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PSYCHIATRIC REPORT

1988

REPORT
OF THE
COMMITTEE OF INQUIRY
INTO PROCEDURES USED IN
CERTAIN PSYCHIATRIC HOSPITALS
IN RELATION TO ADMISSION,
DISCHARGE OR
RELEASE ON LEAVE
OF CERTAIN CLASSES
OF PATIENTS

083737

AUGUST 1988

Ki Te Honore David Caygill
Minita Ote Ora
Whare Paremata
PONEKE

E Tama

TENA RA KOE I RARO I NGA MANAAKITANGA A TE ATUA.

Anei ra ta matau ripoata i whakahau tia ai matau e koe kite kimi rongoa mote hunga mate wairangi. Tae atu hoki kinga whaka whiu ia ratau iroto inga whare here here.

Kote ripoata e whai ake nei nga matau i tatari iroto inga korero a nga iwi katoa o Aotearoa. I tae mai kite whaka takoto ia ratou korero ki mua i a matau.

Ko ta matau tumanako ka whaka tutuki tia e koe a matau tohutohu e whai ake nei.

Te Kai Hautu:



Mema:



Mema:



The Honourable David Caygill
Minister of Health
Parliament Buildings
WELLINGTON

Dear Minister

Abide with the Grace of God.

We submit for your perusal our report and the heralding light of the new dawn in the world of psychiatric care.

The enclosed report is the result of your request to us to produce for you our opinions on aspects of psychiatric care and treatment in prisons, hospitals and in the community.

It is imperative that the wishes of the people of Aotearoa/New Zealand be fulfilled. Your role now Minister; to address and implement the issues raised herein as you see fit. We offer you our sincere greetings for you to act as Captain to guide our people into a new era of psychiatric care.

**THE COMMITTEE OF INQUIRY INTO PROCEDURES USED IN
CERTAIN PSYCHIATRIC HOSPITALS IN RELATION TO ADMISSION,
DISCHARGE OR RELEASE ON LEAVE
OF CERTAIN CLASSES OF PATIENTS**

CHAIRMAN: Kenneth Hector Mason,
District Court Judge

MEMBERS: Allison Bernice Ryan,
Medical Practitioner

Henry Rongomau Bennett, C.B.E., Q.S.O.,
Medical Practitioner

KAUMATUA: John Turei, Q.S.M.

STAFF:

Secretary: Ms Lorna Dyall

Research Officer: Ms Lesley De Mello

**Appointment of Committee of Inquiry into Procedures Used in Certain
Psychiatric Hospitals in Relation to Admission, Discharge or Release on
Leave of Certain Classes of Patients**

To all to whom these presents shall come and to:

KENNETH HECTOR MASON, of Auckland, District
Court Judge,
ALLISON BERNICE RYAN, of Wellington, Medical
Practitioner, and
HENRY RONGOMAU BENNETT, C.B.E., Q.S.O. of
Rotorua, Medical Practitioner.

Whereas concern has been expressed about the procedures used in psychiatric hospitals for the admission, discharge, and release on leave of certain classes of patients: And whereas it is desirable that inquiry should be made into-

- (a) The use of those procedures at the psychiatric hospitals administered by the Auckland Hospital Board, the Waikato Hospital Board, the Wellington Hospital Board, the Canterbury Hospital Board, the Otago Hospital Board, the Wanganui Area Health Board and the Nelson Area Health Board; and
- (b) The law governing those procedures; and
- (c) Other related matters:

Now, therefore, pursuant to section 13(3) of the Hospitals Act 1957 to the extent that this Warrant relates to psychiatric hospitals administered by hospital boards and to section 4(4) of the Area Health Boards Act 1983 to the extent that this Warrant relates to psychiatric hospitals administered by area health boards. I, **MICHAEL EDWARD RAINTON BASSETT**, Minister of Health, hereby appoint you, the said Kenneth Hector Mason, Allison Bernice Ryan, and Henry Rongomau Bennett, to be a Committee of Inquiry to inquire into and report on-

- (a) The administrative and clinical procedures and criteria by which decisions are made in psychiatric hospitals administered by the above-mentioned hospital boards and area health boards with respect to-
 - (i) The admission of persons under sections 42 and 43 of the Mental Health Act 1969; and
 - (ii) The admission of persons ordered to be detained under section 121(2)(b)(ii) of Criminal Justice Act 1985, and the making of reports to the courts in respect of such persons; and
 - (iii) The removal or discharge of persons admitted pursuant to an order made under section 42 or section 43 of the Mental Health Act 1969 or section 121(2)(b)(ii) of the Criminal Justice Act 1985; and
 - (iv) The reclassification of, and subsequent discharge of, persons ordered to be detained under section 115 of the Criminal Justice Act 1985; and
 - (v) The granting of leave to special patients under section 47 of the Mental Health Act 1969, and the granting of leave to committed patients who, immediately before becoming committed patients, were special patients; and
 - (vi) The discharge of persons ordered to be detained under section 118 of the Criminal Justice Act 1985; and

(b) The law relating to-

- (i) The procedures and criteria specified in paragraph (a) of these terms of reference; and
- (ii) Persons released on leave under section 47 of the Mental Health Act 1969; and

(c) The adequacy of the facilities available in psychiatric hospitals administered by the above-mentioned hospital boards and area health boards for the psychiatric examination of persons ordered to be detained under section 121 (2)(b)(ii) of the Criminal Justice Act 1985; and

(d) The extent to which subsequent psychiatric care is provided and other facilities for care and rehabilitation (such as halfway houses) are available to persons discharged or released in accordance with the procedures specified in paragraph (a) of these terms of reference; and

(e) Such other matters as you consider relevant to the matters mentioned above:

And I hereby appoint you, the said Kenneth Hector Mason, to be the Chairman of the Committee:

And, in accordance with section 13(3) of the Hospitals Act 1957 and section 4(5) of the Area Health Boards Act 1983 I direct that you the Committee shall have the powers of a Commission under the Commissions of Inquiry Act 1908 and the provisions of that Act except sections 11 and 12 (which relate to costs), shall apply as if the inquiry were an inquiry under that Act:

And for better enabling you to carry these presents into effect you are hereby authorised and empowered to make and conduct any inquiry under these presents in accordance with the Commissions of Inquiry Act 1908, at such times and places as you consider expedient, with power to adjourn from time to time and from place to place as you think fit and so that these presents shall continue in force and the inquiry may at any time and place be resumed although not regularly adjourned from time to time or from place to place:

And you are hereby required in carrying out the inquiry, to adopt procedures that encourage people to participate in your proceedings:

And it is hereby declared that the powers hereby conferred shall be exercisable notwithstanding the absence at any time of any one of the members hereby appointed so long as the Chairman, or a member deputed by the Chairman to act in his stead, and one other member, are present and concur in the exercise of the powers:

And it is hereby declared that you have liberty to report your proceedings and findings from time to time if you shall judge it expedient to do so:

And, using all due diligence, you are required to report to me in writing under your hands not later than the 31st day of December 1987 your findings and opinions on the matters aforesaid, together with such recommendations as you think fit to make in respect thereof.

Dated at Wellington this 2nd day of July 1987.

Michael Bassett
Minister of Health

**Amending Terms of Reference of Committee of Inquiry into
Procedures Used in Certain Psychiatric Hospitals in Relation
to Admission, Discharge, or Release on Leave of Certain
Classes of Patients**

To all to whom these presents shall come, and to:

KENNETH HECTOR MASON, of Auckland, District
Court Judge,
ALLISON BERNICE RYAN, of Wellington, Medical
Practitioner, and
HENRY RONGOMAU BENNETT, C.B.E., Q.S.O., of
Rotorua, Medical Practitioner:

WHEREAS by Warrant dated the 2nd day of July 1987 you were appointed to be a Committee of Inquiry to inquire into the matters set out in that Warrant, being matters concerning the procedures used in certain psychiatric hospitals in relation to the admission, discharge, or release on leave of certain classes of patients:

And whereas it is desirable that the terms of reference set out in the said Warrant be amended so that inquiry can be made into the use of those procedures at the psychiatric hospitals administered by the West Coast Hospital Board:

Now, therefore, pursuant to section 13(3) of the Hospitals Act 1957, I, **DAVID FRANCIS CAYGILL**, Minister of Health, hereby amend the said Warrant by inserting after the words "Canterbury Hospital Board", the words "West Coast Hospital Board,".

And I hereby confirm the said Warrant dated the 2nd day of July 1987, save as amended by this Warrant.

Dated at Wellington this 9th day of November 1987.

David Caygill
Minister of Health

On the night of 3 June 1987 John Papalii took a carving knife from the kitchen at Papillon boarding house in Auckland and stabbed a man waiting at a bus stop. He returned to the boarding house and early the next morning he fatally stabbed another boarder and severely wounded two others.

Papalii came to New Zealand in the early 1960s. A hit and run accident left him in a coma for a year, and afterwards he was a very different person. On discharge from Middlemore Hospital he assaulted his sister and her two daughters and in August 1966 was admitted to Oakley Hospital.

The next 20 years were spent in psychiatric hospitals including periods in the Lake Alice National Security Unit. For most of that 20 years he had special patient status.

By June 1986 Papalii was back in Oakley Hospital. A former nurse describes his behaviour in the controlled hospital environment as less than satisfactory. He was not compliant with treatment or with any other rule. He was resistive, impulsive, very irritable. In the ward setting he was a bully. Staff often had to struggle with him to administer treatment. He would not participate in a self medication programme, and such a programme is an essential requirement for patients being prepared for community living.

It was under these circumstances that, in July 1986, the clinical team made the decision to place Papalii in the community under the Oakley District Nursing Service.

At 2 a.m. on 30 May 1987 Papalii arrived at Carrington Hospital with a friend. He complained of sleeplessness and said that he was afraid to sleep in case he did not wake up. He said he was afraid that his heart would stop and that there was something wrong with his head. The examining doctor recorded that Papalii had little insight into his current state, that he may be psychiatrically unwell, and that he refused to remain in Carrington for more than one night. It was also noted that Papalii appeared to have a schizophrenic process rather than an affective disorder. The doctor considered that Papalii was in a psychotic state and needed help, but said that there was no action he could force Papalii to take. Further follow-up was arranged and Papalii left the hospital.

At a meeting of clinical heads held at Oakley Hospital on 3 June 1987 concern was expressed about Papalii's mental health and in particular his refusal to take medication. He was at that time considered to be potentially dangerous, and a senior social worker agreed to try and locate him and make an application for his committal under Section 21 Mental Health Act 1969.

At 4 p.m. that day Papalii was located. At 4.45 p.m. approximately, the social worker satisfied himself that committal was appropriate and prepared a draft affidavit for consideration by a District Court Judge. Not unreasonably the social worker believed that a Judge may not be available, and deferred attending the Court until the following day. The killings and assaults previously described took place that night.

John Papalii was the catalyst which resulted in this present Inquiry, but the Papillon incident was merely another in a long series of events, Inquiries, Working Parties and Investigations commencing in 1971 and dealing directly or indirectly with the mentally disordered offender and the question as to who should be responsible for such people.

In 1971 C P Hutchinson Q.C. chaired a Commission of Inquiry to examine conditions at Oakley Hospital. For some time there had been longstanding unrest and dissatisfaction amongst Oakley staff regarding their working conditions. The Hutchinson Inquiry was confronted with opposing views of prison and hospital staff towards the care of mentally disordered offenders.

The prison staff regarded the prison environment as inappropriate for those inmates who were mentally disordered. They asserted that the rigours of a maximum security prison were debilitating and stressful and in any event they emphasized their inability and lack of training to cope with mentally disturbed prison inmates.

On the other hand the hospital staff emphasized that they were trying to promote a therapeutic atmosphere which was being seriously compromised by the presence of disturbed prison inmates who were disruptive and the cause of much anxiety in the hospital. They also complained that the presence of mentally disordered prisoners and remandees resulted in *all* patients being subjected to a higher standard of security than was necessary.

In its findings the Hutchinson Inquiry pointed out the lack of suitable psychiatric services, inadequate patient treatment, serious staff deficiencies and the generally unsuitable treatment environment which then existed.

In 1972 the control of psychiatric hospitals was transferred from the Health Department to Hospital Boards. Oakley continued its role as a secure facility but was split into two separate hospitals, viz Carrington with 800 beds and Oakley with 150 beds. From that point onwards Carrington provided general psychiatric care and treatment whereas Oakley specialized in the care and treatment of psychiatrically disturbed prisoners and remandees.

In February 1982 a remandee, Michael Watene, died at Oakley Hospital following the administration of electro-convulsive treatment (ECT). A subsequent coroner's inquest concluded that his death was due to lack of adequate supervision following the administration of ECT. Allegations of misconduct relating to Mr Watene's treatment while in Oakley Hospital were brought to the attention of the Hospital Board and ultimately this culminated in a Committee of Inquiry into procedures at Oakley Hospital and related matters (the Gallen Inquiry). Yet again another Committee of Inquiry was faced with the responsibility of looking at the interface between the criminal justice system and the psychiatric hospitals. The Gallen Inquiry reported in January, 1983.

We shall have more to say about the findings of that Inquiry at a later stage.

The next significant event occurred in September 1984 when the Minister of Health and Minister of Justice established a Working Party "to report on the need in Auckland for secure facilities for psychiatric patients including prisoners and other offenders and to make recommendations on the action needed to meet the need." That Working Party reported in November, 1984.

We comment on the significant findings of that Working Party later in this Report.

In 1986 and early 1987, there were a series of homicides committed by people with histories of psychiatric disorder. The murder of a six year old child in Christchurch by a known sex offender with a psychiatric history, and his subsequent trial, achieved considerable notoriety.

In Wellington three separate homicides were committed by ex psychiatric patients and were followed some months later by the Papillon homicides and assaults by John Papalii in Auckland.

All of these events attracted wide public apprehension and comment. In particular, many people expressed grave concern at the inadequate follow-up of psychiatric patients who had been discharged from hospital into the community.

It was against this background that we commenced our Inquiry.

THE TERMS OF REFERENCE - WHAT DO THEY MEAN?

In the presentation of our report, the first stage is to unscramble the legal language that gives our terms of reference a daunting and complex appearance. There are three procedures which may result in detention in a psychiatric hospital, only one of which, ie Section 21 of the Mental Health Act, is relevant to our Inquiry.

Under Section 21 of the Mental Health Act 1969 an application may be made to a District Court Judge for a Reception (Committal) Order. That application must be accompanied by two medical certificates certifying that the patient is mentally disordered and requires detention in a hospital for his own good, or in the public interest. If, after considering the certification papers and examining the patient, the Judge is satisfied that the committal criteria have been met, the Reception Order is then made, the patient is committed to a psychiatric hospital and may be detained and treated thereafter without his consent until he is discharged.

It should be noted that no person can be committed to a psychiatric hospital without his consent unless he is first found to be "mentally disordered".

What then is meant by the term "mentally disordered?"

"Mentally disordered" is defined in Section 2 Mental Health Act 1969 as follows:

"Mentally disordered in relation to any person, means suffering from a psychiatric or other disorder, whether continuous or episodic, that substantially impairs mental health, so that the person belongs to one or more of the following classes, namely:

(a) *Mentally ill - that is, requiring care and treatment for mental illness:*

(b) *Mentally infirm - that is, requiring care and treatment by reason of mental infirmity arising from age or deterioration of or injury to the brain:*

(c) *Mentally subnormal - that is, suffering from subnormality of intelligence as a result of arrested or incomplete development of mind."*

It can be seen therefore that mental illness is but one of three categories of mental disorder all of which require that the person be "suffering from a psychiatric or other disorder whether continuous or episodic that substantially impairs mental health".

There are thus three elements that arise from the statutory definition that must be satisfied before a person can be found to be mentally disordered for the purposes of committal. They are:

1. Suffering from a psychiatric or other disorder.

2. The disorder must substantially impair mental health.

3. The disorder must require care and treatment related to mental illness.

No further definition of the terms "mental illness" or "mental health" is set out in the Mental Health Act.

We now set out below brief details of each of the sections referred to in our terms of reference.

Section 42 Mental Health Act 1969:

Section 42 governs the transfer to psychiatric hospitals of people serving a prison sentence.

