Hi
I have had involvement as a forensic psychiatrist in all aspects of the application of the Crimes(MIUT) Act from provision of expert psychiatric opinions on determinations of MI and Fitness through to applications for extended leave and transfer from CSO to NCSO. I have also been involved in the management of those placed directly on NCSO. I have also presented at Forensic Leave Panels on patient leave applications as the treating psychiatrist.
I was also one of a panel involving [redacted] that presented 'The FLP - is it fit for purpose?' at the Vic branch conference of the Forensic Section of the [redacted]; I was presenting the perspective of the treating psychiatrist.

I wish to provide the following views for consideration by the VLRC.

1) The move from Governor's Pleasure to CSO under the Crimes (MIUT) Act does not appear to have facilitated a more responsive and individualised approach to rehabilitation and granting of community tenure.

2) The judiciary process seems just as reluctant to accept the risk of things going awry as existed previously under a more overtly political system.

3) The FLP acts as a cumbersome and not entirely impartial decision making body that imposes micro-management (often with no good evidence) and rarely faces proper scrutiny of its decisions from patient legal representation. As a result patients and treating teams, rather than feeling that their efforts are driving the rehabilitative process, more often feel that they are having to go through a one size fits all (and a rather onerous and hyper vigilant one) management style. The end result is that treating teams and patients on CSO can be left feeling disempowered and that custodial thinking remains the primary driver of decisions.

4) Added to the above two points, the FLP is a panel in name only and the judicial member holds court with the others largely remaining in submissive roles. The vagaries of the judge member determine decisions in a way that further creates a sense of 'pot luck' to patients and treating teams. The Judge often makes ad hoc and personally biased decisions that show either little regard for the patient and treating team perspectives and/or little appreciation of the clinical evidence around rehabilitation and risk management.

5) In keeping with the last point, it is hard to avoid the view that there is a time tariff that must be served irrespective of the risk to the community as penance over and above the need for rehabilitation.

6) The FLP makes decisions that are not about serious endangerment but that ANY potential risk is unacceptable. That the end point of such risk will inevitably be catastrophic despite lack of real evidence to justify such a disproportionate response.

7) That once on a CSO, any risk irrespective of its relationship to the index offence or condition for which mental impairment was found is deemed to justify ongoing incarceration. This appears to place such individuals in the invidious position of being doubly damned and detained on unjustifiable grounds (possibly in breach of their human rights)

8) In a review I conducted regarding decisional processes for similar patients in NSW, Queensland and South Australia, none had such a stringent overview and decisional influence over the clinical process of rehabilitation as practiced by the FLP.

9) The current approach may paradoxically have the effect of increasing risk by creating a sense of 'nothing to lose' or 'may as well be hund for a sheep as a lamb' mentality in patients i.e. if they think there is little hope of reasonable decisions or that they will be harshly punished if they say or do anything out of step.

At a time when law and order is a priority for the state government and the Parole Board is facing a backlash over decisions that have ended in bad outcomes, I do not anticipate that the current socio-political climate is one in which any lessening of judicial oversight will occur. Nevertheless, as a treating psychiatrist and an advocate for the patients on CSO, it is my view that the influence through the FLP of judicial thinking is excessive on rehabilitation. The FLP should be able to allow the treating team greater leeway to make responsive and individualised decisions on month by month management and give a supporting role by adopting a helicopter annual view and assisting the treating team when there is conflict between them and the patient over planned leave decisions. I firmly believe that there will be no risk of increased serious adverse outcomes and therapeutic endeavours will come to the fore to provide the more individualised approach that will mean those who can will be able to return to the community earlier, thereby minimising or negating the dual impact of institutionalisation and custodialism.

Regards
Gunvant Patel

FLP – IS IT FIT FOR PURPOSE?

The Perspective of a Treating Psychiatrist

Gunvant Patel

[redacted]

FLP – Is It Fit for Purpose?

'Professions are a conspiracy against the public'

G B Shaw

Most patients make applications that fit into the expectations of the current systems attitudes and practices. This is not necessarily always in their best interests but without legal advocacy they are none the wiser. Therefore most of the time the system 'works'.

