Forensicare Patient Consulting Group Submission to the Victorian Law Reform Commission regarding the Crimes (Mental Impairment and Unfitness to be Tried) Act

Background

This submission is provided by a group of patients with first-hand experience of the legislation and associated processes in its current format. They are also members of the Forensicare Patient Consulting Group and have been involved in developing an education package for staff and patients of the hospital to improve collective understanding of recovery in forensic psychiatry. Part of that training has involved developing a fictitious case study that serves to improve people's understanding of some of the challenges involved. The case study material is provided as part of the submission to demonstrate some of the key stepping stones for someone detained under the current Act.

In preparing this submission the patients have worked with members of the VLRC one of the Forensicare consumer consultants and clinical staff at the Thomas Embling Hospital who have collated their thoughts, experiences and opinions. The patients are happy for this submission to be made public as part of this process.

There are responses provided to some of the areas requested by the Consultation Paper in bullet point below.

Topic 1: Unfitness to stand trial and the mental impairment defence

Length of the process

- The length of time for trial is considerable, frustrating and often intense – it can be 12 months or more. It was difficult to deal with the uncertainty during this long process and the unexpected and multiple adjournments. 'You are stuck in limbo and you never know what to do or what to think of'. This can be unsettling for someone who might already be unwell.
- There is normally a 12 month period between the offence and the trial – sometimes this can be good and sometimes bad. If there is a bit of delay, you might be able to get well enough to understand what is going on.

Lack of privacy

- There was also a lack of privacy. The press and the public could take pictures outside the courts. We don't want to have our face all over the papers. Part of the problem was that there was no warning that this was going to happen and then all of a sudden there is the 'click, click, click' of all the cameras.

Transport to court

- Transport to court can be overwhelming – the mode of transportation does not factor in the different needs of people with a mental condition. Up until the time of sentencing no distinction is made between patients and prisoners and patients are treated as prisoners. There is very little space in the vehicle and the journey is quite long (it goes around to all the different prisons). An example was given of being in the small space in the van from 6:30am until 9am – can make you feel sick. It is also stressful and mentally draining.

Nominal term and length of supervision

- The nominal term is confusing and does not reflect reality. Some people have an 8–10 year nominal term and are stuck in the system for 20–30 years. Some patients felt that if they knew that relying on the mental impairment defence would result in an indefinite term, they would have considered pleading guilty.
- The nominal term does not always include the time served before the trial.
- There are some patients in the rehab units who are finding it hard to get jobs even when there is a verdict of not guilty because of mental impairment due to the results of police checks. This is affecting rehabilitation. Some patients had the understanding (based on the advice and assurance of their lawyers) that they would not have a criminal record if they went down the mental impairment path.
- Some thought that relying on a mental impairment defence would have resulted in a shorter time in detention than in prison, but prison may have been a better option.
- There seems to be a minimum time people have to stay supervised, regardless of whether you are well or not. Sometimes it feels as though they just have to keep you here for a period of time just because that it what is expected.
- One example was given by a person about being on a supervision order 'I ended a family's son's life. I can never give that back but what I can do is get well to make sure it never happens again.'

Court hearings

- During court hearings there was no opportunity to express views and no chance to speak in court. It would have been good to participate more in the trial.
- Some lawyers helped explain what was happening during the trial. Lawyers seem to have an overview of the process but may not know the ins and outs. It's important to have lawyers with experience of the law and what is actually going to happen and an understanding of mental health.
- Currently a mental impairment defence seems to exacerbate stigma and reduce consultation and collaboration with the defendant as there is an assumption that the defendant won't understand.

- Sometimes lawyers have strong views on the direction the case should take and impose this on defendants.

Reasons for going down the CMIA pathway

- Most people were advised to go down the CMIA pathway – there was a view that there were more opportunities for rehabilitation, maybe shorter detention periods and there would be no 'guilty' verdict on record (which would be important when planning and trying to secure any future career) – but not all of this was true. One person said that they were pushed to go down the CMIA pathway.

- The accountability of community services is an issue – some patients felt let down by community services. The services received were inadequate and there was no pathway for recovery. This could be a resourcing issue – case managers tend to be overworked and have unsustainable patient numbers on their caseloads. It took something severe to happen before they could get help. 'There is no help out there'. Some examples given were:

    - One person had been unwell for months before the offence and had been having physical complications with the medication they were on. The person asked to be discharged from the service and was referred to a GP. The GP then put them on anti-smoking medication and it was the side effects of that that contributed to the offence occurring. The community team involved was not scrutinised for what had happened.
    - One person had been having two stays in hospital per year leading up to the offence and there was no long term help with rehabilitation. 'It's a cycle – you get a bit better and then they let you out'.
    - One person had been admitted to hospital four times in one year and then had been released and been living in the community for 12 months and had ceased the taking of medication and people were saying it was all fine, but it wasn't.

- The prospect returning to community based supports when supervision orders are revoked is better after an admission to TEH as hopefully we will be more independent and expert at managing our own mental illness.

Topic 2: Making and reviewing supervision orders

- There is limited understanding by patients of the implications of extended leave and being on a non-custodial supervision order – it is still a difficult position to be in because of the restrictions. ”patients might think that once you get extended leave, that’s it - but it’s not”.
- There needs to be more flexibility in the system – once you get out of the custody system it can be hard to stay out because it is not very flexible. If people breach an order they could end up back in an acute unit which may make them worse because you are with people who are more unwell than you are. Being thrown back in for the slightest breach – it is disproportionate and it’s not fair ‘being under the microscope to that extent’. For little mistakes there are such big consequences – when ‘you have worked so hard on your mental illness’.
- There is lots of assistance in Thomas Embling to prepare you for release – by the time you are ready to be released, you are going out of the hospital three times a week and are basically only sleeping here (at the hospital). There is assistance to help people adjust to living in the community again – there is less support in the community than there is in Thomas Embling. We are not saying that there should be more support in the community but just a comment that there is less compared with in Thomas Embling. There is a danger that the institutionalisation levels might cause people to struggle with that amount of freedom.

Topic 3: Applying for and taking leave

Forensic Leave Panel

- There is an issue with the wording of Forensic Leave Panel orders. One patient gave an example of being granted leave with his mum and stepdad. Because the order said ‘and’, he was not allowed to go on leave when his stepdad was unable to make it. Sometimes ‘two escorts’ could mean that three staff members are needed because there needs to be one ‘floater’. It is hard to make corrections to these orders – sometimes you have to go back for another determination.
- Different judges have different approaches to leave. There is a lack of clarity on the reasons for their decisions. Sometimes vague reasons like ‘it is too soon’ are provided. It seems to be about the time served rather than rehabilitation.
- Forensic Leave Panel hearings can be intimidating because there is so much riding on it. It can also be exciting if you get your leave or such a downer if you don’t. The Panel can ask difficult questions – it depends on what kind of leave you are applying for. Sometimes you

can get leave really easily and other times you really have to argue for it and 'plead your case'.

- Exiting the hospital involves progressing through the leave process without incident.
- There seems to be too much emphasis on the judge's view. Even though the treating team and Internal Review Committee support the patient, the judge could still take a conservative approach and refuse the leave. This is despite the fact that the treating team know the patient well and the judge only sees them for a short period and don't know enough about their progress.

Practicalities of taking leave

- Mobile phones should be allowed when a person is on leave. Currently only two units allow mobile phones. Other units can only have phones if leave is unescorted. When you have leave with staff mobile phones are not allowed. There are also restrictions on the kind of phone you can have (for example, phones with internet capability are not allowed) and restrictions on internet access. This is about independence.