If the superintendent of a penal institution has reasonable grounds to believe that a prisoner is mentally disordered he or she may make an application for a Reception Order under Section 21 as previously described. If reasonably practicable, one of the medical practitioners who certifies the prisoner shall be the superintendent or medical officer of a psychiatric hospital or a medical practitioner who is an officer of the Mental Health Division of the Department of Health. If the Judge makes the committal order the prisoner is then transferred to a psychiatric hospital. While on transfer the prisoner's sentence continues to run. Persons committed in this way have the status of "special patient".

An example of this process is as follows: "Tom A. was a 25 year old who was arrested and convicted of theft. He was sentenced to imprisonment. During his imprisonment he became very depressed, withdrawn and fearful of others without apparent reason. He was found to be hallucinating, attempting to fend off unseen attackers and screaming wildly. He was assessed by two doctors, one of whom was a psychiatrist, and diagnosed as a paranoid schizophrenic. He was then admitted to a psychiatric hospital under Section 42 of the Mental Health Act 1969. In his disturbed state he had no insight into his condition and was unable to consent to his transfer to hospital. After several months, when his condition stabilized, he was transferred back to prison to complete his sentence."

Section 43 Mental Health Act 1969:

Section 43 enables the Secretary for Justice, in consultation with the Director of Mental Health, to authorize the transfer from prison to hospital of any person who, with his consent, "would benefit from psychiatric care and treatment available in a psychiatric hospital but not available in the penal institution".

This section contrasts with Section 42 in that the prisoner need not be "mentally disordered" within the meaning of Section 2 of the Mental Health Act and must consent to his transfer to hospital. A person admitted to hospital under Section 43 has the status of "special patient".

An example of this process is as follows: "John B. was a 40 year old charged with sexual violation of a child. He was found guilty as charged and sentenced to a term of imprisonment. Like Tom A. (Section 42) John B. became disturbed whilst in prison although his symptoms were not as gross as those of Tom A. Although he was segregated from the other inmates he became increasingly difficult to manage and attempted suicide. A psychiatric assessment resulted in a diagnosis of personality disorder. Though not mentally disordered as defined in the Mental Health Act, he was the type of inmate who has difficulty adjusting to the prison regime and environment. John consented to his transfer to a psychiatric hospital, and following negotiations with the hospital he was admitted under Section 43. His condition rapidly improved in hospital but on return to

prison he again deteriorated. With his consent under Section 43, he was re-admitted to hospital where he completed the last few months of his term of imprisonment. During this time he qualified for release to work and home leave and was incorporated into a therapeutic programme organized by hospital staff. He was subsequently reclassified as an informal patient and later discharged."

Section 121(2)(b)(ii) Criminal Justice Act 1985:

Where any person is awaiting a hearing, trial, appeal or sentence and it appears to the Court to be expedient that a psychiatric report on the person's mental condition should be available, the Court may remand that person to a psychiatric hospital under this subsection. However, such an order cannot be made by the Judge unless:

- (i) the person is charged with or convicted of an offence punishable by imprisonment; and
- (ii) the person is held in custody; and
- (iii) it would not be practicable for the report to be prepared while the person was on bail or held in prison; and
- (iv) a psychiatrist has certified that it would be desirable that a psychiatric examination take place in a psychiatric hospital. Where no such specialist is available, the certificate may be given by another medical practitioner.

The total period of detention ordered under this section shall not exceed one month. On receipt of the psychiatric report the court must order the person's return to custody for proceedings to continue in the normal way. A person detained in hospital under this subsection has the status of "special patient".

This section does not authorize treatment without the consent of the patient.

An example of this process is as follows: "Tom C. was arrested for burning down his neighbour's house. His bizarre behaviour suggested to the arresting police officer that he may be suffering a mental disorder. He insisted on crawling along the ground and screaming wildly. A consultant psychiatrist examined Tom and advised the Court that a remand to a psychiatric hospital would be appropriate so that he could be kept under constant observation for

a two week period, during which time his behaviour could be monitored and his mental condition assessed. The Court then ordered that Tom be remanded to a psychiatric hospital under Section 121 (2)(b)(ii) of the Criminal Justice Act 1985. The subsequent psychiatric report then enabled the Court to determine whether or not Tom was fit to plead to the charge of arson."

Section 115 Criminal Justice Act 1985:

Section 115 applies in cases where a person is found to be under disability or is acquitted on account of insanity.

In that event the Court shall make an order that the person be detained in a hospital as a "special patient" under the Mental Health Act. If however, after hearing medical evidence, the Court is satisfied that it is safe to do so, it may (inter alia) make an order that the person be detained in a hospital as a committed patient.

In the context of this section a person is "under disability" if, because of mental disorder, he or she is unable to plead or to understand the nature or purpose of the proceedings or is unable to communicate adequately with a lawyer for the purpose of conducting a defence.

Section 118 Criminal Justice Act 1985:

This section operates when a person is convicted of an offence.

It enables the Court to make an order that the person be detained in a hospital as a committed patient on the production of certificates by two medical practitioners that the person is mentally disordered and that his mental condition requires that he be detained in a hospital either in his own interests or for the safety of the public. If the Court is so satisfied it may make a Committal Order instead of passing sentence. There is an additional requirement that the offender must not be subject to a full-time custodial sentence. The offender is then placed formally under the care of the Superintendent of the hospital. The Superintendent is, however, obliged to discharge the person when the criteria of Section 73 (1) of the Mental Health Act are satisfied, namely, that the detention is no longer necessary "for his own good" or in the "public interest".

Section 47 Mental Health Act 1969:

Section 47 authorizes the Minister of Health to grant leave to any special patient who has

been acquitted on account of insanity or who is a Section 42 or Section 43 patient. Before exercising that discretion the Minister must be satisfied, on the advice of two medical practitioners, that the special patient is fit to be allowed to be absent from the hospital.

The Section also permits the Director of Mental Health to grant leave, not exceeding seven days, to those special patients who are in hospital pursuant to Section 115 Section 42 and Section 43. In practice, after the first leave period, the Superintendent of a hospital may exercise delegated authority to grant leave. Periods of long leave for those special patients who have been acquitted on account of insanity, and Section 42 and Section 43 patients, may be granted under certain conditions by the Minister of Health.

Special Patients:

Throughout this discussion we have used the term "special patient". It is important to recognize that "special patient" is a legal rather than a clinical term. Section 2 of the Mental Health Act 1969 defines that category of persons whom the law classifies as "special patients". Those persons therefore fall within a legal category and not a psychiatric category. Persons who are committed or transferred to a psychiatric hospital pursuant to Section 42, Section 43, Section 121 (2)(b)(ii), and Section 115 i.e. the group of persons whom we have been discussing above except Section 118 patients, all fall within the "special patients" category.

We endorse an observation made by the Institute of Criminology:

"The designation 'special patient' is thus a status conferred by the statutory provision under which the offender has been committed to a psychiatric hospital and may have little or nothing to do with the nature or extent of their mental disorder or indeed with their perceived dangerousness. For example, in the case of *R v G H* (1977) NZLR.50 Roper, J. committed the defendant as a special patient after a verdict of not guilty by reason of insanity, not because he was regarded as dangerous, but because the "wider public interest" required his detention as a special patient for the offences he had committed."

INTRODUCTION

Initial Proceedings

Our Committee of Inquiry was appointed by the Minister of Health on 2 July, 1987. We first met on 3 August, 1987 to consider the appointment of staff, a timetable for hearings and other ancillary matters.

A Public Notice in Maori and English was published in the metropolitan and some provincial newspapers. A list of individuals and organizations whom we believed would have an interest in the Inquiry, was compiled. A copy of the Terms of Reference and a covering letter was sent to those individuals and organizations. A special effort was made to seek the views of the Maori and Pacific Island communities. The New Zealand Maori Council, the New Zealand Maori Women's Welfare League, all Maori Trust Boards and Incorporations and other identifiable Maori organizations were approached and invited to meet with us.

We invited Mr John Turei of Tuhoë to join us on the Committee as our kaumatua. We were privileged that he accepted our invitation.

Procedure

The Chairman made his opening address in Auckland on 1 September, 1987. He ruled that hearings would be conducted in public but that confidentiality would be observed in cases where that was considered appropriate. We were anxious to avoid the process of a formal legal hearing with cross-examination and re-examination of witnesses. In our view that would not be helpful to a free exchange of information and ideas. Accordingly, we decided to conduct our hearings in an informal manner without the need for sworn evidence.

We dealt with both oral and written submissions.

The formal hearings took place from 7 September 1987 to 18 February 1988.

A list of those persons and organizations who gave oral and written submissions is listed in the appendices.

Karakia was said at the beginning and end of each day.

Preparation for Formal Hearings

Before the formal hearings commenced we visited each of the major psychiatric hospitals covered by our Terms of Reference. Those visits enabled us to meet informally with administrators and others and to indicate in general terms the sort of information which would be helpful to us.

Formal Hearings

We visited the following hospitals:

Carrington Hospital, Auckland
Kingseat Hospital, Auckland
Tokanui Hospital, Te Awamutu
Lake Alice Hospital, Wanganui
Psychiatric Unit, Wanganui General Hospital
Psychiatric Unit, Wellington General Hospital
Porirua Hospital, Wellington
Sunnyside Hospital, Christchurch
Ngawhatu Hospital, Nelson
Cherry Farm Hospital, Dunedin
Psychiatric Unit, Dunedin Public Hospital and Day Hospital
Seaview Hospital, Hokitika

Formal hearings were conducted in all of the above hospitals except the Dunedin Public Hospital Psychiatric Unit, and Seaview Hospital.

We visited the following prisons:

Paremoremo Maximum Security Prison, Auckland
Mt Eden Prison, Auckland
Mt Eden Women's Prison, Auckland
Waikeria Prison, Te Awamutu
Wellington Prison, Wellington
Arohata Women's Prison, Wellington
Paparua Prison, Christchurch
Dunedin Prison, Dunedin

We visited the following Marae:

Arai Te Uru, Dunedin
Rehua, Christchurch
Whakatu, Nelson
Takapuwhia, Porirua
Whaiora, Tokanui Hospital

In Wanganui we met with the Kaumatua Council and were hosted at Lake Alice Hospital by Te Ropu Arahi, a group comprising both staff and patients.

In Auckland kaumatua and kuia from Hoani Waititi Marae met with us, as did several groups of Maori people actively involved in the provision of psychiatric care.

In each hospital which we visited, we looked at the facilities available for the reception and examination of remandees. We also examined the secure facilities in each hospital.

Research

Data obtained from the Department of Statistics, the Department of Health and the Justice Department, is presented as Appendix 1.

The Assessment Team

During the course of our inquiries it became obvious that there were significant differences in the views held by prison personnel on the one hand and hospital personnel on the other regarding the assessment and management of mentally disordered offenders.

We invited an Assessment Team to assist us. That team comprised:

Dr Phil Brinded, Christchurch
Mrs Betty Goodwin, Mangere
Dr Douglas Wilson, Hamilton
Mr Hohua Tutengaehe, Christchurch
Mr Warren Brookbanks, Auckland

The results of the examinations and inquiries undertaken by the Assessment Team are set out later in this report.

Visit to the United Kingdom

Many of the submissions considered by us dealt with the lack of secure facilities within psychiatric hospitals and the inadequacy of follow-up facilities and services for all psychiatric patients. It was suggested that we look at overseas developments in both areas to see whether any of those initiatives could be adopted in New Zealand.

We noted that in 1972 a Committee chaired by Lord Butler was appointed by the British Home Office and the Department of Health and Social Security to consider problems similar to those addressed by our Inquiry. The Butler Committee reported in 1975 and recommended, inter alia, the establishment of regional security units for those psychiatric patients who were unmanageable within the normal psychiatric hospital setting.

We visited the following medium security units:

Dennis Hill Unit, London
Cane Hill Unit, London
The Butler Unit, Dawlish
Knowle Hospital, Fareham,
Southampton
Prestwich, Manchester
Reaside, Birmingham

We also visited the special hospitals at Broadmoor near London and Moss Side in Liverpool.

We examined the community care facilities and services in Southampton and Exeter, those being two regions which are regarded internationally as being innovative in the field of psychiatric after-care.

Our visit to the United Kingdom allowed us to meet with a wide range of people in both the criminal justice and health systems and to profit from their experiences and expertise.

Acknowledgements

During the course of our Inquiry we have received information, advice and support from many people.

In particular, we record our warmest appreciation to our kaumatua John Turei whose wisdom and aroha has sustained us through the course of the Inquiry.

To Dr Phil Brinded, Mrs Betty Goodwin, Dr Douglas Wilson, Mr Hohua Tutengaehe and Mr Warren Brookbanks, the personnel of our Assessment Team; to the Canterbury and Waikato Hospital Boards for releasing Dr Brinded and Dr Wilson respectively from their usual duties, we record our thanks.

We spoke with many prisoners and psychiatric patients during the course of our Inquiry. We extend our thanks and aroha to those people for allowing us to intrude into their lives.

Our visit to England was made easier by the efforts of John Gunn, Professor of Forensic Psy-

chiatry at the Institute of Psychiatry in London. He arranged our itinerary and supported us while we were in England. Mr David King, General Manager of the Exeter Health Authority, facilitated our visit to Exeter, and Dr Brenda Morris gave us her support in the Southampton region. We record our appreciation to those people.

We thank our colleagues in the Judiciary and the Medical profession who tolerated our absence and the additional burden of work for them which resulted.

We are particularly grateful for the splendid support we received from our Research Officer, Ms Leslie De Mello and our Secretary, Ms Lorna

Dyall. Their responsibilities were protracted and onerous and we thank them both for their cheerful forbearance.

We acknowledge also the secretarial and typing duties admirably undertaken by our staff. We record especially the efforts of Sylvia North.

We also thank the Reverend David Guthrie for editing this Report.

Participation in this Inquiry has led to a disruption of our normal family lives. We thank our families for their tolerance, patience and support during this protracted period.

Finally, we thank you, Minister, for the privilege of allowing us to be of service.

PART 1: THE AUCKLAND AREA

THE AUCKLAND SCENE: WHY IS IT SO IMPORTANT?

The issues we address in this report are national issues. The first part of this report, however, deals exclusively with the Auckland area in relation to admission criteria and procedures under Sections 42 & 43 Mental Health Act 1969. The crisis that generated the need for this Inquiry arose in Auckland principally because it is in this region that the pressures on the system have reached their greatest level in the country.

Carrington and Kingseat are the two major psychiatric hospitals administered by the Auckland Hospital Board. Oakley, the third major hospital, closed on 17 August, 1987.

Between 1983 and 1986 there were, nationwide, 149 admissions from prisons to psychiatric hospitals pursuant to Sections 42 and 43, Mental Health Act. Ninety three of those admissions were from Paremoremo Maximum Security Prison, Mt Eden Prison and the Auckland Medium Security Prison, all of which are in the Auckland Hospital Board area. Thus, 62% of all hospital admissions under Sections 42 and 43 originated in the Auckland Hospital Board area. On a purely statistical basis therefore the Auckland region enjoys considerable significance. But there is more to it than that.

We have already referred to the events leading up to this Inquiry. What may not be realized is that since 1971, so we were told, there have been more than 16 Inquiries, Working Parties or Investigations centred largely on the status and activities of psychiatric hospitals in the Auckland area. Over the years, and particularly since 1983, various incidents in those hospitals have

attracted widespread publicity. That in turn has called into question the relationship between the health system and the criminal justice system, the relationship between the psychiatric hospitals and the community and, perhaps more importantly, the administrative efficiency of the Auckland Hospital Board. Popular opinion would have us believe that there has been little real progress since the Hutchinson Report of 1971.

We regard the Gallen Inquiry of 1983 as a landmark. We were concerned to find out what has happened since then and wherever practicable to spell out the views of the participants in the language they themselves have used.

It seems to us that the wider community is entitled to know something of the character, attitudes and beliefs of those who are responsible for making decisions affecting our psychiatric patients. Ultimately, those decisions affect not only the quality of life enjoyed by patients but also their care givers and the wider whanau or family and community.

What now follows is the story of Oakley and Carrington hospitals since January 1983.

We regard the Gallen Inquiry of 1983 as a landmark.

