[redacted] Graeme Hoy
[redacted]

Ms Penny Armytage
Chair
Royal Commission into Mental Health
As addressed

Dear Ms Armytage,

Please find attached my submission as a prisoner, with over **eight years' experience incarcerated by Corrections Victoria**, and in total some **ten years of experience in the criminal justice system in total**.

As I trust is shown in the submission's supporting evidence, in my experience, all lawyers, judges and managers of Corrections Victoria have displayed varying levels of disparagement, ignorance and outright repression of issues of mental health in my past that have had deleterious effects on my adult life.

I mention particularly, regarding my pre-custodial experience of the criminal justice system, the matter of **sexual abuse as a child**, and the concomitant psychological dysfunctionality of much of my adult life. This dysfunctionality was diagnosed and characterised for the first time in my life by a forensic criminal psychologist, Mr David Ball, in his assessment for the court for sentencing in March 2011. One of my lawyers at the time, working for [redacted] I succeeded only after another two years (and two years after sentencing, too, I must add) in prising it free of Galbally & O'Bryan, and it was a revelation, which I should have seen not only before the court saw it (*because I might never have pleaded guilty to an offence which I did not commit*), but also *for my own well-being*.

That report is the central item dealt with in the submission. I trust its inclusion and my comments around it demonstrate how far the law has yet to come in dealing properly with mental health issues when it succumbs to a media-fuelled kangaroo court mode, as it was in my case back in 2008-2011, and when lawyers and judges lack training, insight or even basic empathy, concerning mental health.

The second issue dealt with is the diagnosis and treatment of **Bowel Cancer in the prison environment**, particularly the neglect of, and indeed antipathy toward, the issue of mental health which arises for people diagnosed with a deadly cancer. In my case, I did not know for several days whether I had any chance of surviving, but, in the case of prisoners in Victoria, once hospitalised for assessment and testing, they *are not permitted to have access to their family, even by telephone, leave alone any kind of personal or clinical psychological support.*

This attitude continues into the prison environment (again as described in the submission) once treatment continues (and the attitude continues to this day, some two years later) where you are told by senior management that you 'are subject to a term of imprisonment' and therefore everything has to be done with the 'good order and governance' of the prison uppermost in prison operations, and not the special needs of any individual *in the most extreme health circumstances imaginable*.

Every time a news or other item relevant to psychological distress or mental health appears on TV while in prison, and the *Lifeline* and *Beyondblue* contact numbers come up, those of us prisoners who may be affected by the item ask ourselves, **'Who do *we* call?'** Especially when locked down at night.

Thus I trust you can see that my submission relates particularly to the following Terms of Reference:

- Item 2.1 (best practice treatment and care models that are safe and *person-centred*') - the lack of this latter aspect, that of 'person-centred' care, has created intense and harmful interaction within the prison system, where persons are subject to a so-called 'term of imprisonment', deviation from which is impossible, or will result in effective secondary punishment if it requires that the 'system' adjust to the needs of the person;
- Item 2.3 (strengthened pathway and interfaces between Victoria's mental health system and other services);
- Item 4.2 (How to improve mental health outcomes … for … people … living with mental illness …) and
- Item 4.4 (How to improve mental health outcomes … for … people … in contact … with the forensic mental health system and the justice system)

It is relevant also to Recommendations under paragraphs:

- (e) concerning 'older Victorians', 'victims of crime' and 'adults … in custody';
- (f) 'the need to address stigma associated with mental illness including problems of knowledge, attitude and behaviours towards people living with mental illness' – *I would add particularly regarding training and education for the legal profession and judiciary;*
- (h) existing legislative and regulatory frameworks and 'any associated reforms you consider necessary or desirable …'
- (i) any cross-jurisdictional matters that you consider would streamline the provision of mental health treatment or services …'

I hope the submission and its evidence is of assistance to your valuable and timely inquiry.

Yours sincerely,

Graeme Hoy

PS The attached documents are my only copies now. Could they be returned to me? 2 Prisons do not permit photocopying for prisoners. For copies of these

Your contribution

Should you wish to make a formal submission, please consider the questions below, noting that you do not have to respond to all of the questions, instead you may choose to respond to only some of them.

1. What are your suggestions to improve the Victorian community's understanding of mental illness and reduce stigma and discrimination?