Topic 4: Support and advice for accused persons and people under supervision orders

- There was not enough information about the whole process.
- The hospital runs some information sessions about the process but these are not compulsory.

Information from the Forensicare Patient Consulting Group collated by;

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Consumer Consultant
14th August 2013

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Ian Davey
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Attachments;

1) Fictitious case study outline – Jack
2) “Don’t Come Back Jack” – Educational Powerpoint Presentation including patient script

Case Study: Jack

Introduction

This case study was developed by members of the Patient Consulting Group – whilst fictitious it was designed by them to plot the journey towards recovery for a "typical" patient of Thomas Embling Hospital. It is used by patients when running recovery education sessions for staff and patients at Forensicare.

Case Summary

- Involved in AMHS since 18 years of age
- 1st admission aged 19
- More admissions followed, stopped meds
    - Using drugs (cannabis, speed & meth + alcohol) as a way to deal with stress and managing symptoms
    - Family & work stress
    - Lack of insight or understanding
- Left home after he was kicked out by his parents
- Moved into a shared house
- Got into petty crime (shop lifting) to fund his drugs habit
- Finished VCE, enrolled in TAFE but couldn't focus due to drugs and symptoms
- People in the shared house were threatened by him with a knife
- CAT team called
- 3 week admission to stabilise – olanzapine prescribed – diagnosis of schizophrenia
- @ age 24 Jacks daughter was born
- Continued sporadic compliance
- Drug of choice changed and subsequently offending profile changed
- Continued denial of illness
- Murder of dealer during an altercation

<u>Strengths</u>

- Academic
- Sporty
- Partially qualified carpenter
- Parents still supportive
- Keeps in touch with daughter
- People person with good charisma

3 WEEKS IN MELBOURNE ASSESSMENT PRISON

- Assessed and certified by doctors
- Unfit to plead

SEVERAL YEARS IN THOMAS EMBLING HOSPITAL

A Block

- Resentful of situation
- Feeling guilty due to crime he had committed
- Stressful and hard to get well in A block
- Eventual clarity about court case
- Stabilisation on medication
- Peer support
- Peer inspiration
- Positive interactions with staff
- Referral to Bass
- Accepted to Bass – wait for a bed

Bass

- Over committed to groups & TAFE courses
- Begins to work on drug and offending issues with psychologist
- Medication issues
- Daughter became sick
- Some arguments with other patients
- Relapse
- Developed better understanding of his illness and the some of the trigger points for relapse

Daintree

- Start working with OT & Employment consultant on employment issues
- Further work on drug & offending issues
- Improve links with community TAFE

Jardine

- Discharge delayed as there is no accommodation
- Support from social worker to eventually secure housing

EXTENDED LEAVE

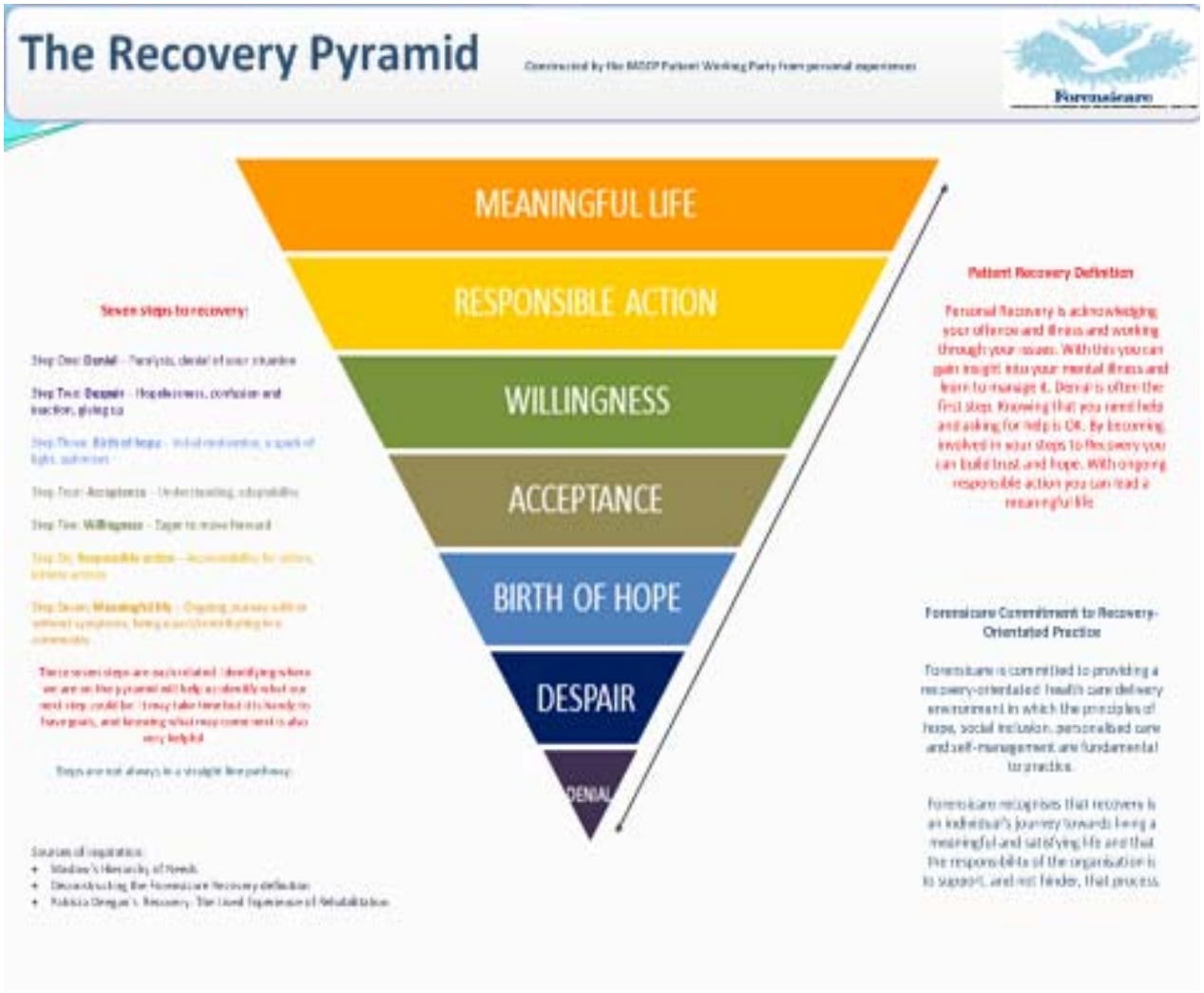
Public Rental

- Working 15 hours per week
- Seeing community case manager regularly
- Regular contact with family
- Significantly less contact and support from services
- Lonely at times
- The risk of doing something wrong is frightening as the consequences are so great
- Challenges remain of not falling back in to old patterns of behaviour

Patient Consulting Group Presents:

Don't Come Back Jack:

A Patient's Recovery Journey



Welcome

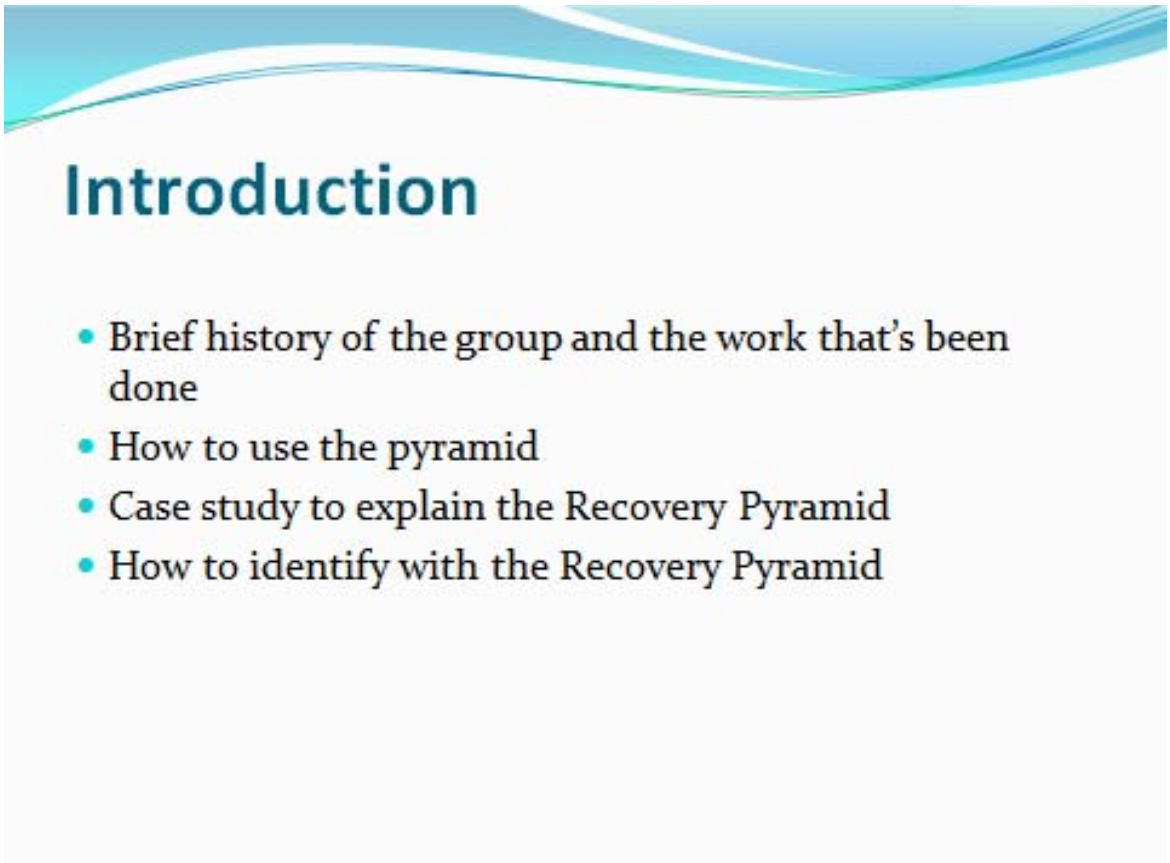
Hello and welcome to the model of care presentation of our case study “Don’t come back Jack”

Jack is a typical patient at T.E.H. We will trace the stages of his recovery with the use of the Recovery pyramid.

We developed the recovery pyramid to help get a clearer image of where we are in our recovery.

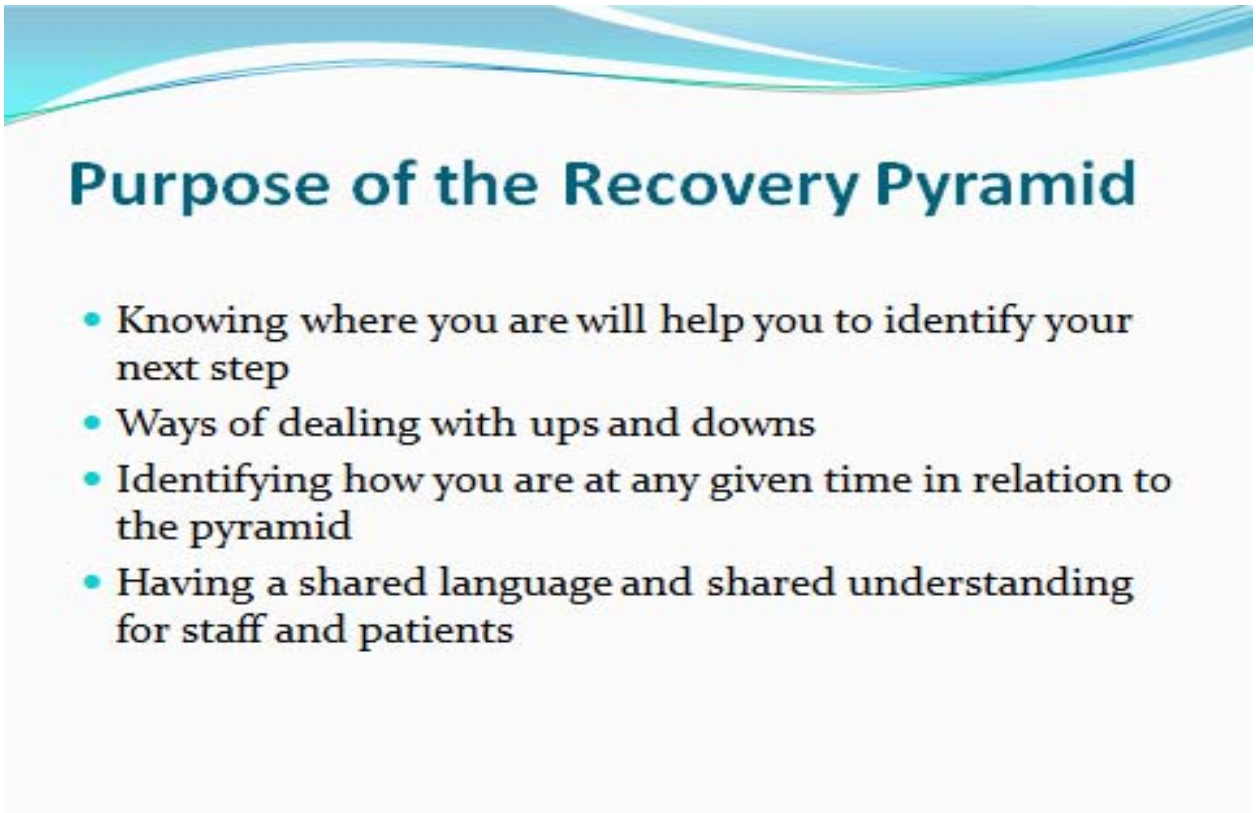
The stages are; denial, despair, birth of hope, acceptance, willingness, Responsible action and meaningful life.

During Jack’s stay in the hospital, he moved both up and down the pyramid depending how well he was.