"The question respecting lunatics and inebriates being placed in prisons or hospitals ought to be settled once and for all. It has been for 10 years, a case of each institution refusing to take them in."

New Zealand Inspector of Prisons
writing in his annual report to Parliament in 1882

A CENTURY LATER: HAVE WE REALLY CHANGED?

"The most frustrating thing is that we don't know where we stand. Some recent incidents have been bizarre. I can recall two prison officers taking an inmate out to Carrington. They were told that the inmate was not acceptable in that hospital. The officers told the staff they had a court order and, as they were in the ward at the time, they said they were going to leave the patient there. The hospital people said they would not let the officers out of the ward unless they took the patient with them. Within a few minutes, by chance, a doctor entered the ward and that allowed these two officers to slip out the door, leaving the body behind along with the appropriate papers. A few minutes later someone from Carrington rang the police and told them to come out and pick up the patient as he was not acceptable. They were told that if they did not come out, the staff would let him go. As I understand it the police were not quick enough. They let the fellow out of the hospital and told him to go. The police picked him up in the driveway and took him back to the police station and he came back here to prison the next day. The medical superintendent was up in arms over this incident. He phoned me and apologized and asked if he could come and see me and square it up. He asked me if I would cooperate with him by not initiating any movements to the hospital because it was embarrassing for him to have his staff refuse. That's the sort of situation we have."

"On another occasion we had an ex Carrington patient who went berserk. Our staff had to go and see him. He had used a knife and stabbed a member of his family. We felt that he could not

come back to the prison because he was a Carrington patient on trial leave. The Judge acted accordingly. The officers took the patient to the hospital but he was refused admission as the staff then considered him too dangerous. We took the fellow back to Court and the Judge had no option but to remand him in to prison custody. He then went to Tokanui Hospital near Hamilton."

"On another recent occasion two of the Oakley/Carrington psychiatrists both said that the fellow should be in hospital and should not be in prison. That report went to the Court. The Judge signed the appropriate papers for us to take the fellow to Carrington. He was refused entry and brought back here. I rang the medical superintendent and asked what was going on. I told him that the inmate had been certified by his own people, not by our people or some strange people, but by his own people. He said it was a mistake. I asked what he meant by a mistake, and he said the hospital was full and the union would only allow four criminal justice remands at a time - that was the limit. He then said that the psychiatrists who had prepared the report were not aware that the hospital was full. I asked what would have happened if the psychiatrists had known the hospital was full and I was informed that the psychiatrists would not have written the report. So to me they were playing around with that fellow's life."

Evidence given by Superintendent
Mt Eden Prison
December 1987

FACTS

- December 1968:** Paremoremo Maximum Security Prison opens.
- December 1968 to January 1983** One Paremoremo inmate commits suicide.
- January 1983:** Gallen Inquiry reports.
- February/March 1983 Onwards** Change in assessment/admission criteria from Paremoremo to Oakley/ Carrington Hospitals.
- March 1983 to December 1987** 13 Paremoremo inmates commit suicide.
- January 1984 to September 1987**
- 10 Paremoremo prisoners committed to psychiatric hospitals pursuant to Section 42, Mental Health Act.
 - 19 Paremoremo prisoners transferred to psychiatric hospitals pursuant to Section 43, Mental Health Act.
 - 24 of these 29 prisoners are transferred to Lake Alice National Security Unit. One prisoner is transferred to Tokanui Hospital and 4 prisoners are transferred to Oakley/ Carrington Hospitals.
 - 21 of the 29 prisoners are Maori.
- 12 November 1987:** Justice Department undertakes census of prison inmates throughout New Zealand. Prison staff consider that 5% (119) of the male inmates and 16% (19) of the female inmates should in a psychiatric institution.

OAKLEY: AN OVERVIEW BEFORE AND AFTER THE GALLEN INQUIRY

Dr Allan Taylor of Carrington Hospital has described Oakley before and after the Gallen Inquiry in this way:

"Prior to the opening of Paremoremo and the division of the then Oakley Hospital by the Hospital Board into Carrington and Oakley, there was a settled policy:

1. That prisoners who were deemed disturbed by prison authorities were admitted automatically to Oakley.
2. That all remands should be admitted to hospital automatically for four weeks inpatient assessment. There were a minority who were assessed as outpatients.

With the opening of Paremoremo, and the establishing of Oakley, this policy was continued, especially at Oakley. There were some moves at Carrington to have remand patients assessed as outpatients. The role of Oakley grew because disturbed prisoners from all round the country were transferred to Paremoremo and then quickly to Oakley Hospital where they had prolonged stays. Many were adept at producing the behaviours that resulted in transfer. Oakley was regarded as a soft option to prison.

Oakley was consistently understaffed with experienced medical staff and the quality of treatment suffered accordingly and predictably, finally resulting in the 1981/82 Oakley Inquiry. However, people who posed risks to themselves because of the stress of prison had their lives saved and people who posed a risk to society were kept out of circulation and many injuries to the general public were prevented.

This was often also because patients were given and maintained in the community on relatively high doses of medication. The bill was footed by the Auckland Hospital Board who justifiably felt it to be inequitable that prisoners from all round the country should become a charge on the Board by Justice Department policy.

After the Oakley Inquiry this was all changed. It became policy to:

1. To send prisoners back to prison quickly.
2. To admit only prisoners with clearly recognized mental illness - predominantly schizophrenia and manic depressive disorders and exclude those with personality disorders or adjustment reactions. (The number of suicides fluctuated in prison depending on the degree of crowding of the prisons and the conditions).
3. To discharge long standing institutionalized patients back into the community where conditions were often worse and follow up patchy, and then at times to refuse to readmit.

.... the PSA imposed a ban on all male Criminal Justice Act patients going to anywhere other than Oakley.

Associated with this, the degree of security in Carrington Hospital was being lowered so that there were basically no secure wards in Carrington and the policy has been to allow people to come and go excepting for those acutely and severely disturbed who, if they were not treated by transfer to Oakley, were locked in seclusion rooms with sub-optimal care because of lowered staff/patient ratios."

On the matter of community care Dr Taylor said:

"In order to transfer money from the hospital to community work the number of patients in hospital has had to be reduced. This has resulted in a denial of asylum to some and forced discharge of others to sub-standard conditions and sub-standard follow up."

Dr Jed Felgate, psychiatrist of Carrington Hospital, gives another word picture in these terms:

"When I arrived at Oakley Hospital 5 years ago there was a hotch potch of patients in hospital of varying diagnostic categories. That is a situation fraught with danger. When you have a mixture of people in one ward it

is very difficult to provide therapeutic programmes for them. There were two patients who required short term treatment for acute illness, there were chronic patients, there were people from the prisons there and there were elderly people; a real mixture of subnormal people. One of the problems was that there were 42 prison inmates who had been in Oakley Hospital. That seemed an enormously large number to me. My previous experience is that there are sometimes only one or two prisoners in a mental hospital - usually none. 42 seemed a statistically significant number. A large number of those 42 people were people who, in my view, were not really committable. They were not mentally ill to the extent that they had to be committed to a mental hospital. They would have been quite willing to be in that hospital on a voluntary basis; the vast majority."

We suggested to Dr Felgate that at some stage

"this hospital cannot protect the public because it does not have the degree of security that criminals require"

two psychiatrists must have certified those patients as being committable otherwise they would not have been there. His response was:

"I'm quite sure that when the Judge made those orders the Mental Health Act had not been entirely complied with, in the sense that one psychiatrist supplying the certificate had not come from the hospital. A lot of those prisoners were the sort of people who have difficulty fitting in to the very vicious culture that exists in gaols. They could not cope with gaol. They were not mad or insane in any way. They had difficulty fitting into the gaol and were distressed by that gaol."

Dr Felgate suggested that such patients should be in a special prison and went on to say:

"This hospital (Carrington) could not provide the degree of security that criminals neededthis hospital cannot protect the public because it does not have the degree of security that criminals require."

THE GALLEN INQUIRY: WHAT DID IT SPELL OUT?

Any person reading this Report could be excused for believing that Oakley has been revisited. We have been told that between 1981 and 1984 five Reports were published which had the status of Oakley as a primary or major concern. The Gallen Inquiry heard evidence in the latter part of 1982 and reported to the Minister in January 1983. It expressed a sense of *deja vu* after it had studied the Hutchinson Report of 1971. We express a similar sense of *deja vu*.

The findings and recommendations of the Gallen Inquiry have already been well documented. It suffices to say that this Inquiry had no hesitation in concluding that the forensic psychiatry practised in Oakley placed far too much emphasis on the provision of security for

those patients placed in its care, to the detriment of a therapeutic regime.

The Inquiry deliberately set out to steer Oakley Hospital, and forensic psychiatry in general, in a new direction.

We believe that several crucial recommendations of the Gallen Inquiry needed adoption by the Auckland Hospital Board if a successful change in direction was to occur. Those recommendations are set out below. Where appropriate, we have included explanatory comments made by the Gallen Inquiry. We have also included, in appropriate cases, the comments made by the Executive Group of the Auckland Hospital Board.

The recommendations follow:

- 19.7.1 Oakley should be amalgamated with Carrington, subject to certain aspects of its operation, retaining a degree of independence.
- 19.7.2 A separate board of control should be set up to be responsible for the new Carrington/Oakley complex and to oversee the changes which we propose as necessary. This board of control should be answerable to the Auckland Hospital Board and should be appointed rather than an elected board. It should be appointed by the Auckland Hospital Board after consultation with the Minister of Health and should if possible include the Director of Mental Health. It should also have a representative from the Department of Psychiatry at the Medical School of the Auckland University. It should consist of no more than seven persons and should assume responsibility for planning forensic psychiatric services through the whole Auckland region.
- 19.14.1 Until such time as a board of control or some equivalent is appointed, the Auckland Hospital Board should accept responsibility to carefully monitor the situation at Oakley Hospital and ensure that such recommendations as are acceptable to the board are complied with.

Gallen Inquiry Comment

"... We believe that because of the special needs it will be required to meet, it should be an appointed rather than an elected Board so that persons of the necessary expertise can be assured of a position on it... We also recommend that in view of the importance which this Committee attaches to the development of forensic psychiatric services in the Auckland region, that this Board should assume responsibility for planning forensic psychiatric services throughout the whole region."

Executive Group Comment (a) The Committee of Inquiry clearly felt there was a need for some form of special organizational arrangement to advise upon and generally monitor changes in Oakley; a need for some special insurance against inaction.

- (b) Without denying the legitimacy of the wish for some provision of this kind, we do feel the particular form of special organizational provision proposed by the Committee to be unclear and ambiguous
- (c) We also note that contrary to recommendation 9.14.1 the Auckland Hospital Board must continue to have the stated responsibilities (and would lose them through the creation of a Board of Control).
- (d) In general the need for a special organization is agreed but the form it should take requires further thought

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- 19.7.3 The person appointed to take responsibility for the reconstituted Oakley Unit as part of the Carrington complex should be given the title of **Director of Forensic Services**. He should have responsibilities beyond the new Oakley Unit itself. He should have the **status of a Medical Superintendent** and be remunerated accordingly. On professional matters related directly to forensic psychiatry he should report directly to the board of control. In matters of administration he should be responsible to the Medical Superintendent of the whole complex.
- 19.7.6 The post should not be filled on a temporary basis by the Medical Superintendent-in-Chief of the Auckland Hospital Board or by the present Medical Superintendent of Oakley Hospital.

Gallen Inquiry Comment

"The Auckland Hospital Board suggested that the post should be filled on a temporary basis by Dr Honeyman, the Medical Superintendent-in-Chief for the Auckland Hospital Board. Without meaning any disrespect to Dr Honeyman, we do not regard this as a satisfactory proposal. Dr Honeyman has many other responsibilities within the administrative framework of the Auckland Hospital Board, he could not be responsible to himself. The person responsible for the new Oakley Unit should be in a position to give it his undivided responsibility over the period during which reconstruction takes place."

Executive Group Comment The difference between the Board's general policy and the Committee's recommendations may to some extent be more terminological than substantial. It is however our firm view that there is no need for a Medical Superintendent for a unit of 100 beds. There are two needs which have to be identified: a need to review administration systems at Oakley; a need to work towards producing a system which diminishes the use of scarce (psychiatric) manpower roles which can be competently filled by others.

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- 19.7.9 A new Principal Nurse, either male or female should be appointed. Such an appointment should be made, if at all possible, contemporaneously with the appointment of the Director and under similar reporting conditions.

Executive Group Comment

The Board's Chief Nurse, Miss A E Murphy, has been elected acting Principal Nurse pursuant to a Board decision of 14 February 1983. Miss Murphy is allocating over 50% of her time to Oakley, is actively managing its nursing service and is a member of its management group. One of her objectives was to recommend alternative more permanent arrangements. She has now recommended advertisement of the Principal Nurse position and this is being arranged.

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- 19.7.18 For the future the new Oakley Unit should draw its patients from three sources: firstly, all prisoners from the Auckland region who have psychiatric problems requiring hospitalization; secondly, it should provide the secure unit for Carrington Hospital; thirdly, it should meet the needs of patients previously associated with the psychiatric therapeutic teams operating in the new Oakley Unit.
- 19.9.2 As soon as possible a new unit should be established for persons remanded under the provisions of the Criminal Justice Act. It should be completely separate from the rest of the hospital. We do not consider that the upstairs area, or indeed any part, of Ward M3 is a suitable place for such a unit to be established. Until a separate unit can be constructed we suggest that the area at present occupied by "C" Group be made available as a separate remand unit with such additional security as is required.

19.9.4 The remand unit should not cater for more than a maximum of eight patients at any one time.

19.11.1 We are opposed to any proposal to construct a prison hospital for psychiatric patients.

Gallen Inquiry Comment

"We do not believe that a hospital is compatible with a prison as such and we do not support any proposal to construct a hospital which is effectively a prison with hospital overtones..... In our view prisoners requiring psychiatric treatment should receive it in a psychiatric hospital where security, though effective, is subordinate to therapy. As we see a reconstituted Oakley Hospital it could meet the needs which arise through the prison service, but in our view, it should be operated and controlled as a hospital and not subject to or incorporated in the prison system."

A CHRONOLOGY OF SIGNIFICANT EVENTS

14 February 1983

Dr Honeyman appointed interim Medical Superintendent; Miss A E Murphy appointed interim Principal Nurse; an interim Oakley Management Group of five persons is established including Dr Honeyman, Miss Murphy and Dr Felgate.

March 1983

Dr Basil James, Director of Mental Health, met with Chairman of the Auckland Hospital Board. His notes record that the interim appointment of the Medical Superintendent-in-Chief and the Chief Nurse were contrary to the recommendations of the Gallen Inquiry.

March 1983 Onwards

Change in criteria for admission of prisoners to psychiatric hospital pursuant to Sections 42 and 43.

29 April 1983

Dr James visited Oakley Hospital. He was informed that the Auckland Hospital Board does not support the appointment of a Director of Forensic Psychiatry. The Board has advertised for a psychiatrist. Recommendations have been made to the Board that a monitoring committee be set up in lieu of a board of control as recommended by the Gallen Inquiry. That monitoring committee is to be a sub-committee of the Auckland Hospital Board.

26 May 1983

First meeting of the monitoring committee. Auckland Hospital Board indicates that the special committee does not have responsibility for planning functions as set out in Gallen recommendation, 19.7.2.

13 June 1983

Meeting between Dr James and Board officials. It was agreed that there was to be no change in Oakley's role as a hospital catering for the psychiatrically disturbed offender. Longer term plans for recruitment/training of staff for Oakley and upgrading services in prisons would be conducted as a parallel exercise.

14 July 1983

Monitoring committee informed that its role was to ensure the Board implemented those Gallen Inquiry recommendations that the Board found acceptable. There was to be no mandate for planning functions. It was noted that there were no suitable applicants for positions of forensic psychiatrist or principal Nurse.

15 September 1983

Chairman of the Auckland Hospital Board confirms that the monitoring committee was an alternative to the board of control.