See attached submission, especially Part 2

2. 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?

As above

3. What is already working well and what can be done better to prevent suicide?

N/A – but attached documents & submission are relevant to the issue of dealing properly with depression.

4. 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.

Prison is an enormous barrier to good mental health, and in fact exacerbates poor mental health. In 2011, the Ombudsman found that 40% + of prisoners had mental health issues. There are far too few resources in prison/justice system to address this. Prisoners with mental health issues, untreated, simply re-offend.

5. What are the drivers behind some communities in Victoria experiencing poorer mental health outcomes and what needs to be done to address this?

The justice system / media emphasis on punishment & retribution creates more crime by failing to address the causes of crime, of which mental illness is one of the most prevalent.

6. What are the needs of family members and carers and what can be done better to support them?

Access to psychological services

7. What can be done to attract, retain and better support the mental health workforce, including peer support workers?
Better pay; make the mental health workforce an attractive place to work – like advertising does currently for the Police.
8. 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?
See Submission Part 2
9. Thinking about what Victoria's mental health system should ideally look like, tell us what areas and reform ideas you would like the Royal Commission to prioritise for change?
See Submission Part 2

10. What can be done now to prepare for changes to Victoria's mental health system and support improvements to last?

11. Is there anything else you would like to share with the Royal Commission?
I believe the issues derive from the Kennett government's closure of many facilities in the 1990's and the subsequent drastic reduction in spending by successive governments on mental health. I have experienced in prison close contact with many people who are suffering serious mental health issues, but for whom prison becomes the result of inadequate identification and treatment by society of mental health issues.

Privacy acknowledgement	I understand that the Royal Commission works with the assistance of its advisers and service providers. I agree that personal information about me and provided by me will be handled as described on the Privacy Page. ☑ Yes ☐ No

Graeme Hoy
[redacted]

May ~~April~~ 2018

Ms Penny Armytage
Chair
Royal Commission into Mental Health
As addressed

Dear Ms Armytage,

This submission comprises two parts, the first covering the provision of personal experience relevant to items in the Terms of Reference, the second asking questions as to how these experiences might open up further and deeper considerations about the operation of the law, and of the agencies involved in administering it, to provide better mental health services to accused and incarcerated persons.

PART 1 – My experience of mental health as it has been dealt with and affected by the practice and effect of the law and legal practitioners, and the criminal justice system.

Of necessity, what follows is a list of experiences which spreads across all four of the identified items relevant to my experience; I have found it impossible to compartmentalise neatly a particular event as being relevant only to, say, Item 2.1, when it has relevance also to, say Item 4.4.

Therefore, the experiences listed are to be viewed as having relevance across one or more of the Terms of Reference, and I have taken a chronological approach in the narrative because that is the manner in which the depth and profound implications of my unrecognised and societally-deprecated mental health issues became aware to me, and my personal situation became more and more precarious, especially as I tried to get basic responsible consideration for it from, firstly, the criminal justice system, and secondly the Corrections system after I contracted Bowel Cancer in prison.

There is one basic fact about which the criminal justice system and I agree, although it is only that most basic of simple facts, one that the justice system has dismissed lightly, even disparagingly, because of its basic simplicity, as being of no relevance to the alleged offending behaviour in this case.

That fact is that I have suffered from depression for a long time. Unfortunately, my mental health is much more complicated than that, and has been for a long time as well, since I had not encountered a professional who interrogated my symptoms forensically and attempted to analyse what was at the bottom of them.

My attendance with many psychologists began in the 1980s, and continued in a period right through until the first decade of this century, a period when 'talking therapies' and then SSRIs became the principal treatment methods for what was then called 'depression'. I had not heard of the *Diagnostic and Statistical Manual* until after I had

been imprisoned in 2011, and I found in the 'library' at Melbourne Assessment Prison a copy of a book about Prozac by a New York psychopharmacologist, Dr Ronald Fieve.

This was a revelation. Remember, at this time [redacted] so I had no idea about the DSM criteria for diagnosis. **Straight away it was clear to me that I met the required number of criteria for bipolar II** – for cyclothymia in fact. This is elaborated in my summation of the impact of bipolar II on my alleged offending in Document 2.