Introduction

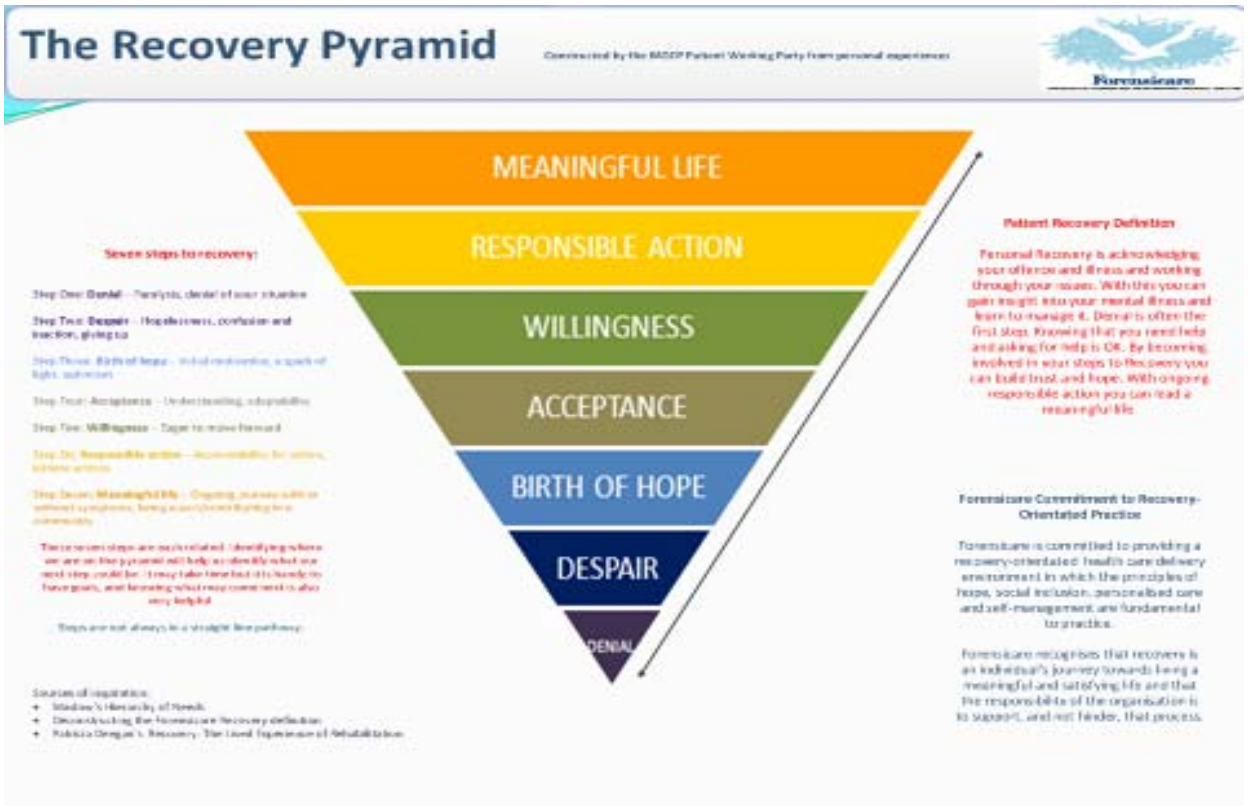
Early in the M.O.C it was proposed that we create a gauge for recovery which would help patients better understand their own recovery journey. So the recovery pyramid was born.



How to use the Recovery Pyramid

We developed this pyramid to help patients gain insight of their recovery and also identify their next step. This is just guidelines of the average patient's path of recovery.

We hope it will add to patient self-awareness but also give staff insight into what a recovering patient may experience. I will now introduce you to the pyramid itself.

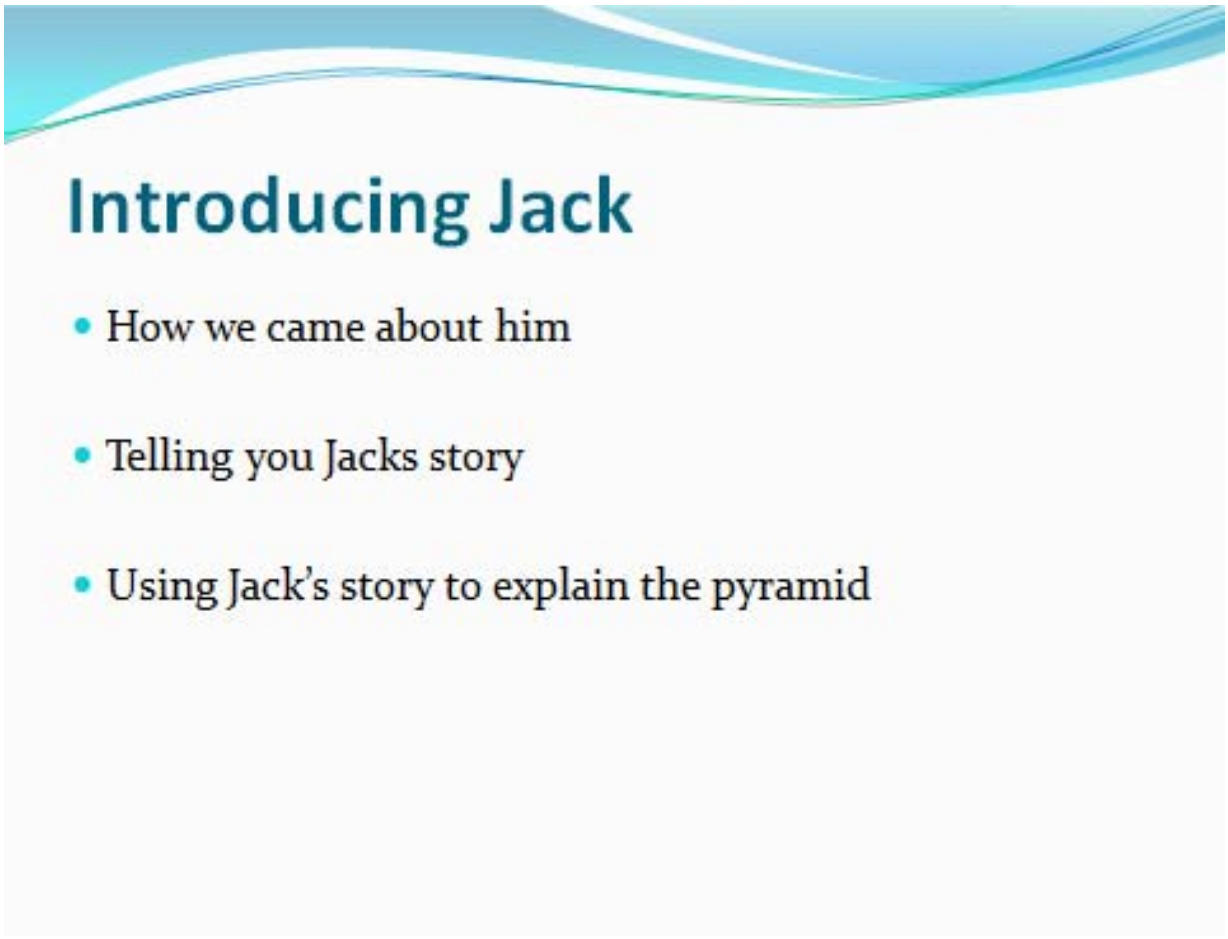


<u>The Recovery Pyramid</u>

Along with the pyramid we also constructed our patient recovery definition which goes as follows; Personal recovery is acknowledging your offence and illness and working through your issues.

With this you can gain insight into your mental illness and learn to manage it. Denial is often the first step, knowing that you need help and asking for help is okay. By becoming involved in your steps to recovery you can build help build trust and hope. And with ongoing responsible action you can lead a meaningful life.

The pyramid itself is not one straight line. People can move up and down and may find themselves experiencing aspects of two different stages at one time, for example; although a patient may be in despair they may be accepting of their situation. We will go into the stages in more detail in a short while. Our sources of inspiration were; Maslow's hierarchy of needs, deconstructing the Forensicare recovery definition and lastly; Patricia Deegans; recover the lived experienced.