29 September 1983

Meeting between Auckland Hospital Board members and officials from Department of Health. At that meeting Dr Honeyman said it was incorrect to assume Oakley was a medium secure facility. Regarding the principal nurse, it was noted that the Hospital Board would follow up another applicant, six or seven applicants not having been considered suitable. It was noted that this recommendation conflicted with the concept of amalgamation as recommended by Gallen Inquiry.

18 October 1983

Dr James wrote to Dr Honeyman suggesting a suitable person for the position of Director of Regional Forensic Services. Strongly advised him to follow up recommendation.

2 November 1983

Dr Honeyman refers to Hospital Board policy adopted in October 1982. He points out that Oakley is to be used by offenders who require medium security while being psychiatrically assessed or treated. He describes Oakley M3 as a closed ward rather than any kind of security unit. He says that Gallen Report stipulates that all *mentally ill* prisoners from the Auckland area should be admitted to M3. It is noted that this is different from recommendation 11.6.9 of Gallen Inquiry which refers to all prisoners from the Auckland region who have *psychiatric problems requiring hospitalization*.

11 November 1983

Dr James notes that non-appointment of Director of Forensic Services makes it difficult to develop forensic services. Department of Health urges appointment of a principal nurse.

21 December 1983

Dr James supports meeting with Auckland Hospital Board, Minister of Justice and Minister of Health regarding treatment and care of prisoners with psychiatric difficulties.

2 March 1984

Meeting with Minister of Health, Minister of Justice, Chairman of Auckland Hospital Board and Departmental and Board officials. This meeting was initiated by a request from the Auckland Hospital Board who wished to make representations for an alternative facility for prisoners who have psychiatric problems requiring hospitalization. Board does not accept that Gallen recommendation 11.6.9 is practicable and considers that M3 is "emphatically not suitable for prisoners who are likely to escape and/or whose escape would be unacceptable". Inter alia, it was decided that pending development of a longterm solution high security prisoners requiring hospitalization would be sent direct to Lake Alice.

Health Department guidelines: "...Each Hospital Board with a psychiatric hospital is to provide safe care for disturbed patients ..."

ment of a longterm solution high security prisoners requiring hospitalization would be sent direct to Lake Alice.

29 August 1984

Health Department issues guidelines on secure forensic facilities required by each Hospital Board. "...Each Hospital Board with a psychiatric hospital is to provide safe care for disturbed patients

12 September 1984

Working Party established by Minister of Health and Minister of Justice. Terms of Reference agreed as follows:

"To report on the need in Auckland for secure facilities for psychiatric patients including prisoners and other offenders and to make recommendations on the action needed to meet the need."

Working Party comprises representatives of Health Department, Justice Department and Auckland Hospital Board.

1984 WORKING PARTY: ITS RECOMMENDATIONS AND SUBSEQUENT EVENTS

The Report of the Working Party was presented in November 1984. It made seven recommendations including the following:

- 6.3 That the Department of Justice establish a special prison in Auckland to be located in Ward M3 of Oakley Hospital
- 6.4 That the Auckland Hospital Board establish a structured living environment for approximately 30 patients as part of Carrington Hospital using the present Oakley ward M7
- 6.5 That the Auckland Hospital Board take immediate steps to improve the accommodation of the acute wards at Carrington Hospital. Such accommodation to include provision of a secure area for the assessment and management of severely disturbed patients who need containment.

The Report noted that, at the time of reporting, the Working Party had no firm proposals for the exact types of inmates to be catered for by the new special prison.

In discussing mental health services for prisoners the Working Party observed:

- 2.10 "A small proportion of inmates with mental disorders can properly be transferred to hospitals for care and treatment; those who following conviction are found to have or develop a major mental disorder, some of whom may be committed to a psychiatric hospital under Section 42 of the Mental Health Act or - in selected cases only - transferred voluntarily subject to the provision of Section 43 of the Mental Health Act. Studies suggest that these may comprise no more than 1.2% of the prison population. Appropriate provision for this small number must be made within the hospital system."

Later, when discussing the role of hospitals, the Working Party said:

- 3.6 "The large majority of psychiatric patients are properly treated in an "open" environment, but a small proportion require containment in a secure setting there must still be suitable secure facilities within the Board's hospitals for some patients including those who are:
 - (a)
 - (b) Mentally disturbed, requiring assessment and acute and long term care. Includes some committed prisoners transferred under Section 42 of the Mental Health Act (a small number)...."

And still later, in discussing the psychiatric intensive care unit, the Working Party recorded:

- 3.17 "We see a need within Carrington Hospital for a small secure facility or unit associated with and managed as part of the hospital's acute wards in order that profoundly disturbed and disruptive patients can better be controlled and treated."
- 3.18 "Given such a facility, Carrington Hospital would be well able to meet the needs of acutely disturbed patients including committed prison inmates transferred under Section 42 of the Mental Health Act in conditions which allowed of the necessary security and containment."

On 10 December 1984, the PSA responded to the Working Party Report. It lodged a formal objection with the Minister of Health and stated that it saw the Working Party recommendations as an attempt "to cover up the present problems in the cheapest possible manner."

The Association rejected the recommendation that M3 Oakley be turned into a prison and was of the opinion that a therapeutic environment was incompatible with a prison environment. The Association also questioned the wisdom of doing anything with M7 given that

it had a life span of only two years. The Association endorsed the recommendations of the Gallen Inquiry and suggested that the Oakley facility be further developed to provide a forensic service as part of Carrington Hospital.

On 15 March 1985 PSA members at Carrington and Kingseat hospitals passed resolutions banning the admission of "Oakley type" patients. The resolutions read, in part:

"These hospitals lack both the secure facilities and the adequate staffing levels essential for the management and treatment of these patients.

Note: In the event of adequate facilities and staff being available, we accept that all psychiatric hospitals in the Auckland region should be able to provide secure facilities for male and female patients in this category."

On 28 January 1986, the Director of Mental Health issued guidelines on the establishment of safe care units to all Hospital Boards and Area Health Boards. He alerted them to their obligations in this particular area of psychiatric care.

It will be apparent that by this stage the PSA had become acutely aware of the need to provide safe care facilities and adequate staffing levels.

Another perspective on the situation which existed at Oakley/Carrington in 1985 and 1986 has been given by Dr John Radcliffe, the then Medical Superintendent at Carrington Hospital. He says that during 1985/1986 there was an increasing unwillingness of medical staff to work in M3 at Oakley. In June 1986, together with a small group of psychiatrists, he drew up an ultimatum to the Auckland Hospital Board. The medical staff would continue to service the ward for 12 months provided the 1984 Working Party recommendations were commissioned within that time, that ceilings of 25 patients and three remand patients were imposed, and that, for good measure, some other long standing plans for hostel accommodation were implemented.

By then, the "Oakley Monitoring Group" of five or six psychiatrists and Dr Radcliffe realized that with the closure of Oakley M3 there would remain a group of patients who could not be accommodated in the new planned

facilities. Accordingly a group of four independent psychiatrists was established with a mandate to advise upon suitable management plans for M3 patients and to advise on the need for secure accommodation. About eight patients were identified to have this need. The purpose of this independent group of psychiatrists was to persuade the Auckland Hospital Board that a unit in the "safe care" range was required. The panel gave its recommendations to Dr Radcliffe which he passed on to the Superintendent-in-Chief. Dr Radcliffe says that he does not know whether those recommendations ever reached the Board.

On 15 September 1986 Dr Radcliffe wrote to the Superintendent-in-Chief, Auckland Hospital Board, regarding M3 at Oakley Hospital:

"... so for a combination of pressure from the Courts, industrial action, and plain lack of resources, M3 is unsafe. There is no doubt that a further Oakley Inquiry held now, would find a number of deficiencies unacceptable to the public"

It is apparent therefore that by 15 September 1986, at the latest, Dr Radcliffe and the independent psychiatric panel were concerned that a safe care unit be ready for occupation by the date of ward M3's planned closure.

Dr Radcliffe has also told us that the Auckland Hospital Board had implied in 1987 that its package of reforms covered security needs. He points out that the package made no proper provision for security for the most commonly required type of patient, i.e. the chronic, psychotic intermittently violent patient referred to by the independent psychiatric panel in its recommendations.

On 15 June 1987 the Minister of Health wrote to the Board regarding safe care facilities and related services. He wrote (in part):

"... your plans to amalgamate Oakley and Carrington are, I know, well advanced. The consummation of the change requires certain actions on my part. I cannot take these steps while the question of secure facilities, and the interface between the Health and Justice systems, remains unsatisfactory."

The Minister sought confirmation that the Board intended to provide a safe care facility

"There is no doubt that a further Oakley Inquiry held now, would find a number of deficiencies unacceptable to the public."

within its institutions. One month later the Board accepted that obligation.

On 15 June 1987 Dr Honeyman attended a meeting of the Carrington Division of Psychiatry. The proposed run down and eventual closure of Oakley was under discussion. Dr Honeyman assured the meeting of his support and of his strong desire to see Oakley close. He said that no consideration should be given to provision of a designated secure facility which could be construed as replacing Ward M3.

On 17 August 1987 staff of Auckland Hospital Board and Carrington management do a swoop on Oakley M3. The Charge Nurse is

Term of Reference (a) (i)

directed to transfer all patients from Oakley M3 to Carrington M7. As soon as patients and staff vacate Oakley M3 the ward is chained and padlocked. Oakley ceases to exist. It is not amalgamated but closed. The 17 patients from Oakley M3 are taken to an open ward which will later be known as the Whare Paia. That ward had been refurbished as an open structured living environment. The patients who would have taken part in that programme are now no longer able to do so. The programme is disbanded. The Oakley patients remain in the open ward.

THE AUCKLAND HOSPITAL BOARD: ITS CRITICS AND THE CRITICISMS

Many of the submissions, both oral and written focussed on events at Oakley and Carrington hospitals since 1983.

Many individuals and organizations were critical of the administrative decisions taken by the Auckland Hospital Board and the effects which those decisions had caused in subsequent patient care.

We set out below representative views of the critics.

PAREMOREMO PRISON STAFF:

On 11 November 1987 we met the Paremoremo Deputy Superintendent and several of his staff including medical and paramedical staff. We did not, on that occasion, meet with the two Justice Department psychiatrists who are employed on a part time basis at the prison. We saw all the prisoners in the Assessment Unit and on the Assessment Block and spoke to many. On the day of our visit the prison muster was 195, of whom 62% were Maori.

Prison officers to whom we spoke overwhelmingly expressed grave concern at their inability to transfer psychiatrically disturbed prisoners to Oakley or Carrington Hospitals. Several officers suggested that the high suicide rate since

1983 was directly related to the reluctance of the psychiatric hospitals to take inmates from the prison system. The officers found this attitude to be quite incomprehensible. One officer summed it up in this way:

"Nobody can tell me that a man who gets a screwdriver and drives it through his head and then a month later drives a four inch nail into his head, is not disturbed. When the Oakley Committee came to look at him we were told that there was nothing wrong with him. A week later he stuck another screwdriver in his head and we still have him. Nobody can tell me that a person who is continually cutting his throat is not disturbed, and yet they will not take him."

Another officer commented that the Oakley staff were occasionally dilatory in responding to a prison request for a psychiatric examination. He said that if prompt action had been taken some of the inmates who had suicided would still be alive. That view was shared by other staff.

We spoke to three prison officers working in the Assessment Unit and the Assessment Block. They told us of the extreme distress which results when they are obliged to deal with mentally disturbed prisoners.

"Nobody can tell me that a man who gets a screwdriver and drives it through his head and then a month later drives a four inch nail into his head, is not disturbed."

One officer said:

"We are not really trained in psychiatric nursing. We are prison officers and yet we have to be nurse, doctor and padre all rolled into one. That is expecting a lot of us. We have not had the training. We have had a two day suicide prevention course but that was very basic."

Several officers said that any attempt to transfer a mentally disturbed prisoner to hospital was an exercise in futility.

Don Swinton, a senior psychologist employed at Paremoremo, suggested that there were three or four inmates presently in the institution who would be examined with some hope rather than expectation that they might be admitted into a psychiatric hospital. He went on to say:

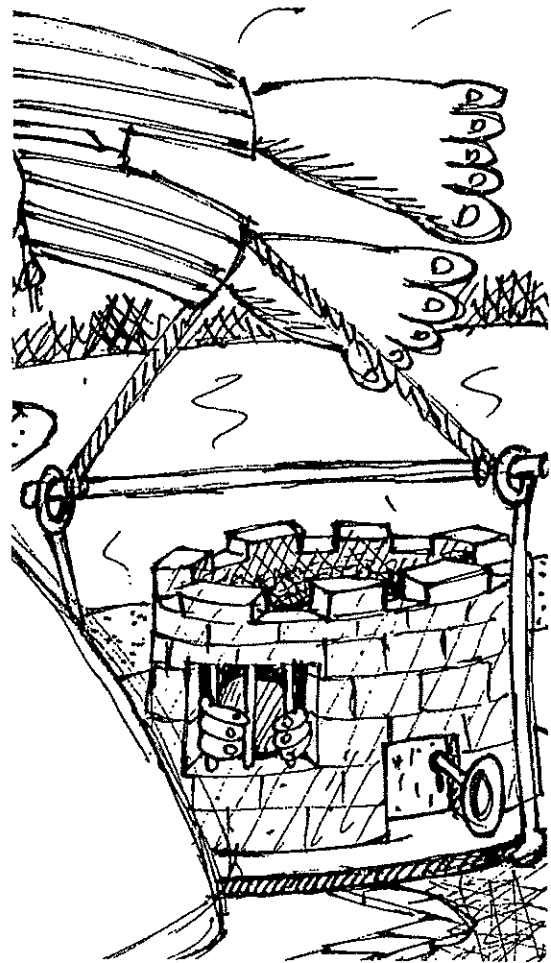
"There are people here who were once dealt with in psychiatric hospitals. We now deal with them in prisons and I feel we are very ill equipped to handle these people because prisons by nature are places of punishment we are being unfair to prison officers expecting them to do this sort of thing. This is not the right environment."

Alan Dowling is a Divisional Officer on the Assessment Block at Paremoremo. He said that the establishment of the Assessment Unit and the Assessment Block had provided some relief both for inmates and prison officers but emphasized that it was only a stop gap measure which would never work while it was contained within the prison system. In his view at least half the Paremoremo suicides since 1983 could have been prevented if the inmates had been placed in psychiatric hospitals. He lamented the fact that disturbed inmates did not have access to psychiatric care.

We also spoke to Greg Price, formerly a First Officer at Paremoremo but now Superintendent at Dunedin Prison. Mr Price said that he had been actively involved in 9 of the 13 Paremoremo suicides. He expressed very strong views about the application of the Mental Health Act by the Auckland Hospital Board and he criticized the elaborate public relations exercise embarked on by the Oakley administration. He says that exercise was designed to ensure that local reaction to the proposed Oakley prison would be such that the proposal would be doomed to failure from the start. Mr Price said

that 10 of the 13 suicides were preventable and the responsibility for those deaths, he suggested, rests primarily with the Hospital Board and to a lesser extent the Justice Department for not making sufficient protest earlier. Perhaps the best way to sum up Mr Price's concern and frustration is to refer to a report which he wrote following the suicide of an inmate by hanging:

"Here we had an inmate crying out for help throughout his sentence; we promised him the world but did not deliver. Dr Whittington did everything in his power to help but got no assistance from the powers that be outside this prison. In summary, what we had was a man with a psychiatric disorder who was refused treatment. What the system basically said was, 'You're not mad, you can't get treatment, you can't go anywhere else, no one wants to know you on release - go hang yourself'."



MT EDEN PRISON STAFF:

On 18 December 1987 we met the Superintendent and several of his staff at Mt Eden prison. John Dephoff is a Probation Officer employed on a full-time basis at the prison. He was convinced that a psychiatric wing was of little benefit in a prison environment. He said:

"It is still gaol. The deliberate criminalizing of mental illness is wrong because these people who are sick should not be here at all."

We then spoke with Humphrey Stroud the prison Superintendent. In general terms he repeated many of the comments which had been made by the staff at Par-emoremo prison. He also noted that his staff were not trained in nursing and commented on the difficulty of trying to deal with psychiatrically disturbed inmates within the army-type routine of a prison. He suggested that continuity of routines was essential within a prison setting if the institution was to run effectively.