It is important to note that the details of symptoms and diagnosis described in Document 2 were only available to me *after I had received (or rather, after I had finally been given 'permission' to receive) the Ball Report from Galbally's in 2013, and then conducted my own research into depression.* The Ball Report is Document 1.

It is also important to note that Document 2 had been tendered to the Court of Appeal as part of a late application for leave to appeal the conviction on the plea of guilty, but was nowhere referenced in the reasons for denial of the application in April 2016. The presiding judge, Justice Weinberg, dismissed the application because he could see no valid reason for its 'belated' nature. This was a most extraordinary statement. I was an unrepresented prisoner, had a clear psychological dysfunction (the critical parts of which his Honour ignored, and the issue of depression he simply belittled) and I had had no access to any of the tools for development of a legal case which lawyers have instant and unlimited access to.

This diagnosis in Document 2 helped my understanding of my predicament for some time, (although I could not get a diagnosis and treatment in prison without referring myself back to MAP, *where there was no guarantee that there would be any outcome that benefited me, since the psych. services at MAP were known by prisoners to be a precursor to being removed from the mainstream and/or classified to Thomas Embling Hospital* – called by one prisoner I met 'Thomas Assembly'!)

This last point, about perceptions of, and potentially treatment of, mental health in prison, is a major barrier even to the slightest recognition of mental illness, leave alone its proper treatment. The 'system's' interest is in avoiding trouble, conflict and any potential liability (or 'covering your arse'); any mental health issue is seen as a potential for drama, so the system goes into self-protection mode: isolation and 'flagging' of the prisoner, including records on the Prisoner Information Management System which can affect the granting of parole. *Prisoners have no access to, or specific input to, the PIMS when it comes to health matters.*

The Ball Forensic Psychological Report (Document 1)

In the application for leave to appeal conviction in 2016, Justice Weinberg, in dismissing the relevance of the fact that I had not seen the Ball report until 2013, *two years after the plea hearing*, told me that this report may have been withheld from me by my lawyers because they were concerned that I might have been 'upset' by what it disclosed.

This explanation lacks all credibility and integrity.

Evidence to be presented to a court on behalf of a defendant, by law, must have been agreed to by the defendant beforehand. In any case, *if its contents were so serious and potentially damaging to a person, ought not his/her solicitor to have organised an urgent meeting with a professional psychologist (and preferably the forensic psychologist concerned) to assist the person to deal with and integrate the serious and damaging information into a treatment plan and regime?*

From this basis, the whole application for leave to appeal descended into the second kangaroo court process I have had to endure from the Victorian criminal justice system, notwithstanding my clearly defined mental health issues.

The Ball report is highlighted at places particularly relevant to the Terms of Reference of this Commission, insofar as they concern the practice of the criminal law *and the obvious need for serious and substantial legislative and procedural change* to ensure that *proper attention and consideration is given to mental health issues* where they have been flagged by *psychological professionals*, and especially where those professionals are *forensic psychologists of significant standing with the criminal justice system.*

My submission is that this report ought to have raised serious concerns as to the probative value of a plea of guilty, as well as serious concerns for the well-being of someone who was about to be sentenced to a likely significant term of imprisonment, yet whose professional diagnosis revealed a highly dysfunctional personality, viz, scoring highly on scales of 'disclosure' and 'debasement', as well as exhibiting 'self-defeating behaviour' and satisfying the DSM IV criteria for dysthymic mood disorder.

It was a serious dereliction of duty to a client by solicitor [redacted] junior barrister Leighton Gwynne and Senior Counsel Peter Morrissey not to have brought these matters to the attention of the court and to have failed to argue their significance before the judge.

It was also a serious dereliction of duty to justice (and specifically to the judge's oath of office to deal with matters without fear or favour) for Justice Forrest to seek to minimise the impact of the depressive illness on the defendant by using its 'fluctuating chronicity' as a means of derogating its significance in the alleged offending.

Both with regard to the lawyers involved, and the judge (who is in any case a lawyer by training), clearly, I submit, additional training is required in the knowledge of psychology, its role in alleged offending and the weighting it should be given in considerations of legal representation and judicial decision-making.

The failings of justice in this matter, resulting from the inadequate consideration of mental health by the legal process, demonstrate the necessity for the justice system in Victoria to abandon the simple open outcry in court of a plea of guilty, in favour of a structured process of interrogation of a plea of guilty by a judge, in conjunction with the requisite psychological and other medical professionals. This may require legislative as well as procedural change.

