financial burdens. "

What are the needs of family members and carers and what can be done better to support them?
Family members are often the forgotten victims of mental health. Asking some-one if they are OK is important and following up is vital for there psychological well-being.

What can be done to attract, retain and better support the mental health workforce,

including peer support workers?
I am pleased to say that I have attracted and retained qualified senior clinicians by making provision for a work life balance and encouraging on-going training across all mental health areas. I am not sure what else can be done.

What are the opportunities in the Victorian community for people living with mental illness to improve their social and economic participation, and what needs to be done to realise these opportunities?
I am not sure

Thinking about what Victorias mental health system should ideally look like, tell us what areas and reform ideas you would like the Royal Commission to prioritise for change?
"There is no ideal answer, but I would like the Royal Commission to listen to my horror story of how my beautiful husband died following what only can be described as less than adequate care at a regional emergency department. "

What can be done now to prepare for changes to Victorias mental health system and support improvements to last?
"I would like to see the following happen 1.When a person triage's some-one and that person is psychotic with a plan and intent it should be mandatory that they are kept safe for 48 hours and undergo a complete assessment with a senior psychiatrist which includes, blood tests, full history, organic screening if necessary, and medication review. This will save lives. 2.There should be an over-riding ruling that can be applied to an individual to keep them safe. If a person is taken to triage or a mental health clinician and that person knows that they are not safe with a plan, intent and the level of lethality is such that there is no coming back from, the support person should be able to apply a rule that overrides the clinician who is doing the assessment. The patient would be kept safe for the 48 hour period until fully assessed. "

Is there anything else you would like to share with the Royal Commission?
"Mental illness is a real problem and people are in often in crisis when they attend Triage or counselling services. Triage/mental health services often have staff who have had inadequate training to assess and treat individuals who present with suicidal ideation and suicidal intent. They are not equipped to complete a full assessment on the individual and this has dire consequences for them if they are misdiagnosed or not sectioned under the mental health act. The impact on family and friends is also profound when some-one takes their life because the system failed them. The mental health system is in crisis and the only way you will find this out is if you hear horror stories from individual's where the system has failed them and a life has been lost. I would like to share my story of how the mental health system failed my beautiful husband and failed me as an experienced mental health service provider for 20 years. My husband D[redacted] had no history of mental health until he suffered from workplace burnout in 2015 whilst working on a project in NSW that was over budget and behind of schedule when he arrived. He was a capable intelligent man who had a high level executive position. He was placed on medication by his GP and provided with a certificate to have six weeks off work. He returned to his employment in mid-2015 and the company he worked for went into administration. He returned to Victoria and was head hunted by another company in the same industry and he commenced employment for them in December, 2016. D[redacted] was working from home and was working long hours with little to no support. He knew the job backwards, but I watched him decline to the point where we talked about

him resigning and having a complete rest. His GP did not place him on Workcover, but did place him on medication. D[redacted] started to display symptoms such as loss of executive function, confusion, shaking, catastrophizing, heightened anxiety, sleeplessness and paranoia. He resigned without support from his GP in May of 2016. He returned to his GP in mid-June of 2016 and took the list of his symptoms we both had identified. His medication was increased and his condition worsened to the point where I took him to my GP for a second opinion on July 6th. D[redacted]'s medication was changed and he was prescribed Valium because he was sleep deprived. D[redacted] showed some signs of recovery in the days following, but two days prior to triaging him he told me he had been suicidal. This was not D[redacted] and certainly not what he stood for. He apologized for having those thoughts and we talked about triage on that day. He promised me he would tell me if he didn't feel safe again. On the morning of July 12th, 2016 D[redacted] told me he did not feel safe and with his permission I immediately rang Triage. D[redacted] knew he would have to be admitted on the basis of a medication review. We both knew something was not right about the medication he had been prescribed. D[redacted] was high risk and the intake worker noted this and suggested we pack a bag with the intention of having D[redacted] admitted. D[redacted] was not in control of his thoughts and I did not believe he could guarantee his safety and neither could I. D[redacted] was clearly psychotic because he told me people were watching him. I was deeply concerned for him. We arrived at the hospital at around 10.00 am and I assisted D[redacted] to the emergency department when he was first assessed by a mental health clinician. D[redacted] did not believe he was a mental health clinician. He told him he knew he was the police and he had been watching him for the last three weeks. He told him that he was only going to kill himself. He told him that he was not going to kill me. D[redacted] went on to tell the clinician that he had planned to stab himself in the heart about three weeks prior and that there were cameras in the house watching him. D[redacted] was acutely psychotic and my thoughts went back to the medication increase three weeks prior and I believed D[redacted] was in a drug induced psychosis. I was horrified by his commentary and so concerned for his safety and well-being. This was not the D[redacted] I knew and I gave a full history to the clinician D[redacted]'s brother who had died of an aggressive brain tumour 18 months prior and I wanted a MRI to rule out an organic cause. The mental health clinician recorded in his notes that a psychiatric assessment was necessary, organic screening and that D[redacted] was high risk. I knew that. D[redacted] was then seen by a fifth year psychiatric registrar for about five minutes. I asked him about the MRI and he told me in front of D[redacted] that the only way D[redacted] would get a MRI was if he came back through emergency with a head trauma or obtained a referral from his GP. He told D[redacted] and me that there were no beds available at the psychiatric facility and he could not keep an acute patient in emergency or admit him to the wards. I pleaded with him to keep D[redacted] safe. I believed the psychiatric registrar was looking for a bed for D[redacted]. He was then assessed by a senior doctor and a junior intern. He had bloods and further questions were asked. I re-iterated time and time again that this was not D[redacted]. I had never seen him like that. They also knew of my training in mental health, but I felt I was not heard. I asked him again to keep D[redacted] safe. D[redacted] was discharged with a script by the psychiatric registrar. I was told to not give D[redacted] his medication until 6.00pm. He did not even go to the hospital pharmacy to have this script filled for us. No formal assessment was done on D[redacted], no organic screening, and because there were no beds available at the psychiatric facility, D[redacted] was sent home in an acutely psychotic state with only myself to look after him. Sadly D[redacted] was not safe and neither was I. D[redacted] did not make 6.00pm. At 5.30 pm, D[redacted] walked ahead of me to the garage as we were going to get a take away meal. I heard noises coming from the garage and thought that D[redacted] had smashed his car because he was waiting on Vic roads approval to continue driving. I immediately raced to the garage where I saw D[redacted] standing near the door. He said to me I am sorry [redacted], I have done something really stupid. Thinking that it was his car that he had smashed, I said It is Ok. Everything will be Ok. I did not