We next spoke with Robert Douglas who is the Nurse in Charge of the medical services at Mt Eden. Mr Douglas has had seven years experience as a psychiatric nurse. He told us about the number of emotionally disordered inmates whom he and his staff had identified during the months of August, September and October 1987. They were:-

August	25
September	65
October	34

Mr Douglas also said that each emotionally disturbed inmate had asked that he be sent to Carrington Hospital. We asked whether it was possible that the inmates were malingering. He acknowledged that that was a possibility but said that fairly elaborate medical questionnaires were maintained and that many of the prisoners he referred to had a psychiatric history. He believed that he and his staff would have no difficulty in weeding out those prisoners who were trying to beat the system as distinct from those who genuinely needed psychiatric care. We then asked how many of those inmates

would be certifiable according to the standards which applied other than in Auckland. He said:

"I would say that about half of these people could quite easily have been admitted to a psychiatric hospital. We don't even attempt that because it is a waste of time and paperwork. It is a waste of the Judge's time and it is a waste of our (Mt Eden) doctor's time."

Another experienced prison officer said that in his view the psychiatric hospitals were only interested in taking patients who were manageable and that any person who was obviously a little unstable and showed some aggressive traits was not acceptable. He said that when admission to the hospital was refused the stock answer seemed to be that the inmate had a behavioural problem and not a psychiatric problem.

Miss Dorothy Coster has been the Officer in Charge of the Women's Prison at Mt Eden for 21 years. Miss Coster confirmed that during the past 18 months or so it had been difficult for female inmates to be admitted to Carrington Hospital. She suggested that perhaps Judges were hesitant about sending people to Carrington because the chances were that the patient would be admitted on one day and released two days later.

Miss Coster told us that the prison muster was 20. She said that in 1987 there were 12 women prisoners who were borderline mentally ill of whom three, in her view, were definitely certifiable. She said:

"In the old days we would have had no problem at all sending them out to Carrington. The others (9 inmates) would have benefitted from psychiatric care rather than coming in here."

Miss Coster also said that it was very difficult to deal with people who were either certifiable or who needed some degree of psychiatric care as such people had to be placed with the mainstream prisoners. As a consequence life became more difficult, not only for the psychiatrically disturbed inmates, but also for the remaining inmates and staff.

"The deliberate criminalizing of mental illness is wrong because these people who are sick should not be here at all."

**STAFF : SCHOOL OF MEDICINE,
UNIVERSITY OF AUCKLAND**

Professor J S Werry, Associate Professor J J Wright, Dr R R Kydd and Dr R G Large are on the senior academic staff at the School of Medicine, Auckland. All have professional qualifications in psychiatry. They emphasized that they were expressing personal views.

In their submission, Auckland is tragically behind in the provision of adequate psychiatric services. They told us that since 1982 the Hospital Board administration has been narrowly focussed on Carrington Hospital and that the failure to take action on significant matters outside Carrington contrasts dramatically with the Board's stated intentions in its strategic plan. That was a policy which they regarded as unbelievably short sighted. Professor Wright put it this way:

"It is our collective view that the sequence of events since the Oakley Inquiry of 1982 could have been avoided if a different set of decisions had been made by the Executive of the Auckland Hospital Board other than those that were made. In particular, we believe that by becoming Superintendent at Oakley Hospital Dr Honeyman broke the terms of the Oakley Inquiry's recommendation and proceeded to endeavour to solve the problems by actions that cut off the flow of the psychiatrically ill from the prisons and thus caused congestion in the prison and a psychiatric crisis in that area. At the same time, Dr Honeyman failed to improve psychiatric services within the city.

In particular, he has paid inadequate attention to the development of the workforce and recruitment of suitably qualified consultants. Indeed, the direction of attention by the Executive in respect of Carrington has resulted in simply a series of escalating difficulties with the Public Service Association and with professional relationships within the hospital until ultimately the hospital became unworkable."

Professor Wright then went on to say that there should have been a "holding operation" at Oakley following the Gallen Inquiry. He and

his colleagues acknowledged that there were patients who were inappropriately placed in Oakley and who were subsequently placed in other hospitals. He suggested however that the patients from the prisons should still have been admitted to Oakley Hospital. An effort should have been made to retain the security of the old Oakley hospital whilst at the same time avoiding the practices which resulted in people being locked in a single room. There would then have been a reasonably humane forensic service without great change at Oakley hospital. He then went on to say:

"We believe that there should have been a widespread process of consultation with the psychiatrists in the city and the development of a plan for coordinated services between general hospitals, mental hospitals, day hospitals and other facilities. Token gestures towards this were made in the delivery of a strategic plan, and ultimately an operational plan by the executive of the Hospital Board, but no action was pursued. We believe that the course of events (in Auckland) would have been predictable on the basis of experiences in Britain and America. We could have learnt from their experiences and avoided these problems

but now we are stuck with the worst of all possible worlds; we have high imprisonment rates, low hospitalization rates, bad conditions for psychiatric patients within the community and demoralization of the hospital services."

All four persons regarded the recommendations of the Gallen Inquiry as significant. They said

that important recommendations were ignored or overruled and that advisory groups, such as the Auckland Council of Psychiatrists, the Psychiatric Advisory Committee and the College of Psychiatrists, also had their views ignored on all but trivial issues. They said that the Hospital Board Administration had paid lip service to the long term proposals of that Inquiry. They also spoke about the involvement of Dr Honeyman and Miss Murphy in the events since the Gallen Inquiry. Professor Werry said this:

"There is a spirit of mistrust between the Hospital Board executive and the psychia-

"... the sequence of events since the Oakley Inquiry of 1982 could have been avoided if a different set of decisions had been made ..."

trists. Instead of finding people within the psychiatric community to do the job, the position which was taken by both the Chief Nurse and Dr Honeyman was that the only people who could really do it were themselves. I think the situation is ludicrous if you think about all the duties that the Superintendent-in-Chief and the Chief Nurse have to do. They have to look after the system as a whole without trying to run probably the most difficult spot in the system altogether."

And in respect of the Hospital Board Executive, this was said:

"Their own agenda appears to have given priority to confrontation with the Public Service Association, displacement of the clinical load of violent prisoners and patients to other facilities and the development of unorthodox lines of authority within Carrington Hospital. We believe that unless the paramount need for the maintenance of clinical standards and the safety and well-being of patients is asserted then further and increasing difficulties are to be expected. To achieve this the recommendations of the second Oakley Committee of Inquiry need urgently to be implemented."

We asked Professor Werry whether he and his colleagues were accusing Dr Honeyman and Miss Murphy of incompetence. He replied:

"I think they have made terrible mistakes. Possibly those mistakes could have been avoided if they had been more open to assistance and advice and had other people doing things in the job. However, having said that, there comes a point at which, if you are in a management position, and you make gross errors, whether they are incompetent or unfortunate, then you cease to be effective in that position any longer."

It was urged on us that we recommend the appointment of a Director of Psychiatric Services. The qualification was made that it would be futile to create that position and then allow the appointee to fall under the direct authority of the existing management group of the Auckland Hospital Board.

"... there comes a point at which, if you are in a management position, and you make gross errors, whether they are incompetent or unfortunate, then you cease to be effective in that position any longer."

On the question of dangerousness and the need for safe care facilities, we were told that the vast majority of the psychiatrically ill people are harmless but that there is a small extraordinarily dangerous minority who require the highest levels of security. It is the responsibility of psychiatry to identify those people and then be prepared to take the moral responsibility of keeping them locked up if necessary because they are a danger to others.

They confirmed a statement of concern which they had previously issued:

"The Auckland Hospital Board has taken the position that all dangerous, highly disturbed patients can be handled in an open ward. We endorse this statement in principle but wish to state that at this time we consider such a position is probably impracticable and can be achieved, if at all, only by the present tactic of keeping the most difficult patients out of Carrington Hospital in gaol, or Lake

Alice, or by the investment of such amounts of nursing resources that other services will suffer."

Finally, we were told that since 1982 the Oakley problem has now been transferred to Paremoremo and Mt Eden prisons and Carrington and Lake Alice Hospitals. That was the extent of "progress".

NEW ZEALAND POLICE:

We met with Detective Chief Inspector Bruce Scott and other police representatives on 20 November 1987. The police expressed concern at the ease with which committed patients walk out of hospital and in some cases become involved in crime.

They cited the case of a 19 year old youth who was committed to Carrington Hospital on 12 September 1987 under section 21 of the Mental Health Act. The police assisted the mother with the committal. One week later the mother called the police to her address to take her son back to hospital. He had simply walked out. On 22 September last the patient walked out of hospital again. His condition was described as psychotic.

The second case concerned a man who was

seen by police leaving a tavern at 13.30 hours on 18 August 1987. The same man had been transported to Carrington as a committed patient from the North Shore District Court the previous day. The bar manager complained that the man had created havoc after having had one drink. He was not located at that time. When the police left the man at Carrington on 17 August the comment was made by hospital staff that *"It is all very well for police to commit them, but they can come and go as they please because there is no security."*

The police submitted that there is a need for a tightening up of supervision and security for committed patients, and pointed to the need for a change of attitude on the part of some staff and hospital authorities. They continued:

"It seems ironical that in many of the instances police encounter, while they and the relatives readily perceive that a person is in need of care and treatment, psychiatrists often have a differing view despite the facts being placed squarely in front of them. It could be argued that in some instances the theoretical niceties blur out the practical realities."

The police made several other helpful submissions which are not relevant to this part of our report.

JUSTICE DEPARTMENT:

We met with the Deputy Secretary for Justice, Mel Smith, and departmental officials. Mr Smith told us that prison superintendents were experiencing increasing difficulty in admitting disturbed inmates to psychiatric hospitals. He pointed out that there had been a dramatic decline in Section 42 admissions since 1983 which had been matched by an equally dramatic rise in the number of inmate suicides, attempted suicides and self mutilations. In 1986 the superintendent at Paremoremo had reported that since 1983 there had been 126 self mutilations, 13 hanging attempts and 8 suicides. Mr Smith said that the Justice Department could not establish any causal link between events at Oakley and the prison suicides but commented that the figures were highly suggestive.

He went on to say:

"... some Hospital Boards are ignoring the spirit, if not the letter of the law, in excluding such patients from their care."

"We believe that things have now swung too far to the other extreme. It is our contention that Hospital Boards have a clear responsibility, in terms of their general concern with providing health care to those in need of it and, more narrowly, a statutory obligation under the Mental Health Act 1969 and the Criminal Justice Act 1985 to provide facilities to deal with disturbed inmates. It is also our contention that some Hospital Boards are ignoring the spirit, if not the letter of the law, in excluding such patients from their care."

Mr Smith also said that there were some psychiatrically disturbed inmates who could be dealt with adequately in prison and that since 1981 his department had been improving its psychiatric and psychological services in prison. As worthwhile improvements, he pointed to the establishment of the assessment unit and the assessment block at Paremoremo and the current establishment of the psychiatric wing for remandees at Mt Eden.

He then said:

"However, we do not feel that this absolves Hospital Boards from the responsibility of providing care for those inmates who would be more appropriately cared for in hospital. We find the actions of the Auckland Hospital Board in closing Oakley Hospital in 1987 particularly hard to understand. The closure of Oakley meant that there were no adequate facilities for the disposition of disturbed inmates. It also meant that there is now no adequate provision for keeping dangerous patients in secure facilities"

"What remains important is that such people are adequately cared for in circumstances that improve their mental condition, or at least do not undermine it, and that staff at prisons and hospitals, the other patients or inmates, as well as the public, are protected. Traditionally, and legally, psychiatric hospitals have an important role to play in this care. We feel that they should continue to play such a role. Attempts by the prison-system to dump all difficult cases onto hospitals or, conversely, of psychiatric hospitals to

wash their hands of inmates who are disturbed seem equally irresponsible."

Mr Smith went on to say that the Justice Department supported the development of greater care in the community for psychiatric patients but emphasized that there were two important points to be made. The first is that a need for secure facilities for some patients will remain and must be accepted by hospitals. The second is that such a philosophy, if it is to be successful, implies the provision of adequate facilities in the community.

The Justice Department was adamant that the lack of appropriate facilities at Kingsseat and Carrington hospitals, and the policies adopted by the Oakley administration since 1983, had nullified the provisions of the Mental Health Act.

We were told that the Auckland Hospital Board seems to have ignored the law regarding disturbed inmates. One officer said that, given Auckland's very large population relative to the rest of New Zealand and the fact that New Zealand's only maximum security prison is situated in the region, it is not surprising that the need for forensic psychiatric resources has always been at its highest in Auckland. Consequently the lack of those facilities had created particular problems for the Justice Department.

The Department also expressed grave con-

cern regarding the interpretation of the term "mentally disordered". Mr Smith said this:

"We are particularly concerned with the use of what seems an overly rigorous interpretation of the definition of 'mentally disordered' given in S2 of the Mental Health Act to exclude inmates in genuine

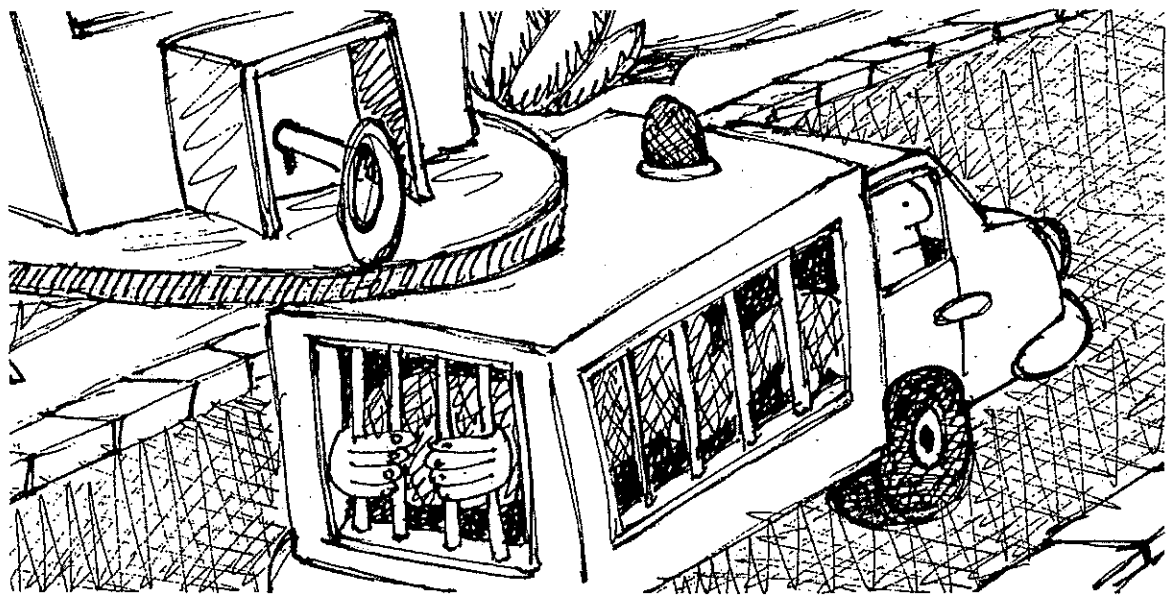
need of psychiatric help that prison simply cannot provide. It seems that hospitals are only willing to take straightforward cases of mental disorder that will readily respond to a therapeutic regime. We would only point out that the first category of those defined as "mentally disordered" does not seem to require that a patient fall neatly into a particular clinically defined

mental illness. It certainly contains no hint of the criteria of 'treatability' i.e. will be cured or show significant signs of improvement within a limited time span, that has increasingly been applied by hospitals."

The concern expressed by those in the prison system is that prisons will become a dumping ground for those difficult cases other institutions or organizations in society are unwilling to deal with.

Mr Smith said he felt it necessary to emphasize that psychiatric hospitals must accept the responsibility to provide secure facilities for the minority of patients who required such facili-

"... prisons will become a dumping ground for those difficult cases other institutions or organizations in society are unwilling to deal with."



ties. He said that this includes not only those who are transferred from the prisons but those disturbed people who are potentially dangerous to themselves or to others. There were some people, he suggested, for whom the "open door" treatment is not adequate.

The Justice Department argued that a limited form of secure containment is inevitable in psychiatric hospitals however difficult that may be to fit in with prevailing philosophies of psychiatric medicine.