The remaining Documents enclosed comprise submissions I made to the then Attorney-General Mr Martin Pakula, and the Corrections system, subsequent to my diagnosis of Bowel Cancer.

These documents reveal the desperation of my situation at times, and the obvious fact of unrelieved distress at the hands of both Mr Pakula and/or his office and of Corrections Victoria, which makes no provision for the mental health or well-being of prisoners who become physically ill. Indeed, the placement of seriously ill prisoners in the maximum security prison, Port Phillip, while undergoing treatment (and in my case for more than 12 months) is the most serious dereliction of the duty of care possible or imaginable by the state of Victoria.

The extreme and dangerous conditions imposed on ill prisoners by Port Phillip Prison are summarised in Documents 3 – 5, as is the impact on my mental condition of the severity of these circumstances. This impact was in addition to the impact of the diagnosis and treatment of the cancer, *which prisoners are forced to endure without recourse to any psychological or other support services apart from those strictly necessary medically.* Indeed, I requested psychological help at Port Phillip Prison early in 2017, and finally was given an appointment with a psychiatrist in August of that year, who advised that there was nothing he could do (because that was the way things were done in Corrections) other than increase my dosage of SSRIs.

Two further examples of the conditions and risks associated with Port Phillip Prison will assist in understanding how seriously derelict is the state of Victoria in its duty of care, not just in sending ill prisoners there, but in failing to provide a safe environment for any prisoner. On one occasion, while recovering in my cell from a chemo treatment, another prisoner entered the cell and 'brandished' his erect penis, offering to satisfy my desires if I would satisfy his. Given my background of sexual abuse, this was extremely distressing, but I managed to get this deranged prisoner to leave, pleading illness and weakness. With prison lore forbidding 'lagging', one cannot obtain assistance from the officers in such cases, and one has to manage as best as one can.

On another occasion, I was approached by a prisoner on my way from the accommodation unit, [redacted] to the [redacted], at a place between the two units, [redacted] and [redacted] where there is no security camera coverage, and asked to convey drugs to a person in [redacted] I refused, and was then threatened violently. Again, prison lore means one is on one's own in these circumstances. I was, all the time I was at Port Phillip, on the lowest security rating for prisoners, and ought to have been at a low security prison in transition and rehabilitation, well away from perverts and drug dealers. Yet Corrections Victoria apparently has a contract with [redacted] that requires ill prisoners on low security ratings to be housed with violent and perverted prisoners while undergoing treatment.

This is scandalous, and potentially criminally negligent on the part of the state of Victoria, as a regime of 'treatment' for prisoners who have serious physical or mental health conditions (or both, in my case).

PART 2 – Some implications for the law, and the criminal justice system, of my experience of how my mental health and condition had been dealt with since 2011, pursuant to Recommendations Items (e), (f), (h) and (j).

There are two overarching cultural and political factors which have led to my having been sentenced for such a record term for such offending, and then the resulting indifference, indeed hostility, exhibited by the criminal justice system to the needs of a person with particular mental health needs, both in the management of prisons and in the political process of the executive government in managing the criminal justice system.

They are:

1. The fact that, in cases, and potential cases, of high profile criminal charges in financial matters, the political interest of either or both of enforcement agencies and/or politicians/'the media' will be in *finding and apportioning blame, and not in administering justice.* Australia (and Victoria in particular) has a history of 'kangaroo' courts, where the result is based on what is *required*, and not on objective justice, and the *result* is often influenced by a lynch mob or prejudiced media publicity. Under these conditions, the true facts of alleged offending, and the personal circumstances of an accused, can be either or both of hard to see objectively, and/or deliberately ignored or downplayed in the interest of the required blame and retribution being achieved.
2. Once the *required result* has been achieved, and an accused has been imprisoned, the status of the accused as a convicted prisoner results in a greater degree of hardship and an exacerbation of any thus-far-ignored mental dysfunction. Apart from the prison system's potential (and actual, in this case) failures in the general duty of care, the very specific needs of prisoners with mental health needs that arise further from both imprisonment and the failures of the duty of care are ignored, because of the general attitude that a 'term of imprisonment' has been imposed, and will be carried out without exception, irrespective of the circumstances, *and any materially significant change in them*, of the prisoner. This has been demonstrated in **Part 1**, where neither appeals to Corrections Victoria about specific conditions and circumstances were addressed (such as, in particular, the notorious Vehicle Transfer of 3 February 2017 and its aftermath), nor was the reasonable Petition of Mercy (based on the severity of the illness and the horrendous realities it presented to mental well-being) *dealt with in any way other than the bland denial of the Petition.* In other words, the conviction is the conviction, and the sentence is the sentence, *no matter what.*