Intro

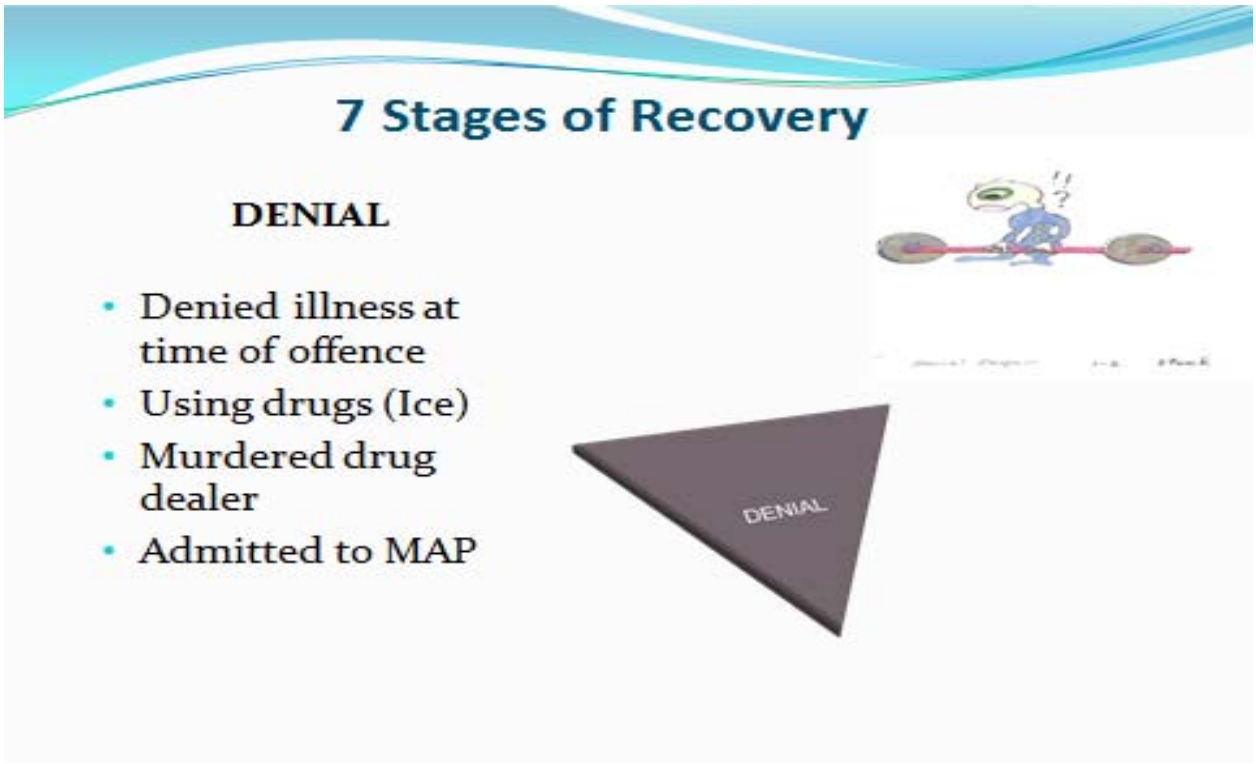
Although Jack's story is fictitious we came about his story by the Patient Consulting Group. We came up with Jack to outline what most patients experience in their time at Thomas Embling.

Its aim is to illustrate where patients have, been, where they are and where they want to go.

It also allows staff to get a look into a patient's world.

At the same time, highlighting the need for better communication and more transparency.

We will now explain the pyramid to aid in Jack's story. Which brings me to the first stage' denial'.

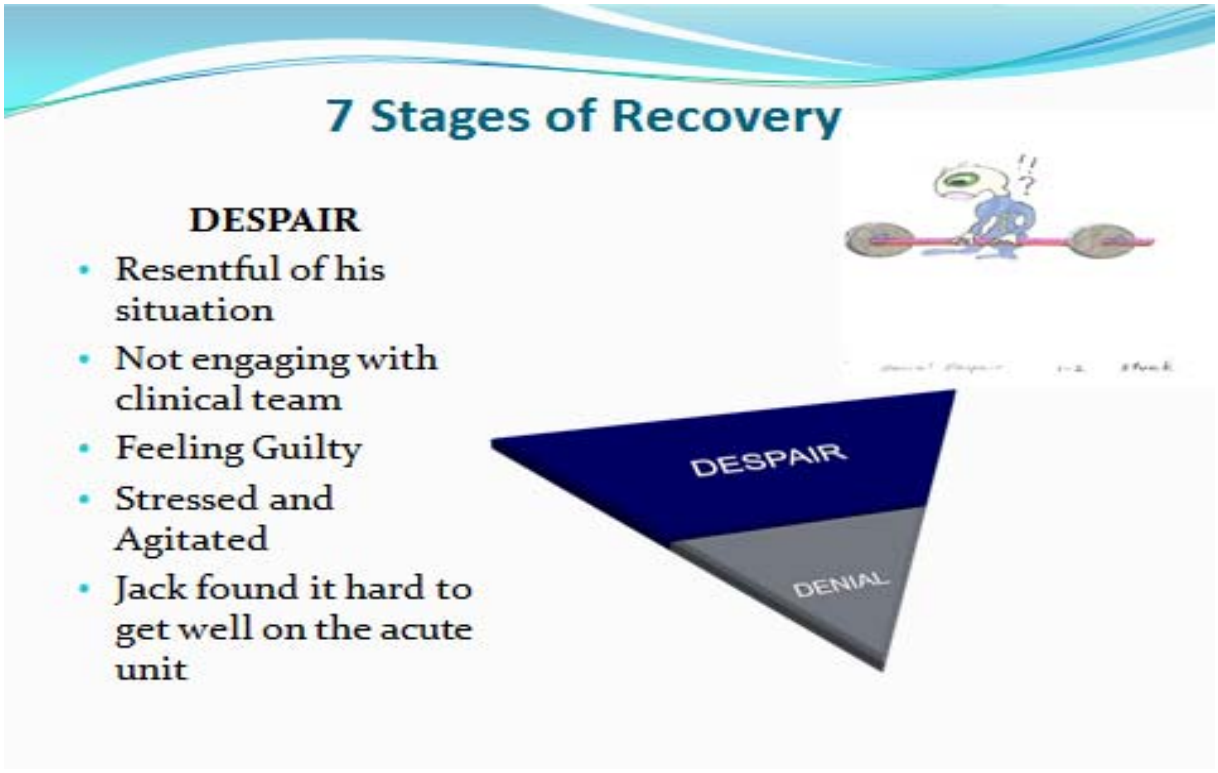


Denial

Jack at this stage did not admit he was 'unwell', even though friends and family were trying to tell him. Jack was using drugs mainly 'ice', things got further and further out of control. After arguments with his drug dealer, things escalated and Jack became 'unwell'. Jack having an altered perception, not knowing what else to do, turned to violence. This resulted in the murder of his drug dealer.

Police arrived and after an interview and a night in the cells, corrections deemed him 'unwell' and he was admitted to the A.A.U at the M.A.P.