We asked Mr Smith about the prison hospital which the department proposed building near Paremoremo. He said that the proposed conversion of Oakley M3 into a hospital prison had been rejected by the local authority and the department was therefore required to look elsewhere. He pointed out that the idea of a prison hospital was strongly rejected by the Gallen Inquiry and went on to say:

"Increasingly the Auckland Hospital Board has been unwilling to provide adequate secure facilities to cope with either convicted inmates or dangerous patients. The Justice Department has been forced to undertake the development of precisely the type of prison hospital the Oakley Committee had so vehemently opposed. Currently Paremoremo and Mt Eden are having to cope with prisoners who are seriously disturbed. As had been feared Hospital Boards have used a strict interpretation of the rather vague definition of "mentally disordered" contained in the Mental Health Act 1969 Section 2 to exclude many disturbed people who would be more appropriately placed in hospital.

What many in the Justice Department feared in 1980 has in fact occurred."

We then asked why the department was building a psychiatric wing for remandees at Mt Eden. Mr Smith replied:

"Mainly because of the intransigence of the Auckland Hospital Board in failing to provide an appropriate facility and our perception that there was an urgent need in human terms to "do something", we then decided to develop the psychiatric remand unit"

"... the Auckland Hospital Board has been unwilling to provide adequate secure facilities to cope with either convicted inmates or dangerous patients."

DR PETER McGEORGE:

Dr McGeorge was appointed as the medical superintendent at Carrington hospital for six months commencing September 1987. He said that since the Gallen Inquiry ideological disputes had arisen between groups who believe in the absolute necessity for locked wards and seclusion rooms and others who believe it is impossible to treat violence properly in those circumstances. He commented that this had resulted in the propagation of myths such as, "people with personality disorders are untreatable and are therefore not the responsibility of the health system". He said that to dispense such people to the justice system without recognizing that some of them may respond to appropriately tailored programmes simply condemns them and the public to expense and suffering.

Dr McGeorge, while recognizing the risks of incarceration, also said that the myth that patient treatment can only be carried out in an open environment may have dangerous implications for the public and patient alike. He was critical at the lack of information relating to specific events and planning at Carrington, and suggested that the lack of information may have had a significant bearing on the tragic saga that had beset Carrington in recent months.

That in turn, he suggested, had implications for what was necessary to correct procedures within the Auckland Hospital Board's services.

We were told that 20 years ago the patient population of Carrington was in excess of 1300; ten years ago it was 800; and in 1987 it varied between 250 and 300. We asked Dr McGeorge whether there had been any real progress during the short period he had been medical superintendent at

Carrington. He responded:

"I am afraid to say that that is an indication of the way that the Board has functioned in regard to mental health services. There needs to be a crisis before things happen."

Regarding secure facilities Dr McGeorge said:

"We no longer have a secure unit in Carrington hospital. The best that we can offer or the worst that we can offer.... would be seclusion rooms on the acute ward."

He acknowledged that the acute ward was

not locked. He said that the existing facilities were set up to deal with patients who could be managed in an open environment and that the hospital had not really faced the issue of the need for secure facilities.

Finally, Dr McGeorge told us that the assessment team which was responsible for deciding which prisoners, if any, should be admitted to Carrington Hospital, was exercising stringent gate keeping.

DR JOHN HALL:

Dr Hall is the Chief Medical Officer to the Northland Area Health Board. He was formerly Deputy Director of Mental Health in the Health Department and for 11 years was the Medical Superintendent at Porirua Hospital. He is a member of the prison's parole board. Dr Hall made several useful submissions, two of which are set out below.

"My main concern now about admissions under Sections 42 and 43 would be as a member of the Parole Board concerning the persistent difficulties over such admissions in Auckland. The Parole Board visits Paramoremo Prison at least every 6 months I am well aware of the difficulties which were caused at Oakley Hospital when Dr Savage was much more willing to accept patients from prison. I must now express the view that the pendulum has swung too far. I have seen some cases, and have been told convincingly of others, where it would have been prudent for those persons to have been admitted to a psychiatric hospital. Enthusiasm by Auckland Hospital Board staff to reduce the difficulties criticized during the Oakley Hospital Inquiry has been commendable. Nevertheless I believe this has been taken too far in reluctance to accept admission of forensic psychiatry patients. This has placed an unfair burden on prison staff."

"Although I support fully the general movement in psychiatric hospitals towards having all the suitable wards unlocked I also believe that all large psychiatric hospitals must accept their public responsibility

to provide accommodation which can safely house patients who may be potentially dangerous. For some remand patients and for some other difficult patients this will often require the availability of a ward or part of ward which does provide a reasonable degree of security."

PUBLIC SERVICE ASSOCIATION:

The Public Service Association includes nurses, psychologists, occupational therapists, social workers and physiotherapists in its membership. We met with the Regional Secretary of the Association, Marney Ainsworth, and several of its members on two separate occasions. Ms Ainsworth said that prior to the Gallen Inquiry the PSA had expressed a high level of concern about conditions at Oakley Hospital and that since the Inquiry the relationship with the Auckland Hospital Board could best be described as one of continuing dispute.

The PSA felt very strongly that the Board had not implemented any of the recommendations of the Gallen Inquiry that might cost money or were likely to make substantial changes. She

"... the Board had not implemented any of the recommendations of the Gallen Inquiry that might cost money or were likely to make substantial changes."

acknowledged that some of the recommendations had been implemented but said that they were mere "window dressing" which was designed to improve the Hospital Board image and the public image rather than actually address the problems that existed. As an example she pointed out that there had been a large number of so called "escapes" from Oakley, and suggested that this was not necessarily due to the "open-door" policy following the Gallen Inquiry. Rather they were a consequence of the failure of the Auckland Hospital Board to follow up the reduced security by increasing the number of staff. What used to be attained with lock and key now requires the allocation of people to maintain adequate supervision. The PSA lamented the inadequate resources which the Board provided.

The PSA also contended that the Auckland Hospital Board had changed its admission policy so that it became almost impossible for a prisoner to be admitted under section 42. It argued that the high level of suicides in prison was a result of a lack of adequate and appropriate

nursing intervention. Ms Ainsworth told us that alternatives needed to be provided once the Board had re-defined the role of Oakley M3. She said:

"The Auckland Hospital Board has a statutory responsibility to ensure that adequate health treatment facilities are available for everybody in the Auckland Hospital Board catchment area and we would argue that that responsibility applies to those people in prison and that loss of liberty does not equal loss of health. The Auckland Hospital Board provides facilities, hospital-based treatment facilities, for those people with physical illness. They refuse to provide hospital-based treatment facilities for those with psychiatric illnesses."

Those present also asserted that prisoners should be subjected to the same medical test which applies to an ordinary citizen in the community and that a prisoner who requires hospitalization should have access to that facility. The PSA stated the need for an assessment team so that prisoners who were intent on "beating the system" could be weeded out.

We suggested that the presence of a secure facility in a psychiatric hospital may escalate violence and dangerousness rather than control it. We were told that security could be built into a facility by way of innovative architecture and by providing a high patient/staff level. Patients would be under constant supervision and could be diverted into programmes which would not result in aggressive or reactive behaviour.

We asked about the PSA ban in Auckland. One PSA member confirmed that there had been a long-standing ban on the admission of "Oakley type" patients to Carrington Hospital. They were emphatic however that they were concerned about staffing levels, the lack of facilities, and the inappropriate environment in which they were required to work, rather than with an intrinsic fear of having to deal with prisoners and remandees as patients. Consequently, they had real apprehensions as to the

service which they could provide to treat those people. One member commented:

... "given adequate facilities we are quite prepared to treat them."

The PSA suggested to us that the Auckland Hospital Board should provide a special regional secure unit thus making Auckland psychiatric services autonomous and negating the need to transfer patients to Lake Alice National Security Unit. Patients would not then be separated from their families and peer networks.

Further comment was made about the relationship between the PSA and the Auckland Hospital Board. Ms Ainsworth said that this had been characterized by frequent conflict, often caused by the seeming inability of the Board to consult with the affected workers before making decisions, and its inability to distinguish between the clinical and industrial implications of its decisions. The closure of Oakley Hospital was given as an example. She said that the PSA wished to be consulted regarding the placement of patients following the

closure of Oakley M3. The Board insisted that this was a clinical matter and was not subject to negotiation. Consultation finally began less than 1 month before the date of closure and only after the PSA had made it clear that attempts to place patients in open wards would be treated as a health and safety matter.

The PSA members present suggested that for the future their relationship with the Board would improve immensely if there was an absolute fundamental commitment to recognize the right of the union to be consulted. They said that the consultation process should be an honest one and that it should not be seen as part of a cynical manipulation of the situation. We were told that there was a tendency for people in the medical profession to dabble in areas of personnel and industrial relations instead of leaving industrial relations to those who were properly trained and briefed. The PSA said that it would welcome a definite protocol of prior consultation.

...prisoners should be subjected to the same medical test which applies to an ordinary citizen in the community and that a prisoner who requires hospitalization should have access to that facility.

We then questioned the PSA members as to the events between the imposition of the ban in March 1985 and the closure of Oakley M3 on 17 August 1987. The events in turn had led to a situation which Dr Honeyman in September 1987 reportedly described as:

"Orders from management have been countermanded ... The situation amounts to anarchy."

Space does not permit us to describe the stand-off which occurred during that period. It suffices to say that we were concerned as to whether or not the PSA had refused to nurse the 17 Oakley patients who were in ward M3 at the date of closure.

The PSA response was:

"We say that we felt a deep sense of outrage and betrayal because had the Board abided by the agreements which they had sought and we had given, none of this would have happened. We would argue that the nurses did not walk out. We would argue that the Auckland Hospital Board removed those people from responsible nursing care in an agreed environment and that the Auckland Hospital Board itself created the situation that developed."

The PSA were critical of the Auckland Hospital Board and said that one of its fundamental errors was in not appointing the right people to take charge of Oakley Hospital. They were critical of the interim appointments of Miss Murphy, the Chief Nurse who became the acting principal nurse, and Dr Honeyman, the Medical Superintendent-in-Chief who became the acting Medical Superintendent. They also pointed out that Dr Honeyman had assumed a similar role, albeit for a brief period, following the departure of Dr Radcliffe from Carrington Hospital. The PSA also commented that the structure of the Auckland Hospital Board did not permit its members to have any real control. We were told:

"There is a lot of power based in the hands of the executive group which consists of the Chief Executive, the Medical Superintendent-in-Chief and the Chief Nurse. That particular structure has a high degree of

autonomy without the necessary checks and balances on what the individuals say and do."

The PSA also said that its members were victimized by the management, that is by people who had vested interests and who were attempting to implement change.

One member said:

"The Auckland Hospital Board does not have the answer as to how Oakley should or could be run. They had some 11 years to put their answers into practice. The fact is they did not. Oakley stood as an example of the neglect, and the general neglect in our society, of psychiatric services."

Finally Ms Ainsworth, on behalf of the PSA, stated that its members were prepared to provide care and management in both prisons and psychiatric hospitals. In either setting, however, they needed the facilities and resources to carry out the work. She said that until the question of resource allocation had been properly considered the likelihood of further incidents, such as those which prompted our Inquiry, could not be ignored.

"There is a lot of power based in the hands of the executive group... That particular structure has a high degree of autonomy without the necessary checks and balances on what the individuals say and do."

NURSE:

We met with several nurses from Oakley/Carrington both collectively and individually. The nurse who presented this submission was working at Carrington, and had previously worked at Oakley for many years.

He stressed the need for a safe care unit at Carrington. He said that some of the patients who would otherwise have been in a safe care unit had been placed in admission wards where they presented severe management problems. Both patients and staff were at risk. He said that subsequent to 17 August 1987 the Hospital Board had looked at the establishment of a project team to advise on the desirability of a safe care unit. He was not optimistic that the Board would want such a facility and pointed out that it had taken three months just to get the personnel of the Committee together.

He also told us that an assessment team from

the hospital had recently been formed to assess referrals from prisons and the courts. The assessment team's experience to date demonstrated very clearly the inadequacy of services and facilities at both the prisons and the hospital. Because no services had been developed to meet the specific needs of prisoners, they remained in gaol. Hospital staff were deciding autonomously on admissions on an individual patient basis, depending on the day to day state of the hospital.

Finally, this nurse commented that the closure of Oakley Hospital was not in accord with the recommendation of the Gallen Inquiry. He said:

"What we now have is a *closure* as distinct from an *amalgamation*.. If there had been an amalgamation Ward M3 would still be operating as a forensic type hospital."

EDGAR ROUT:

Edgar Rout is a long term senior social worker employed at Carrington. He has been employed at either Oakley or Carrington for more than 20 years. There would be few, if any, employees who know as much about Oakley and Carrington Hospitals as he does.

Mr Rout believes that from 1982 onwards, perhaps much earlier, the Hospital Board had an agenda to close Oakley Hospital. He also believes that the lack of safe care facilities was largely the explanation for the March 1985 PSA ban. He said that, following the departure of Dr Savage from Oakley Hospital and the arrival of Dr Honeyman, the criteria for admission of prison inmates altered very markedly. As he put it:

"Slashing yourself with a razor blade or whatever had been tantamount to a one way ticket to Oakley prior to 1983. Slashing yourself or trying to hang yourself was no longer considered a reason for admission. I saw some of the inmates at Paremora... I remember talking with Dr one day and actually saying, "Look, if you had seen that guy in any other situation you would have admitted him to hospital." The inmate was depressed, he was almost inac-

"Look, if you had seen that guy in any other situation you would have admitted him to hospital."



cessible and yet they considered he wasn't certifiable and yet I am sure if they had seen him as an average citizen in the street, they would have admitted him promptly."

Mr Rout also told us of the considerable relaxation of security following the appointment of Dr Honeyman. Hitherto, security had been achieved by lock and key. We were told:

"Those keys were taken off. Prison inmates were taken out for runs every morning around the grounds. Some continued to run and one of them landed in Australia. The policy was that it (M3) was no longer a secure unit

so they could not accept people who needed care in a secure unit. The physical structure of the building had not been altered at all."

Mr Rout was unable to pinpoint when the admission policy changed or who was privy to it. He was adamant however that the change in policy resulted in people, who in other circumstances would have been regarded as mentally ill, being excluded from hospital. Because there had been a relaxation in security at Oakley M3, the period 1983-84 was characterized by "escapes" and walk-outs and transfers of section 42 patients to an open ward. Mr Rout then went on to say:

"The new policy initiated in the time of Dr Honeyman was really a calculated course to close Oakley down. I believe that Dr Honeyman had an agenda to close Oakley Hospital as quickly as possible."

Mr Rout suggested that the blame for that state of affairs was directly attributable to the policy makers. He was unable to say whether that would be the elected Hospital Board or the executive group of the Board. He said that many of the matters he had referred to in his evidence occurred at the executive level, possibly in consultation with some people at Oakley Hospital. He believed that the change in policy was introduced verbally and not in writing. He said:

"Miss Murphy and Dr Honeyman were coming out to Oakley on an almost daily basis and decisions were being made by the management group or the executive group without consulting staff at all. When I use the term "management group" I refer to the management group at the hospital - Miss Murphy, Dr Felgate and Dr Honeyman."

We asked whether there had been a change in admission policy or a changed method of assessing prisoners. He believed that it was both.

"There was certainly a change in assessment procedures but M3 was no longer seen as a secure area and in fact many of those who were assessed and who were deemed to be in need of psychiatric care were trundled straight off to Lake Alice."

He said, that Oakley was no longer a secure area because someone had said, "Keep the doors open". He said that the building was still the same as in the time of Dr. Savage; it was just that the locks had started to come off.

"I think there was a very different and much stricter criterion introduced...I think it was at the direct instigation of the Board. They (the psychiatrists) were interpreting the criteria as laid down in DSM3 in a much stricter fashion. Unless somebody

"I believe that Dr Honeyman had an agenda to close Oakley Hospital as quickly as possible."

showed all of these particular symptoms and characteristics they were not going to be admitted..... regarding the removal or discharge of persons admitted under Section 42 and 43, the new hospital policy returned inmates to prison faster and more vigorously than before."