see any blood as the garage was dark. To my absolute horror, D then proceeded to move the . I watched this happen three or four times and a struggle broke out between us in order to get the from him. I managed to do this and put it on the workbench in the garage while I ran back into the house to get my phone to call 000 for an ambulance. When I returned D had got up off the floor and found the and proceeded the hit himself again. I watched this horror unfold. His eyes were glazed and he had clearly crossed the line into insanity. I further struggled with him and eventually managed to get the from his grasp and I kicked it under the car. He then held my two arms tightly and picked up a from the workbench in the garage and started . He went to lunge at me with the . The was close to my heart and he had enormous strength. He dropped the , walked a couple of metres and crashed to the ground. This horrific scene will never leave me. D was airlifted to the hospital where he was placed on life support. He developed a blood clot and he ended up having a bi-lateral stroke. His life support was turned off on the 19th of July at 10.00 am. His heart stopped beating at 10.09. I was by his side as he took his last breath. This situation should have never happened, but what followed has only added to my trauma.

D lost his life tragically and my life ended as I knew it on . Nothing will ever be the same. I have vowed that I need to make some change, but have not notified any authorities such as AHPRA

In my time as a clinician, I have never had anyone take their life whilst under my care. I have been a competent capable and responsible clinician who has gone above and beyond with my patients. I had no intention of returning to work in my chosen field until friends of mine had their daughter, J admitted to a psychiatric facility over the Christmas period. She was both suicidal and homicidal as well as being psychotic. I could have run across the world, rather than deal with mental health clinicians in a triage setting. J was let out after three days and reached out to me. She was clearly not well and went to Sydney. On her return she called me when she was going to walk in front of a train. I encouraged her to go back to the psychiatric facility and request admission. I was four hours away but was ready to go to her when she rang me again telling me they would not admit her. I demanded an admission and checked her medication against her history of psychosis. J had several attempts to hit her head against a wall. During J's admission, one girl hung herself , and another J admitted that she was going to go home and kill her parents and kill herself. This was not the J I knew. We discovered that her medication and the increase of such prescribed by a psychiatrist had led her into psychosis. I am pleased to say that J's parent's acted quickly on my advice and had J slowly wean off the medication whilst in the psychiatric facility. J and her parents are greatful and believe my intervention saved J. J is now doing extremely well and has

enrolled at University to do psy nursing. She has lost weight, attends the gym and has returned to the confident happy girl I knew. Not only was J[redacted]'s life saved, but she saved mine. I hope to return to my practice in the next month after having three years off to recover from this trauma. Sadly the impact of D[redacted]'s death has been profound. He was a son, brother, father, uncle, work colleague, friend, but most of all he was my beautiful husband whom I shared 20 years of my life with. It is imperative that change happens and that D[redacted]'s death has not been in vain In honour of D[redacted], I would like to see D[redacted]'s Rule be applied to anyone presenting at mental health facilities who feel that their loved one won't be safe if not assessed properly and admitted. This rule could allow time for a thorough assessment and review. This will save lives. Should anyone need to speak with me regarding this submission, please call me on [redacted]. Thank you for taking the time to read D[redacted]'s story. Kind regards Lynne. "