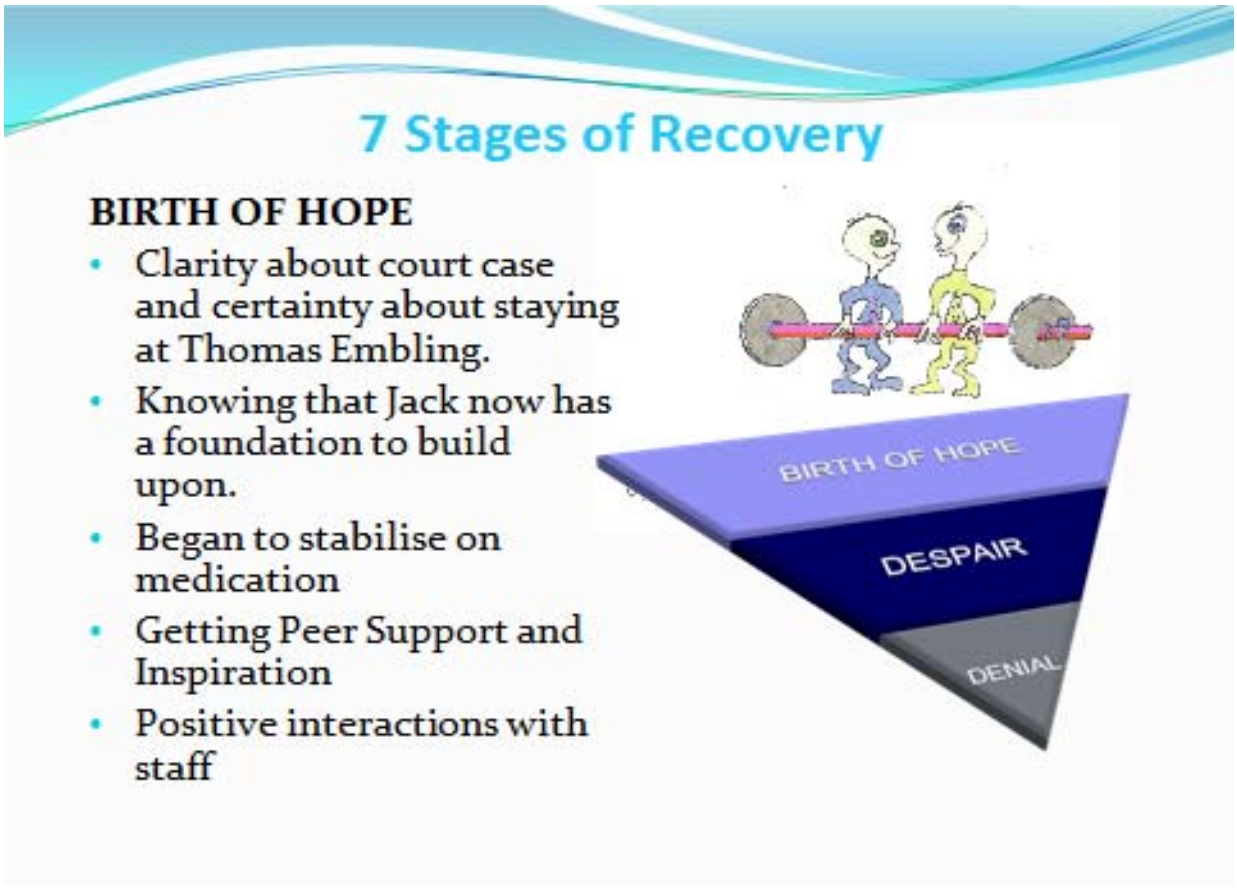
Jack was not accepting. He never fully admitted at that time that he had a mental illness. He refused to take medication and was transferred to Thomas Embling.



Despair

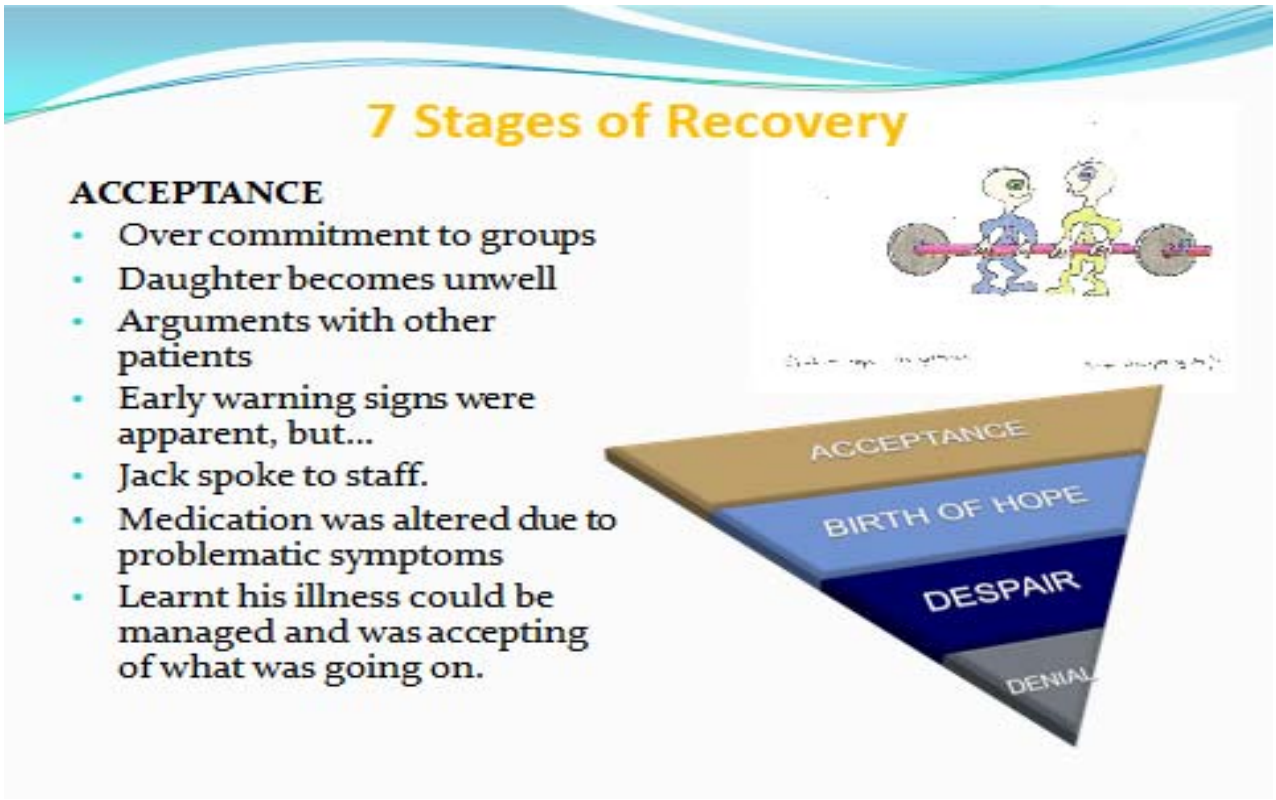
Jack has been admitted to Thomas Embling. He is now in 'despair'. He feels desperate and is in an unfamiliar environment. He feels resentful of his situation, feels alone and feels like there is nothing to look forward to. He is in the acute units and is finding it hard to get well. Jack is getting into fights and is depressed about not seeing his family and kids.

He resents having his freedom away from him. It's a living nightmare. He hates being treated like a child; he hates the idea of having to take medication for the rest of his life. He feels isolated and out of reach. All he wants to do is go home. Jack begins to take his meds and gains some insight. Although Jack starts to put on some weight he begins to get better.