These overarching factors must be addressed and taken into account, both in the manner in which the *courts* deal with accused persons, and the manner in which the criminal justice system then deals with convicted persons based on their established mental health.

Note that, because of the narrowness of legal practitioners' training, and their susceptibility to being overwhelmed by the perceived public prejudice against an accused person, it is not enough for the courts to rely on the fact of legal representation alone in determining the probative value of a guilty plea, or indeed of the veracity of the mental state of any accuse person.

Instead, there must be a system for the *court* to establish the *bona fides* of the accused and the probative value of *any* plea. This should include forensic psychological assessment, which the judge will be *required* to take into account (particularly any recommendations as to continuing support and/or assessment of the accused). It is not sufficient for the content of any such report to become only the object of advocacy by counsel in a contest. It must be taken into account, and be *seen* to be taken into account, by verification of the court. As such, any forensic psychological report to a court must be specifically referenced in the reasons for judgement (although the report itself may remain confidential, except of course to the accused and their representatives).

Next, there must be established by law a *Criminal Cases Review Commission*, of the kind established already in the United Kingdom and South Australia, to replace totally the present Petition of Mercy process, and to hear cases (among other potential miscarriages of justice) where the mental health of a convicted person has not been properly taken onto account in the conviction and sentencing processes, and where there has been a material change in the health circumstances of the offender, which could not have been foreseen at the time of sentencing, but which, had it been known at that time, might have affected the length and/or circumstances of incarceration.

This Commission would be staffed by legally and psychologically qualified *and experienced* practitioners; not as a part of the Supreme Court or its Court of Appeal, but with the power to modify the effect of sentences, such as in granting pardons or remissions, which are presently the province only of the executive government. Because of this power, the Commission must be independent of the Supreme Court and the Court of Appeal, as well as the executive government – much like the DPP is supposed to be - and should publish to applicants and the relevant lower court(s) the reasons for its decisions.

The Executive government, being a political entity, is subject to making legal decisions on a political basis, which is hazardous to the safety and soundness of legal decisions, and is also subversive of democracy and has great potential to subjugate basic and essential human rights to executive whim or imperative. Presently, the executive can make decisions about convictions and sentences without giving reasons, and therefore there can be no assurance that these decisions have been made on correct and proper grounds, rather than purely political ones.

There is a third overarching cultural and political factor at work in the criminal justice system, and that is the flawed concept of the so-called 'finality of justice'.

This principle holds that there 'cannot' be a never-ending round of appeals and re-considerations of matters.

But why not, if *legitimate matters of law and objective fact* have been *overlooked* and/or proven to have become *superseded or obsolete*? If Lindy and Michael Chamberlain had accepted and observed this false doctrine of 'finality', then Michael would have died in jail, and Lindy *would still be there*.

Anything which raises legitimate doubt as the *proof beyond reasonable doubt* as to guilt on all the elements of an offence, *at any time*, must be permitted to have an impact on the previous standing of any conviction. All convictions must always, and at all times, be safe and sound. Likewise, anything which becomes apparent as to the circumstances of the offender, and which has not been considered previously in sentencing, must create a review of the sentence.

Neither the overturning of a false conviction, nor the review of a flawed sentence, will result in the collapse of the justice system nor its being brought into disrepute. Rather, such a process will enhance the operation of true justice and provide confidence to citizens that justice will be served at all times and in all cases.

Finally, concerning Recommendations (e), (f), (h) and (i), it is obvious from the enclosed Documents 3 - 5 that there are serious shortcomings, if not criminal neglect, in the management of people with mental health conditions in the Corrections system – as there are as well with the management of people with serious physical health conditions, especially from the acute mental trauma which then rises from diagnoses and treatment of illnesses such as cancer, *and for which no psychological support or assistance is provided* by Corrections, which operates purely on the principle that one is subjected to a 'term of imprisonment', from which there will be no deviation – and which will result in secondary punishment, in effect, because the system will make a square peg fit into around hole *no matter what*.