We then asked what effect, if any, the changed policies had had on the situation at Paremoremo prison. He replied:

"I think this has a direct relationship to the suicide rates in prison. I understand the attitude of the Board and can see that they did not want to be responsible for caring for people whom they felt were the responsibility of the Justice Department. As the legislation stood I saw that there was no option. The law makes provision for people who are mentally disturbed in prison to

be admitted to hospital for psychiatric care."

He then went on to say that of the 13 prisoners who had suicided in Paremoremo since 1983 there was only one whom he did not know on a personal level. He said that some of those prisoners should certainly have been in a psychiatric hospital. Mr Rout commented that in general terms he agreed that management in an open ward was desirable but said that for some patients locked or secure conditions were absolutely essential. He saw the Auckland Hospital Board as having a major responsibility to provide gradations of security in a special security unit in its own geographical area.

NURSE:

This nurse has worked at both Oakley and Carrington. He said that following the Gallen Inquiry the Hospital Board decided that it would not admit to psychiatric hospitals those persons who were convicted offenders who required secure facilities, and those who did not have a treatable mental illness. He said that on specific occasions nursing staff had voiced objections to

the decisions which were being made. They were told that it was not the responsibility of the Hospital Board to admit every potential suicide, and that if people chose to commit violent crimes then that was up to the criminal justice system to deal with them.

We asked whether nursing staff had refused to nurse patients from Oakley M3. The reply was:

"I would disagree very strongly with that. I would say that the nursing staff were happy to nurse all of those men and would nurse any man who required to be in a secure facility. They were not prepared to nurse people whom they believed were simply being set up to commit crimes by placing them in an open environment with very vulnerable patients around. But we were only too happy to nurse them in a secure unit. The hospital was determined to close Male 3 without providing a secure unit and that is where the strife came."

"...It is completely unfair to say that the nurses were not prepared to nurse those men. The implication is that they were not prepared to nurse them under any circumstances. They were prepared to nurse them. If we believed that the facilities were such that the men were more likely to commit crimes and that they could not be contained, then that in a sense is really setting people up to commit crimes. What you are really saying is that other people are expendableand it is just too bad. If that is done in order to carry out some vision of some plan I think that that is ethically diabolical."

CARRINGTON NURSES

This group comprised five nurses four of whom had worked at either Oakley or Carrington for 5 years. We were told that four of the five present intended leaving the ward on which they were working and transferring elsewhere in the hospital. The nurses spoke about the undesirable mix of patients in their ward and some of the conditions under which they were working. They then said:

"What you are really saying is that other people are expendable... I think that that is ethically diabolical."

"We have been forced to abandon our therapeutic programme. We are disgraced by the standard of care that we are able to offer. We are exhausted in our efforts not to compromise our standards and yield only with the shadow of our own personal distress and vulnerability becoming increasingly patent. We accept that there were shortcomings at M3, Oakley Hospital, largely related to the isolation and gender segregation of staff and patients from the mainstream at Carrington. However, some of the functions of M3 were necessary and adequate provision for those has not been made."

The nurses emphasized that they would be willing to nurse special patients or persons who were difficult to manage but considered that, in appropriate cases, a safe care unit would be necessary if their nursing skills were to be properly used. They hastened to add that they were not asking for a return of Oakley M3 philosophy. The nurses clearly regarded the provision of a safe care unit as a priority and also drew the following matters to our attention: "No one

seems to be taking adequate responsibility. The Justice Department doesn't and somebody needs to."

"There needs to be more involvement with the staff at ward level regarding decision making. Those people who are making the decisions aren't in touch with what is actually happening on the ward."

"It is obvious that psychiatric community care and psychiatry generally needs adequate funding and if adequate funding were available everybody would agree as to what needs to be done."

"I have had enough of being a poor relation and getting what is less than 10% of the Auckland Hospital Board budget."

"I endorse the need for a safe care unit at Carrington Hospital."

"It is really important that some sort of formula for accountability be arrived at. No one seems accountable for anything that happens within the psychiatric services, but if people were accountable then we would not be in the situation we are in now."

TIMOTI GEORGE

Timoti George commenced his psychiatric nursing at Oakley Hospital in 1971. He is currently employed as a mediation officer with the Human Rights Commission. Mr George said that in his opinion the Auckland Hospital Board had been playing politics with Oakley and thereby with the safety of PSA members and the public of Auckland. The result has been tragedy.

He also said:

"It is an inescapable conclusion that Hospital Board management are unable to grasp the fact that security and therapy are compatible concepts and are easily implemented given the will to do so."

"I remain firmly of the opinion that prison inmates and remandees suspected of being mentally unbalanced should be assessed, cared for and managed in a hospital setting rather than a prison setting. It would be against the prin-

The Auckland Hospital Board had been playing politics with Oakley and thereby with the safety of PSA members and the public of Auckland. The result has been tragedy.

Term of Reference (a) (i)
ciples of a fair and civilized society if prisoners are denied or otherwise restricted in their access to mental health services."

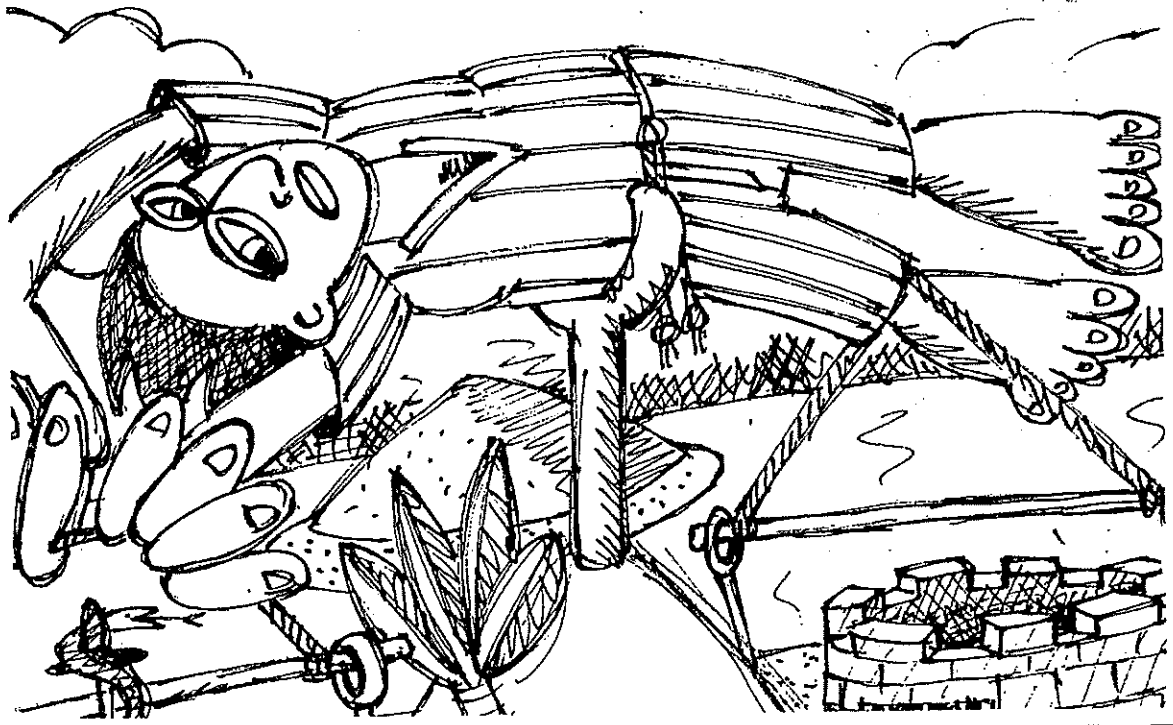
"These patients should not be seen as an unsalvageable pariah group but as a challenge to those care givers who have in the past managed to salvage many of these individuals and assisted in making them law abiding and earning citizens."

"I am firmly of the opinion that had the recommendations of the Gallen Inquiry been implemented in full, as I believed they should have been, then there may have not been any need for the Inquiry that you are presently conducting."

**DR FRANK WHITTINGTON,
DR RACHEL MAULE, AND
WINSTON MANIOPOTO**

Dr Whittington and Dr Maule are Justice Department psychiatrists employed at Paremoremo and Mt Eden prisons. Mr Maniopoto is a probation officer with a special interest in Maori offenders.

Dr Whittington said that in



general terms the Justice Department had taken advantage of the relatively easy admission criteria to Oakley in the period prior to the Gallen Inquiry. He commented on the increasing difficulty of getting prisoners admitted to Oakley or Carrington and said that no provision had been made for those genuinely psychotic people within the prison system. He saw that as a very disquieting trend. Dr Maule also agreed that the pre 1983 attitudes at Oakley "held the clock back" with the result that the Justice Department simply presumed that the Hospital Board would continue to provide the same service which had existed during Dr Savage's period at Oakley. She also commented on the decreasing suicide rate at Paremoremo since the assessment block was established. She said that the assessment block and the assessment unit was an attempt to operate a therapeutic community, albeit poorly structured, in an environment which is not conducive to therapy.

Dr Whittington made it clear that he was opposed to a psychiatric facility within a prison setting. He said:

"I have always been opposed to the creation of a therapeutic environment in the bowels of a maximum security prison. It's a contradiction, its almost an impossibility."

Both doctors agreed that prisons should not cater for the seriously mentally ill and that psychiatric hospitals should be accessible to those individuals.

Dr Whittington then said that there were differences between himself and the Oakley team as to the admission criteria from prison to hospital. He believed that the Oakley team's criteria were too narrow.

We asked the group if they could explain why the vast majority of inmates who had transferred out of Paremoremo had gone to the Lake Alice National Security Unit when there were two psychiatric hospitals just a few miles from the prison. Dr Whittington responded:

"They (the hospital authorities) said that they could not offer the security that is required for a maximum security inmate and as the hospital was a short term facility

the inmates would require long term maximum security which they did not have."

Dr Maule agreed that the explanation was probably one of security. Dr Whittington added that it seemed anomalous that any prisoner would volunteer to go to Lake Alice where the security was rather more stringent than at Paremoremo.

We point out at this stage that Mr Maniopoto provided us with very helpful information and advice concerning the interface between the prisons and the psychiatric hospitals and in particular the effects on Maori persons who entered those institutions. His views are not relevant to this part of our Report but will be included as part of our general comment in the chapters relating to Maori psychiatric patients and Maori health.

DR LAURIE GLUCKMAN

Dr Gluckman is a senior consultant psychiatrist and attends at Carrington Hospital on a part time basis. Four of his more pertinent submissions are set out below:

"It is a terrible thing when a sick person must be sent to a psychiatric hospital near Marton when there are two psychiatric facilities in Auckland."

"The sick person who happens to be a criminal is entitled to much the same treatment as if he were a sick person, not a criminal. Otherwise second class management is part of the punitive process. The concepts of psychiatric hospital and prison are near irreconcilable. There is arising in society the view that the definition of psychiatric illness is an illness which, like pneumonia,

will respond to medication in a short time. Anyone who will not so respond is not wanted in hospital."

"Sadly society now sees the role of a psychiatric hospital as an acute hospital with emphasis on community care and too often community care in my experience is community neglect."

"Staff want patients who will respond

"I have always been opposed to the creation of a therapeutic environment in the bowels of a maximum security prison. It's a contradiction, its almost an impossibility."

quickly and make them feel their work is worthwhile. That is a bad philosophy. It is not too long since those with untreatable pathologies were regarded as Satan possessed and executed. We are excommunicating patients, not to the fire, but to the prison where psychological death, as opposed to physical death, is increasing and that psychological death of course may lead to suicide."

DR D L ANTCLIFF

Dr Antcliff is a psychiatrist at Carrington Hospital. She told us that poor judgement and a lack of insight are an integral part of most psychiatric illnesses and that decisions quite frequently have to be made on patients' behalf. She said that it was possible, but not yet clearly established, that the liberalized attitude in Carrington Hospital has led to excessive personal freedom and has allowed patients to make some decisions they were not fit to make. She observed that excessively restrictive and excessively permissive policies can have detrimental effects on people suffering psychiatric illnesses.

She commented that psychiatric services nationally were grossly under-resourced with 40% of the nation's patients and 14% of the health budget. She said that this had generated a sense of hopelessness and personal failure amongst both staff and patients.

psychiatric services nationally were grossly under-resourced with 40% of the nation's patients and 14% of the health budget.

Term of Reference (a) (i)

Dealing more particularly with Carrington Hospital Dr Antcliff said:

"The term *"personality disorder"* is being widely misused at Carrington. It is used in a loose pejorative fashion without any attempt to establish appropriate diagnostic criteria. It is used to exclude people exhibiting obnoxious undesirable behaviours from treatment facilities in spite of often flagrant psychiatric phenomena. This reflects a low standard of diagnostic expertise among non-

medical disciplines at the hospital and indeed among the very junior inexperienced medical staff who staff the acute wards. It is also untrue that *"personality disorders"* are untreatable. This is a specious term used to justify once again excluding these people from treatment facilities if they are not acutely psychotic because the management of such people is often protracted and difficult. A significant

proportion of patients who are acutely psychotic do present a risk to others. This ranges from quite frequently being assaultive and resistive to very rarely being actively homicidal.... These people are acutely ill and are made worse by feeling they are being incarcerated. They deserve to be treated humanely in an environment which actively addresses their acute illness. If violence is an issue the intensive care unit should be capable of containing them in the initial phase of their treatment "

THE AUCKLAND HOSPITAL BOARD - THE OTHER SIDE OF THE COIN

We met with the Chairman and officials of the Auckland Hospital Board on 3 December 1987. They were: Sir Frank Rutter, Chairman; Mrs Judith Bassett, Deputy Chairperson; Dr A. L. Honeyman, Superintendent-in-Chief; Mr I.A.N. Campbell, Chief Executive; and Miss A. Murphy, Chief Nurse. Dr Honeyman, Miss Murphy and Mr Campbell comprise the executive group of the Board. Mr Campbell was appointed Chief Executive in December 1985. Dr Honeyman and Miss Murphy held their present positions at the time the Gallen Inquiry reported in January 1983. The then Chief Executive was Mr L. Corkery.

We asked whether consensus decisions were made by the Executive Group. Miss Murphy said:

"...We believe we are able to work through things to arrive in a decision making mode not necessarily consensus consensus means compromise we are adult enough to work it through and arrive at a decision in a way which covers most of the aspects of the debate that requires to be put on the table."

Dr Honeyman said:

"The proper verb is to 'agree'. You can agree with the decision or you can agree that somebody else's ideas will hold sway at that time...."

Mr Campbell said:

"...If there is a serious disagreement we would refer the issue to the Board...."

We were told that the Board's current range of services for the mentally ill and its intentions for the future development of those services were set out in the Board's strategic plan, July 1986. That reads (in part):

"7.7.25 The Board accepts the responsibility for providing psychiatric advice in the Courts and liaison with prison medical services. It also has the

responsibility for providing care and treatment to prison inmates who can be appropriately accommodated in a psychiatric hospital.

7.7.35 In regard to a forensic service and facilities for the psychiatrically disturbed offenders, the objectives will be to provide:

(i) A consultative service to the Courts for persons in their legal custody.

(ii) A consultative service to the Justice Department for prisoners.

(iii) Care for inmates who require psychiatric hospital admission."

Our attention was also drawn to the recommendations of the 1984 Working Party. We were told that the Board had established at Carrington an open structured living environment, a closed structured living environment and an intensive care unit for the short-term

management of severely disturbed patients. With the commissioning of those units in September 1987 ward M3 had been closed.

We were told that the Board was currently establishing a special project team to re-examine the provision of safe care units, to determine the precise need for further secure facilities and to develop detailed plans accordingly.

Dr Honeyman confirmed there had been a change in the assessment criteria for the admission of Section 42 and Section 43 patients since the Gallen Inquiry. He said that before 1983 there were prisoners in Oakley Hospital who, had they not been prisoners, would not have been committable under Section 21 of the Mental Health Act. He told us that prisoners were now being assessed on the same basis as a civil patient i.e. the criteria set out in Section 21 of the Mental Health Act 1969. He also said that he was not sure when and under what circumstances the criteria had changed but said there had certainly been open and frank discussion

Dr Honeyman confirmed there had been a change in the assessment criteria for the admission of Section 42 and Section 43 patients since the Gallen Inquiry.

among several psychiatrists regarding the abuse of Section 42.