Birth of Hope

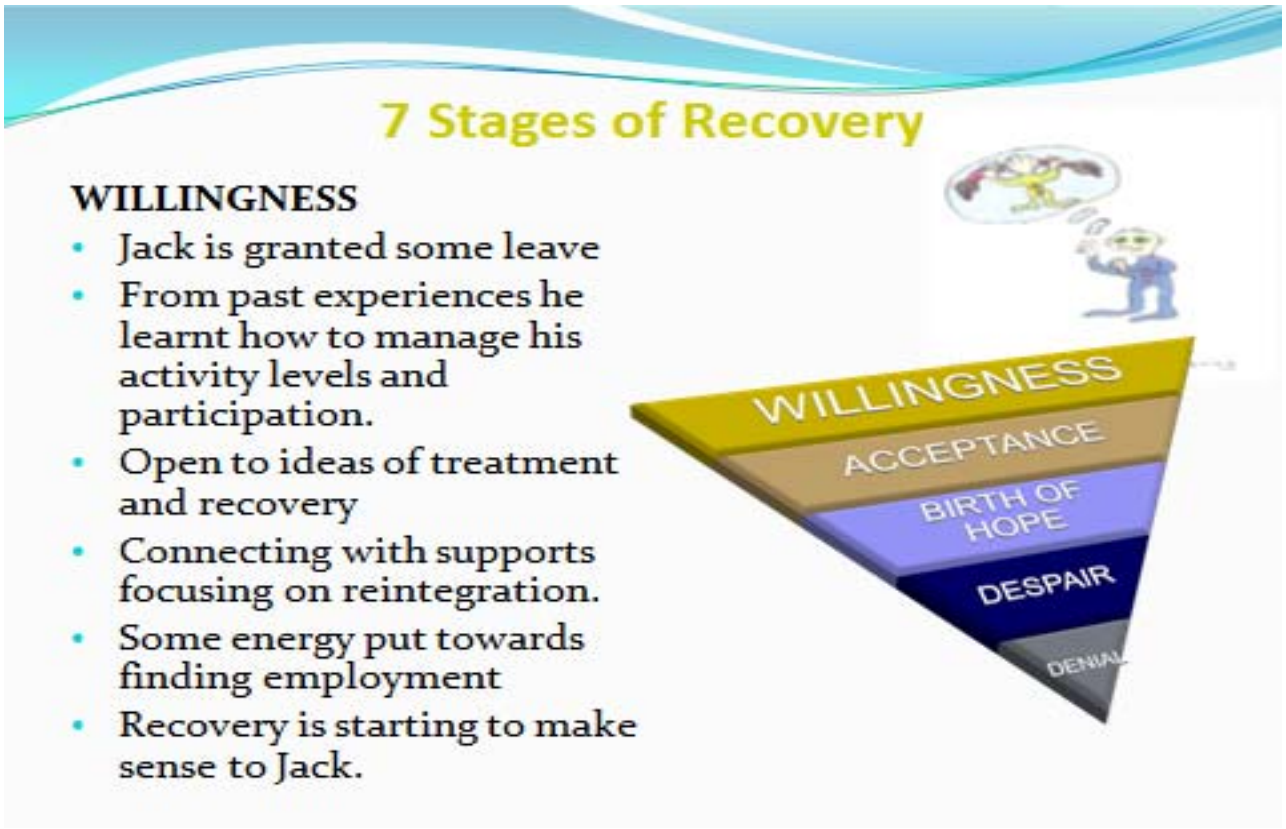
The first glimmer of hope is when Jack starts looking forward to the future. He becomes stabilized on medication and sees value in taking it. He has positive interactions with other patients and staff. Other features of this stage are getting clarity about his court case, gaining of grounds leaves and feeling more positive and self-confident. He now has faith in support people, his treating team. He reconnects with his family and starts seeing his children again.



Acceptance

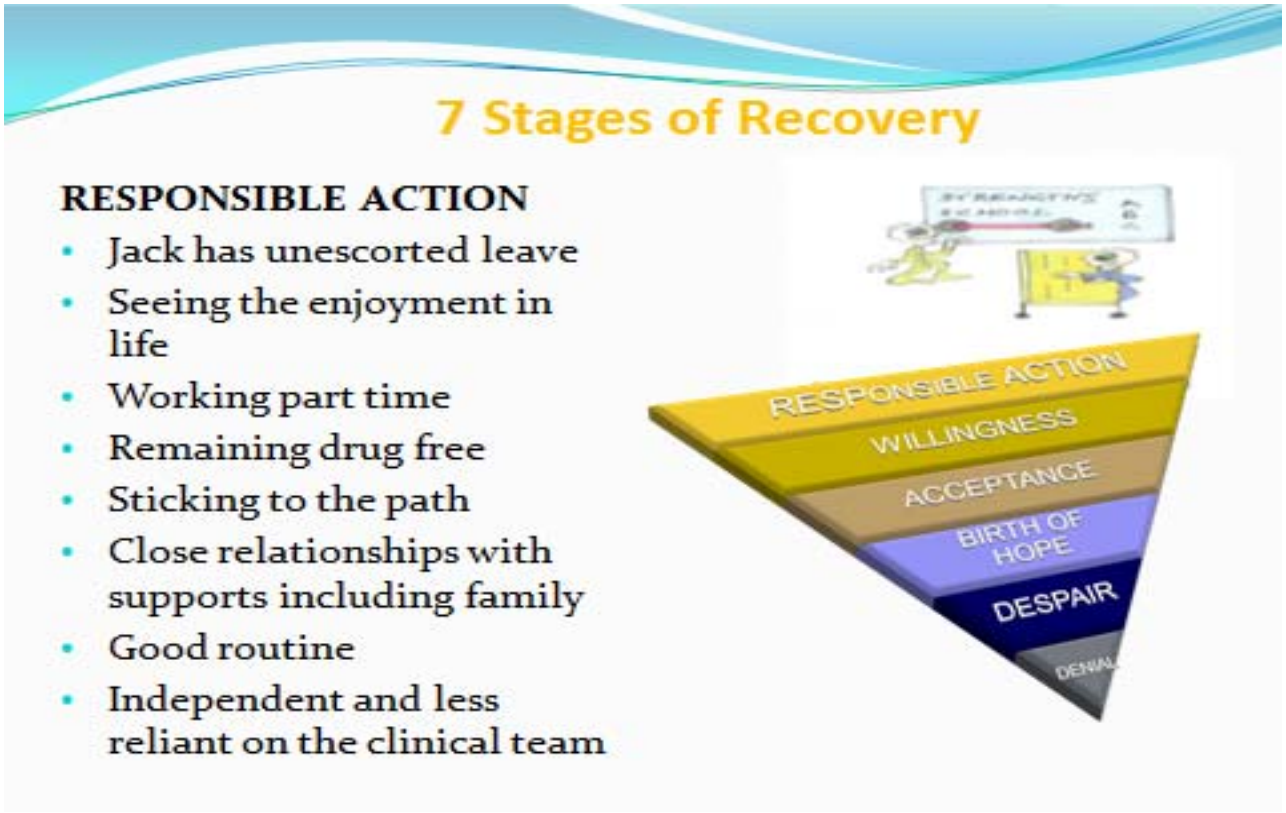
Jack was doing his structured day activities and found it overwhelming, plus his daughter fell ill, which added to his stress.

Jack feared elapse, early warning signs were noticed. He opened up to his primary nurse, who spoke to the doctor and his medication was altered. Having experienced these issues, he accepted his illness can be managed.



Willingness

Jack is learning how to handle stress better, allowing him to engage in his treatment. Plus he is involved in several TAFE courses within T.E.H, of which Trades and Tech he is most fond of, and this rekindles his love of carpentry. Jack wants to be part of the community again. He puts effort into regaining employment and staying on track. He is working with the psychologist weekly on offence issues and trauma. Jack is doing everything in his power to stay well.