Corrections Victoria needs to develop completely different policies, procedures and protocols for dealing with these issues. Many more psychologists and health professionals will be needed, as well as an adaptation of the culture and management of Corrections to take account of individual difference and circumstance in the assessment and treatment of prisoners with physical and mental health conditions.

Presently, Corrections operates in the same culture as the judiciary and the entire criminal justice system (and the parliament itself, which makes deficient laws in the first place): it is dominated by an erroneous and out-dated belief that the slightest concession to the strict operation of a 'term of imprisonment', to deviate from a 'one-size-fits-all' approach, will cause the collapse of social order and cohesion, and make administration of the system impossible.

I submit that, *with a recidivism rate in excess of 40%,* Corrections is hardly in apposition to point to the efficacy or efficiency of the ways in which it presently operates. **Any organisation whose failure rate is more than 40% is, and ought to be seen as, an organisation whose every policy and procedure of operation must be subjected to rigorous analysis to determine the causes of, and remedies for, such a catastrophic dysfunctionality.**

At the latest count of which I am certain, that of the Ombudsman's Report into Prisons in 2011, it was confirmed back then that more than 40% of the male prison population

had a mental illness. That was when the prison population was around 5,000. Now, with nearly 8,000, and probably a larger proportion of drug and alcohol affected prisoners, the percentage may be higher.

I suspect that the failure to assess and deal with properly the mental health issues of prisoners is a large part of the cause of the high rate of recidivism. I suspect, as well, that the serious neglect of mental health services by government, over many years now, is among the most significant factors in the dramatic rise in the rate of incarceration in Victoria.

Quite simply, with the de-institutionalisation of mental health services since the 1990s, and the subsequent down-grading of mental health as an issue since then, there are now insufficient services in the community, and inadequate knowledge of those that exist, and how to access them, for people with mental health issues. **As a result, many people with psychological dysfunctionality become imprisoned, and then become enmeshed in the tyranny of the criminal justice system, from which there is no escape for people with dysfunctionality.**

I know this; I am living proof that, no matter your intelligence or cognitive ability, without psychological insight and a functioning personality, you will find your way to prison, and then you will never be free of the reach of the criminal justice system, since you will always be tainted and stigmatised, and become the first suspect when anything goes wrong with whatever you are involved in.

This Royal Commission needs to take dramatic and practical steps to end this socially destructive cycle. This will take years of determined and forced change.

In conclusion, I also enclose at Document 6 [redacted]

While I can accept that the government (or more particularly the Attorney General) has a very large agenda at present, nevertheless the government itself, in appointing this Commission, recognises the critical importance of mental health as an issue for society and its institutions. **Perhaps the government (and particularly the Attorney) needs to take a closer look at its own dysfunctionality as a major contributor to the scourge of mental illness in society.** There is, in my experience of the bureaucracy in Corrections and the Attorney's office, endless procrastination and evasion and denial of responsibility for misjudgements, errors of policy and administration, and simple, plain ignorance.

Such attitudes and practices of the government, its agencies and its public servants undermine, at every juncture, the professed determination of the government to do something effective about the prevalence of mental health issues in society. I include Document 6 because it gives a strong flavour of the prejudice against, and ignorance of, the importance of mental health, at the highest and most experienced levels of the judiciary, the bureaucracy and legal practitioners.

APPENDIX TWO

Diagnostic criteria for Dysthymic Disorder

A. Depressed mood for most of the day, for more days than not, as indicated either by subjective account or observation by others, for at least 2 years.

B. Presence, while depressed, of two (or more) of the following:

(1) Poor appetite or overeating
(2) Insomnia or hypersomnia
(3) Low energy or fatigue
(4) Low self-esteem
(5) Poor concentration or difficulty making decisions
(6) Feelings of hopelessness

C. During the 2-year period of the disturbance, the person has never been without the symptoms of Criteria A and B for more than 2 months at a time.