FLP – Is It Fit for Purpose?

Vincent Review led to two stage process for approval of treating team's recommendations.

Leave Review Committee – internal review with no terms of reference or clarity around membership. No fixed no. of members required and restricted to psychiatrists and unit managers. Chaired by the ACD (In-Patient &Prison Services)

FLP – Is It Fit for Purpose?

Over time the internal review (Leave Review Committee) which makes formal recommendations to the FLP regarding the application has gained increasing authority in the eyes of the FLP.

FLP has rarely over-ridden the LRC's view even if it is not congruent with that of the treating team ("The FLP is not going to approve this application without the support of the LRC")

FLP – Is It Fit for Purpose?

Treating team is disempowered through a committee that that makes a consensus statement based on no current direct knowledge of the FP and often with retrospective biases based on prior contact with the FP ("I remember how he was X years ago, he was very challenging")

As a result the downwards pressure on the FP and treating team results over time in a sense of resignation and rigid institutionalised responses rather than feeling engaged in a dynamic process- stifles creative problem solving.

FLP – Is It Fit for Purpose?

Lack of any standardisation of decision-making – *Marked variability in attitude and style of the FLP chair to both rehabilitation and risk management.*

Any risk-taking/deviation equated with serious endangerment – *taking THC on leave, watching a violent movie on leave etc – no allowance for therapeutic risk-taking as means of open engagement between the treating team and the FP*

[redacted]

FLP – Is It Fit for Purpose?

Risk *of* absconding conflated with risks *from* absconding – *tendency is to see any risk of absconding as high and attached risks from absconding as also high. Rates of absconding have not varied pre- and post-LRC and not led to serious adverse outcome.*

Time-tariff mindset – *minimum periods at specific stage of recovery independent of FP's particulars seen as necessary to build trust with FLP.*

[redacted]

FLP – Is It Fit for Purpose?

Micro-management of leaves with a focus on taking prescribed steps –*'one size fits all'*

Setting of FLP – *court-like and not conducive to relaxing the FP or treating psychiatrist;*

Time –pressure – *hearings every 15 mins create little sense of having full opportunity to present one's viewpoint. Also gets focused on specific leaves rather than a broad overview of the plan over the next six-twelve months.*

FLP – Is It Fit for Purpose?

Lack of representation of treating team's multidisciplinary perspective – *results in psychiatrist attempting to respond to questions that are best answered by other team members. Often comes across as unsure or vague that gives misleading impression of the team's appreciation and decisional thinking regarding leaves.*

FLP – Is It Fit for Purpose?

HENCE

Much braking in evidence with little acceleration being applied resulting in a regimented unresponsive standardised framework that has led to no change in lengths of detention since the Crimes Act 1997 came into force (Ruffles, PhD thesis)

THE FUTURE…

[redacted]

FLP – Is It Fit for Purpose?

RECOVERY !

What good will it be for a man if he gains the whole world ***(acceptance, status)****, yet forfeits his soul* ***(identity, meaning, purpose)****?*

Matthew 16:26

FLP – Is It Fit for Purpose?

This approach emanates from a consumer advocacy movement that distinguishes between *clinical recovery* and *personal recovery*.

Clinical Recovery	Personal Recovery
It is an outcome/state – often dichotomous	**Hope** - future oriented personal goals
Observable – 'non-subjective'	**Identity**- unique characteristics by which we connect
Expert rated not patient rated	**Meaning** – integrating narrative of mental illness experience into identity
Definition is invariant across individuals	**Responsibility** – values, thoughts, feelings and behaviours that lead to engagement in life

Slade M, Personal Recovery and Mental Illness

FLP – Is It Fit for Purpose?

Risk Management & Recovery

Immediate risk management – Physical > Relational

BUT

Future Risk Management e.g on leaves – Relational >> Physical

THEREFORE

Personal Recovery better than Clinical Recovery for informing practice around leaves

FLP – Is It Fit for Purpose?

Points for Discussion

- Consumer representation – FLP/LRC
- Multidisciplinary perspective?
- More in-depth review by FLP of overall leave plan over six-twelve months vs. 'here & now' focus – *empowerment of treating team*