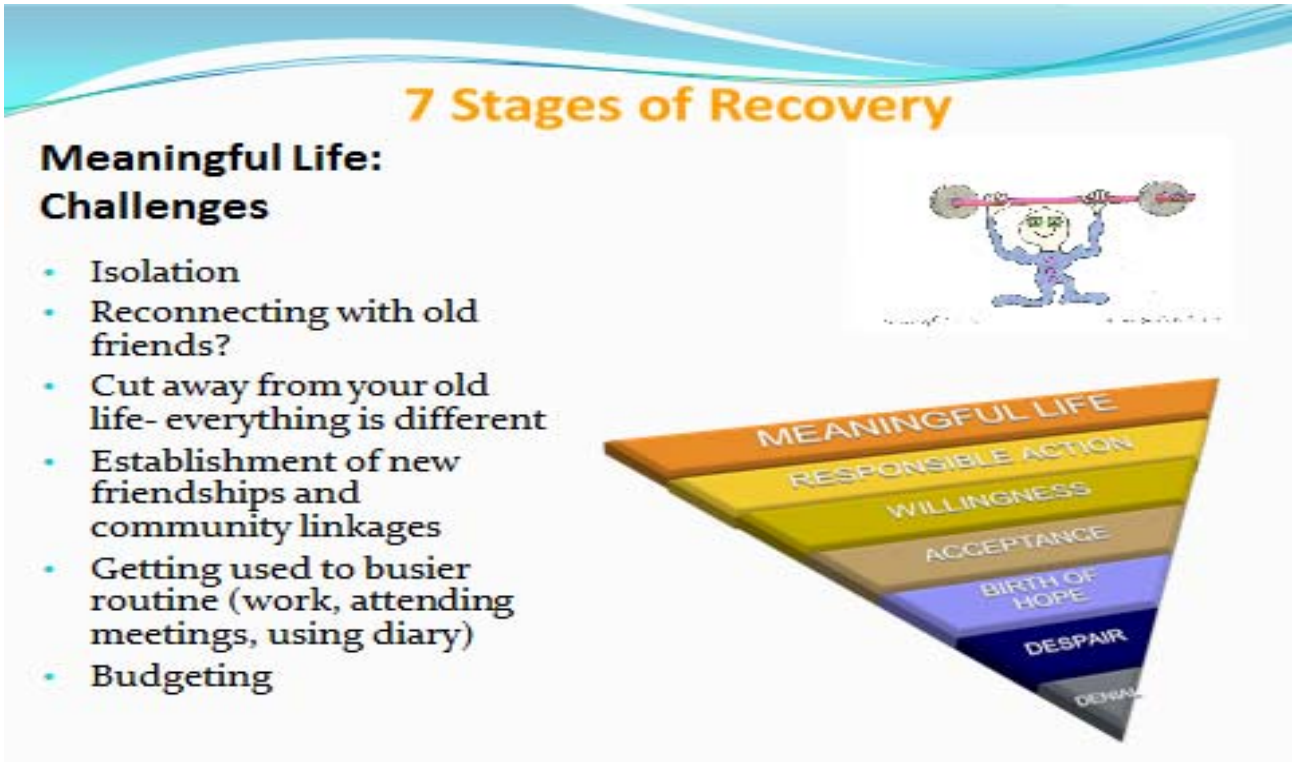


Responsible Action

At this stage of his recovering, Jack has insight into his illness he has a desire to remain drug free as he knows drugs contributed to his illness. He now is positive about his future.

He is also seeking part-time work in carpenter but is working with his O.T so as not to overload himself.

Jack's family is happy with his progress and enjoy accompanied leave with Jack. It's a good that he can get away for a few hours without having to worry about staff attending. He also has external groups such as NEAMI and Sprouts which gets him involved in gardening.

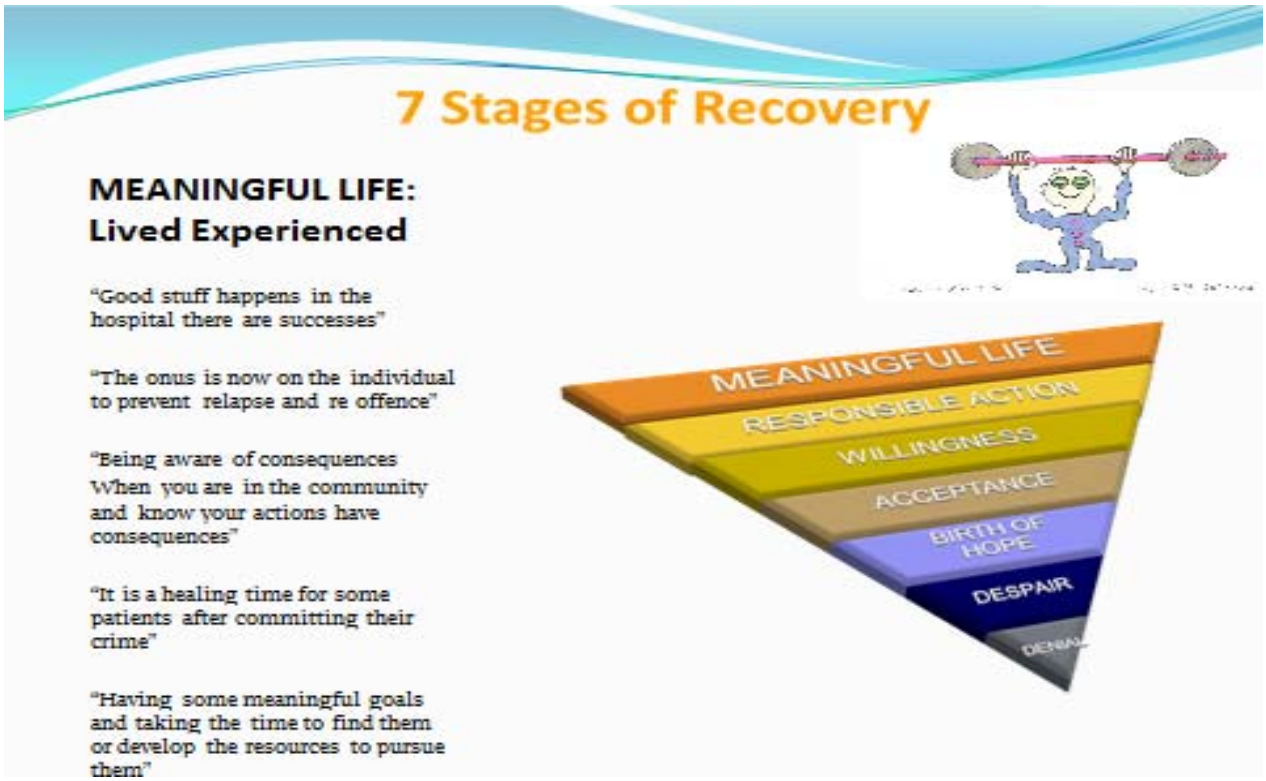


<u>Meaningful life- The negatives;</u>

Jack has now left the hospital and resides in a private rental. At first Jack struggled with isolation and not socialising with a lot of people on a day to day basis. Jack now has to manage his appointments and medication on his own. He finds it difficult using up his time as now there is a lot less structured activities. Because of Jack busy schedule of appointments, he can only work part time. During his recovery, Jack has moved up and down the pyramid but has needed all stages to get where he is now.

Meaningful life -The positives;

Jack is on the right medication and the right dose for a good amount of time now. He's relationship with his family has strengthened. He takes his daughter shopping weekly. Jack has found peace in his new sense of freedom; he is active and enjoys even simple things like walking along the beach. Jack's attitude has changed. Jack has new-found respect for his life and life itself.



<u>Meaningful life - The lived experience</u>

We got the following quotes by interview past patients who are now living in the community.

- "Good stuff happens in the hospital, there are successes"
- "The onus is now on the individual to prevent relapse and re-offend"
- "Being aware of consequences when you're in the community and knowing your actions have consequences"
- "It is a healing time for some patients after committing their crime."
- "Having some meaning goals and taking the time to find or develop the resources to peruse them."

Summary

- The Recovery Pyramid is a simple tool that was created by us, a group of patients who have lived experience of treatment in a high secure psychiatric hospital.
- It is a useful tool to instil hope
- It has helped us make sense of our journey towards recovery.
- Jacks story, whilst fictitious will sound familiar to many.

Where to:

We hope that now you've learnt about the pyramid you'll use it in your sessions to think about where you are at and what you need to do to get where you want to be....

"Meaningful Life"