D. No Major Depressive Episode has been present during the first 2 years of the disturbance.

E. There has never been a Manic Episode, a Mixed Episode, or a Hypomanic Episode, and criteria have never been met for Cyclothymic Disorder.

F. The disturbance does not occur exclusively during the course of a chronic Psychotic Disorder, such as Schizophrenia or Delusional Disorder.

G. The symptoms are not due to the direct physiological effects of a substance or a general medical condition.

H. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

FOR THE ROYAL COMMISSION INTO MENTAL HEALTH – this is now DOCUMENT 2

EXHIBIT 3

EXTRACTS AND SUMMARY FROM *DSM IV* AND OTHER PUBLISHED SOURCES ON THE MENTAL CONDITION OF BIPOLAR II, TOGETHER WITH REFERENCE TO THE CIRCUMSTANCES OF BOTH THE ALLEGED OFFENDER AND THE ALLEGED OFFENDING IN THIS MATTER

Reference to matters and symptoms which affected the appellant prior to, at the time of, and subsequent to the offending, are marked by text in italics, together with any additional clarification required by way of parenthetic [] remarks.

Hypomanic episodes

Hypomania is characterised by *euphoria and/or an irritable mood.* Symptoms of mania and hypomania are similar, though mania is more severe and may precipitate psychosis. Commonly, *depressive episodes are more frequent and more intense than hypomanic episodes.* Of all individuals *initially diagnosed with major depressive disorder [*as was the appellant in 1990], between 40% and 50% *will later be diagnosed* with either bipolar I or bipolar II. *Substance abuse disorders* (which have high comorbidity with BP-II) and periods of mixed depression *may also make it more difficult to accurately identify BP-II. Anti-depressant use, in the absence of mood stabilisers, is correlated with worsening BP-II symptoms.* Concurrent use of SSRI antidepressants may help some with BP-II, *although these medications should be used with caution because they may cause a hypomanic switch.*

It is important to distinguish between mania and hypomania. Mania is generally greater in severity and impairs function, sometimes leading to hospitalisation. *In contrast, hypomania usually increases functioning. For this reason, it is not uncommon for hypomania to go unnoticed. Often it is not until individuals are in a depressive episode that they seek treatment, and even then their history of hypomania may go undiagnosed. Even though hypomania may increase functioning, episodes need to be treated because they may precipitate a depressive episode.*

The presence of *three or more* of the following symptoms indicates the presence of BP-II. [The appellant presents *five*, as indicated]

- Inflated self-esteem or grandiosity [*very prevalent in the appellant, and obvious in much of the alleged offending behaviour which was assumed to have been criminal in nature*]
- Decreased need for sleep
- More talkative than usual or pressure to keep talking [*the appellant was extremely enthusiastic, voluble and persuasive in speaking with investors,* or what Justice Forrest referred to as 'blandishments' and 'inducements']
- Flight of ideas or subjective experience that thoughts are racing [*the appellant's belief that there was always some way, or combination of ways, that the business could prosper, and it was only necessary to move fast and with intensity*]
- Distractability
- Increase in goal-directed activity [*what Justice Forrest described as 'relentless' pursuit of new investors*]
- Excessive involvement in activities that have a high potential for painful consequences, such as engaging in *unrestrained buying sprees* ['lavish lifestyle'], sexual indiscretions or *foolish business investments*

Diagnosis

The presence of *three or more* of the above symptoms confirms a diagnosis of BP-II, Although BP-II is thought to be less severe than BP-I in regards to symptom intensity, *it is usually more severe and distressing with respect to episode frequency and overall course.* [The period 2002-2008 in the appellant's mental health history, represents a culminating series of episodes of hypomania, consequent upon previous misdiagnoses and misprescriptions of SSRI ant-depressants without mood stabilisation. The subsequent 'crash' of 2008 was misdiagnosed by at least one psychologist, and mischaracterised by Justice Forrest, as a merely reactive condition, of 'fluctuating chronicity', brought about by the circumstances of the collapse of the business, which, because it was caused by so-called criminal motivation and action, was brought about by the alleged offender's own criminal behaviour having failed, rather than by any real pre-existing condition. This was a

serious, if understandable, misdescription of the reality of the circumstances of both the alleged offender and the alleged offending.]

The deficits in functioning associated with BP-II disorder stem mostly from the *recurrent depression* that BP-II patients suffer from. Depressive symptoms are much more disabling than hypomanic symptoms and are potentially as, or more disabling than mania symptoms. Functional impairment has been shown to be directly linked with increasing percentages of depressive symptoms, and because *sub-syndromal symptoms are more common – and frequent – in BP-II disorder, they have been implicated heavily as a major cause of psychosocial disability. There is evidence that shows the mild depressive symptoms, or even sub-syndromal symptoms, are responsible for the non-recovery of social functioning, which furthers the idea that residual depressive symptoms are detrimental for functional recovery in patients being treated for BP-II. It has been suggested that symptom interference in relation to social and interpersonal relationships in BP-II disorder is worse than symptom interference in other chronic medical illnesses such as cancer. This social impairment can last for years, even after treatment has resulted in a resolution of mood symptoms.* [The appellant has relapsed often (since 2006) into a catatonic or near catatonic state, especially in 2010-2011 under the stress of court proceedings. While in the dock especially, but also in the early stages of imprisonment, he experienced dissociation and inability to process or respond adequately to what was happening around him. This in part explains what Ball described as 'psychologically unsophisticated' and 'lacks insight into the general functioning of his personality'. The lay observer might describe it as 'being like a rabbit caught in the spotlight'.]

The factors related to this persistent social impairment are *residual depressive symptoms, limited illness insight* (a very common occurrence in patients with BP-II disorder), and *impaired executive functioning.* Impaired executive functioning is directly tied to poor psychosocial functioning, a common side effect in patients with BP-II. This in turn leads to poor semantic memory, *which dysfunction can manipulate thoughts and lead to the formation of delusions, and then to serious interpersonal issues.* [The appellant's irritable and intemperate outbursts in 2001-2 led to the break-up of his marriage. Combine all this with lack of 'psychological sophistication' and 'insight into the general functioning of his personality', and one can understand how one could be persuaded to plead guilty when one did not

understand how one *could* be guilty of fraud – other failings perhaps, but not that - when one had never *intended* that people should lose their money.]

BP-II is *very recurrent* and results in *severe disabilities, interpersonal relationship problems, barriers to academic, financial and vocational goals, and loss of standing in the community.* [The appellant described many such events in his book, *'J'accuse'*, which events he can now see were the result of his dysfunctional upbringing (as identified by Ball), *combined* with BP-II.]

Treatment

The tendency of BP-II to be misdiagnosed and treated ineffectively, or not at all in some cases, also leads to increased risk of suicide.

[The appellant experienced bouts of 'cycling' in prison in the period up to about the end of 2013, until he had persuaded medical staff in the prison that his depressive condition was worsening, and he was then prescribed an increase in his SSRI (fluoxetene) dosage to 40mg per day. Fortunately, by about this time he had been referred further material from outside the prison on depression and hypomania, and was able to institute non-pharmaceutical self-administered therapies which helped, including cognitive behavioural therapy (CBT), psychodynamic therapy, mindfulness, music therapy and a fitness regime – although the latter's release of endorphins sometimes led to sub-syndromal symptoms of hypomania, which fortunately was quickly controlled with CBT and mindfulness.]

The prison environment is the worst possible environment for a BP-II sufferer, since he doesn't present as 'seriously ill', and with the prison's focus on punishment and control, rather than care and attention, this petitioner would have been in an acute situation but for his above-average intellectual capacity to understand and manage his condition, and to stabilise – at least outwardly – his interpersonal and social interactions.

this year.) JLTC staff would not have to do anything special or different to accommodate me.

In short, JLTC would be fulfilling its function, in catering for prisoners with special transition needs; it's just that my transition has even greater special needs, in that, in the absence of 'freedom' / parole, my integration into the community can commence while I have some life left — which may not be the case by the time I got to the 'normal' JLTC time of my sentence (i.e., 2019).

Now, I know you've mentioned to me previously that a 'mentor' role is not something that was needed in January but, even if it's not needed now, I have always been of help to other prisoners 'unofficially', in calming them down, helping them to devise other ways of getting results for themselves, and encouraging the fight against recidivism.

Of course, should I lose my fight against this tumour, or others that may arise, then at that stage I have no doubt a post petition for mercy would be granted, as was the case with James Kavanagh earlier this year, who may even have passed away by now.

Yours sincerely,