We then referred to the PSA ban and asked whether any of those present wished to express a view as to why the ban arose. There was an obvious reluctance to do so. Miss Murphy said:

"I would love to know I think I would be open to great criticism if I put forward a view that I thought was the correct and proper view as I am sure there would be many other people around who would tell me that my view was incorrect."

She continued:

"The Public Service Association placed a ban on the admission of patients into the institutions under the control of the Auckland Hospital Board. That was the end of the story they did not communicate. They just placed the ban."

And later:

"...The PSA could well have said that there were insufficient staff and that there was insufficient accommodation...."

Mr Campbell said:

"...The crux of the issue was that we had declared our plan to close Oakley Hospital. There was a conflict between the Board and the PSA view that Oakley was to blame the Board's plan was that Oakley would close as a separate hospital."

Sir Frank Rutter commented that the closure of Oakley was one of the recommendations of the Oakley Committee of Inquiry. He also said in relation to the PSA ban:

"There is a hidden agenda which we don't want to inflame."

We then asked what the Board was going to do about Section 42 and Section 43 patients who may come into the hospital system quite legitimately. Dr Honeyman told us that if a Section 42 certificate is made out the patient will be admitted. He said that the PSA ban was all that had stopped patients being admitted. He agreed that as at the date of our meeting the ban had been lifted. We then asked where those patients would be placed and Dr Honeyman's response was:

"Where it is clinically appropriate. In general terms they would go to Carrington I think."

We asked whether the Board would accept Section 43 patients from Paremoremo prison. Dr Honeyman said that the Board would accept people that it was capable of handling but that the Board's plans for facilities for such people had been based on the presumption that there would be a special prison available to accommodate them.

We then discussed matters relating to nursing and the adequacy of facilities. We informed Miss Murphy that we had spoken to a group of nurses who had said that they were disgraced by the quality of care they could provide. Miss Murphy commented on her admiration for nurses and the nursing profession and said:

".... But I do not feel proud of nursing staff who come and say "we are disgraced by the standard of care which we can give them". I am totally opposed to any nursing staff who try to use patients for their own ends. I am totally supportive of any nurse in this world who is out to look after the patient."

We commented that some nurses had told us about the inadequate facilities at Carrington Hospital. Miss

Murphy again responded:

"It is my opinion and the opinion of the senior nursing administration at Carrington...that appropriate areas are available for the care of people who are psychiatrically disturbed. There is an opinion which ranges freely around the institution by some of the nursing staff that what is available is inadequate. There is another group of nursing staff who do not know what is adequate and do not mind which way we work. You will receive a tremendous variety of opinions as to which and what are the most appropriate conditions at this moment in time depending on the individual person that comes to us with a question of Section 42's if the staff accept that the patient is a prisoner then the staff can deal with the person. It is about attitudes, it is about receptions, it is about drives. It is about where you are coming from as opposed to where somebody else is coming from. This of course is the eternal debate for psychiatry as opposed to almost all other specialities."

"The Public Service Association placed a ban on the admission of patients... That was the end of the story they did not communicate. They just placed the ban."

We asked whether the Auckland Hospital Board was able to receive patients transferred from the Lake Alice National Security Unit. Mr Campbell said:

"...There are a number of wards, a large number of wards, in Carrington which may be locked and there are a large number of single rooms which may be locked for the security, if that is the issue, to be provided. We have commissioned a project team to review the range of facilities, to relate it to the assessed demand and to pursue the issue to its conclusion and report back on whether there is indeed a need for an additional secure facility."

We asked Mr Campbell whether, as at 3 December 1987, the Board was not too sure whether it had a responsibility to provide a safe care unit for prisoners. He replied:

"I think I was trying to say that within the range of facilities at Carrington there are a number of things which, on my understanding of the term, do offer safe care. Whether there is a need for an additional one remains to be seen."

He also said that when the Board looks more closely at the issue of safe care facilities it may find that there are actually enough facilities but that the pressure on them may need to be eased.

We discussed the Paremoremo suicides and pointed out that there had been one suicide in Paremoremo between 1968 and 1983 and thirteen from 1983 to 1987. We asked for comment. Dr Honeyman suggested that we were not comparing like with like and that if a true perspective was to be obtained a comparison should also be made with the number of suicides at Oakley during each of the two periods referred to. He undertook to provide us with the appropriate figures.

Dr Honeyman told us that prisoners have certain rights and that one of those rights is health care. He said:

"... They have the same right of access to health care as other persons... a very important question... is whose duty is it to provide the health care for these persons and I am firmly convinced that it is not the primary obligation

of the Auckland Hospital Board to provide a medical service in prison. We do not do it for physical illness and I cannot for the life of me see why we should be doing it, or attempting to do it, for mental illnesses save only for the historical accident that most treatment of psychiatric illnesses was done in large mental hospitals. That in this day is irrelevant. Most psychiatric treatment is done on an outpatient basis in the community and so forth and in fact whether you like it or not the prisoners' community is in the prison and I commend the notion that not only is the place for this most needed is in a prison but a different prison and secondly, that the duty lies really with those who do the locking up and not with the local hospital board."

We then suggested to Dr Honeyman that that hypothesis flew directly in the face of Sections 42 and 43 of the Mental Health Act. We commented that those sections permitted mentally disturbed prisoners to be transferred in appropriate circumstances to psychiatric hospitals. Dr Honeyman said:

"The law is a piece of enablement. It gives people power to do things. It is not necessarily a sound basis 20 years later for the structure of medical services. I know that the law is there, regardless as to whether what I say is true or not true. It is there and I accept that. I am not arguing against the law at all and believe that the law will always need to be there in one way or another. What I am talking about is the provision of medical services."

Sir Frank Rutter observed that when the Mt Albert Borough Council turned down the Justice Department application to convert Oakley M3 into a special prison, that immediately created a three year gap which the Board was trying to fill. He said that all the Board's thinking was predicated on the basis that the special prison hospital would provide the sort of security we had been talking about. He said that the Board's expertise was in treatment and not in custody and that the assistance of the Justice Department would be required when the question of a custodial duty arose.

"... within the range of facilities at Carrington there are a number of things which... do offer safe care. Whether there is a need for an additional one remains to be seen."

Dr Honeyman emphasised that it is and will be the policy of the Auckland Hospital Board that its staff obey the law. He also commented that pointing to deficiencies is a simple matter but pointing to the remedy is a rarity because most of the causes of the deficiencies are in themselves complex.

Mr Campbell commented that following the Gallen Inquiry the Board was very conscious of the shame of past events at Oakley and the need to ensure that there was an improvement. He also suggested that some of the voices amongst the babble of voices since the Gallen Inquiry had not been reasonable.

Miss Murphy then told us about the 17 patients who had been transferred from Oakley M3 to ward M7 on 17 August 1987. She said that those patients:

"....Had been viewed by staff at Carrington to be far too dangerous, far too anything, to be cared for in our ordinary wards."

She said that staff were not prepared to nurse those patients and that they were now living in a unit (the Whare Paia) which does not have a locked door. Miss Murphy commented that the term "safe care" did not necessarily mean that one had to resort to locks and keys. In general terms she suggested that people with appropriate skills could fulfil that function by providing a therapeutic environment and providing also that they were committed people. She said that Section 42 and Section 43 patients could be dealt with in this way. Miss Murphy said that if such units were staffed by people who have appropriate skills then it would be unnecessary to resort to locked doors and seclusion. She said that she was totally opposed to seclusion.

We pointed out that at the Gallen Inquiry in 1982 the then Chief Executive Mr Corkery had said that prisoners should not be in psychiatric hospitals and that the care and management of disturbed prisoners was the Justice Department's problem and not that of the Auckland Hospital Board. Sir Frank Rutter acknowledged that that comment had been made but said that Mr Corkery was merely drawing attention to the fact that the Board's expertise was in therapy and the Justice Department's expertise was

in custody. He said that the Board had never had such a policy.

Dr Honeyman commented that if an order is made by a Judge under section 42 or 43 then the Board is obliged to comply with it. He said that the Board may have difficulty complying with it but that is the law.

We then asked those present whether they wished to comment on the oral evidence given by Professor Werry, Associate Professor Wright and their colleagues. Mr Campbell observed that the evidence did not reflect the world as he knew it. Dr Honeyman suggested that much of

the evidence was hearsay and Mrs Bassett pointed out that the philosophical outlook of Professor Werry and his colleagues was rather similar to that of Dr Honeyman and Miss Murphy. She indicated that in her view personalities and personal antagonisms may

have coloured the evidence which the senior academic staff had presented to us.

We then moved on to discuss the way in which the Board had dealt with the recommendations of the Gallen Inquiry. We said that we had received a great deal of adverse criticism from a wide range of people about the Board's actions in this regard.

Sir Frank Rutter said:

"Regarding the Director of forensic services; the Board carefully considered this recommendation and felt that its principal adviser had to be the Superintendent-in-Chief ... so the Board took a positive decision not to appoint the Director. However the Board does believe that a coordinator of psychiatric services, including forensic psychiatric services, would be appropriate and I believe I am right in saying that we are taking steps to put this into effect."

Mr Campbell said that most of the Gallen Inquiry recommendations had been implemented but acknowledged that there were a number of specific recommendations which the Board did not accept. He said:

"...The Board would contest criticism of a failure to implement recommendations if in fact they did not accept them. They included the concept of the Board of Control...and the inappropriateness of the Medical Superintendent being the Superintendent-in-Chief.

**...the term "safe care"
did not necessarily
mean that one had to
resort to locks and
keys.**

The Board as I recall it was well aware that 75% of Hospital Boards in this country have positions such that the Superintendent-in-Chief is also the Medical Superintendent of a hospital. There is no inherent unsuitability about the arrangement which the Gallen Committee appeared to believe there was. Regarding the Director of forensic services the Board actually made a conscious decision ..that they didn't wish to follow through the recommendation."

Mr Campbell also told us that the Board at that time was moving to integrate the nursing services under one principal nurse and hence Miss Murphy's appointment to the position at Oakley.

Sir Frank Rutter told us that Dr Honeyman was appointed Medical Superintendent because, to the best of his recollection, Dr Fraser McDonald was unavailable at the time and consequently there was no way in which the Hospital (Oakley) could be medically administered unless Dr Honeyman took on that responsibility.

Dr Honeyman said:

"There is an arguable case that Hospital Boards have to be responsible for what they manage and they can't give it to somebody else. We would contend that the recommendation was actually ill-founded."

Dr Honeyman said that he had been Medical Superintendent at Oakley for 3, 4, or 6 months.

Sir Frank Rutter commented further about the non-appointment of a Board of Control as recommended by the Gallen Inquiry. He said that although the Hospital Board did not set up a Board of Control they had established a Committee of the Board which was chaired by (now) Sir William Manchester. He said:

".... That Committee met regularly at Oakley and had people on it who were outside the Board. The job of the Committee was to oversee and implement those recommendations that had been adopted by the Hospital Board. The Board felt strongly that the Board of Control (Gallen recommendation) was not administratively possible within the structure of the Auckland Hospital Board and we felt that the Auck-

land Hospital Board plus the Committee in fact constituted adequate control."

He agreed that there were no representatives of the PSA on the Committee. He also said that the committee reported to the Auckland Hospital Board but it did not have delegated authority to act.

Mr Campbell said:

"There was a difference in what was implemented and what was recommended and it would be true that some of the people on the committee...felt that the committee should have had more power than it was actually given. There was some tension about that."

MRS JANET QUINLAN

We met with Mrs Quinlan, the Principal Nurse at Carrington Hospital, on 12 November 1987. Mrs Quinlan said that Hospital Boards have a responsibility to provide a wide range of psychiatric services and that as far as possible people should be treated in the environment with which they are familiar and where they will have community support and networks.

She said that prisoners are often sent to Carrington Hospital because they needed to be contained for prison reasons rather than mental health reasons. It was her belief that very few prisoners are mentally ill per se and therefore requiring hospitalisation, but acknowledged that they did require some form of treatment. She did not believe

that it was the responsibility of Carrington Hospital to provide that treatment and asserted that it was the responsibility of the Health Department and the Justice Department to come to some agreement as to how those people could be treated because of the need for containment. She said that hospital was not the place for that.

Mrs Quinlan said that she was happy to have people in the hospital who have an acute psychotic illness which is treatable in the short term so that they could then be returned to the place from whence they came. She also said:

"We are happy to have people who have an illness that may take some time longer if we have the facilities."

It was her belief that very few prisoners are mentally ill per se and therefore requiring hospitalisation,

We then suggested to her that realistically there was no chance of a prisoner from Paremoremo ending up in Carrington Hospital. She replied:

"I'm saying that we could accommodate a small proportion of those people if in point of fact the move was swift. Because we have not got any other facilities in this hospital I don't think we should have to look after that person once the acute episode is over."

Mrs Quinlan also said that she regarded a psychiatric hospital as a place in which to treat mental illnesses. She did not believe that a hospital was a place to lock people up. Nor did she believe that prisoners who suffer from psychiatric illnesses should be excluded from treatment but suggested that the treatment should be carried out where it was most appropriate and a psychiatric hospital she asserted should be kept for those people who are mentally ill and require that 24 hour treatment that is necessary in a psychiatric hospital. We then asked where a prisoner should be treated. She replied:

"I don't know because I don't know what's possible in prisons, but I would say...a prison is a community and in that community should be the services that the community needs."

Mrs Quinlan did not agree to our suggestion that it was virtually impossible to undertake a therapeutic regime in a prison environment. She said:

"There are people in prison.. who are being contained for reasons of the law. There must be ways in which you can treat these people according to their needs."

We said we would welcome her advice as to how that could be achieved. She replied:

"I would have to go in there and see but I am positive that it could be done. We have lots of

closed environments in our society. We have boarding schools and convents."

Mrs Quinlan said that not many prisoners would require 24 hour medical and nursing care for their psychiatric disorders and that many of them would fall into the category of those who were inadequate and unable to cope.

We mentioned that there had been 13 suicides in Paremoremo during the past 4 years and invited her response. She replied:

"How many suicides are there in our society?"

We then discussed treatment regimes and Mrs Quinlan said that the method of treating men in Paremoremo was counter-productive. By way of explanation she said:

"Just to go back to Oakley. There were 25 patients in Oakley who were said to be dangerous. Oakley was closed. 17 patients now remain in the Whare Paia. There is no seclusion. There are no locked doors. There's a minimum of medication and there has been no violence. They are in an environ-

ment which is different. I believe the prison environment does escalate people who are unable to cope but you have got to address the environment; it is a very unhealthy environment."

Mrs Quinlan made several observations regarding dangerousness and violence and concluded by saying:

"... If you lock people up continuously all together and don't let them out, their violence usually escalates."

We point out that Mrs Quinlan lamented the fact that insufficient funding had been made available for psychiatric services and facilities in the community. She emphasised that she supported that approach and suggested that many of our existing problems would not have arisen had the money been spent in those areas.

There were 25 patients in Oakley who were said to be dangerous. Oakley was closed. 17 patients now remain in the Whare Paia. There is no seclusion. There are no locked doors. There's a minimum of medication and there has been no violence.

THE ASSESSMENT TEAM: WHY WAS IT FORMED AND WHAT DID IT DO?

It will be apparent from the preceding pages that many individuals and groups were highly critical of the change in hospital admission criteria since 1983 and the consequences which flowed from that change.

It was said that the lack of safe care facilities and an insistence by medical staff that inmates must be suffering from a treatable mental illness effectively blocked the flow of prisoners from Paremoremo to Oakley/Carrington and that this was the hidden agenda of the Auckland Hospital Board.

This then resulted in prisoners either remaining in gaol or, alternatively, being admitted to the National Security Unit at Lake Alice. One inference that could be drawn therefore is that since the changed criteria came into force, the Oakley/Carrington psychiatrists had adopted an "accommodation" test rather than a "psychiatric" test in deciding whether to sign committal papers pursuant to Section 42 and 43 Mental Health Act.

We were concerned to test the validity of this. We were also gravely concerned at what appeared to be an inordinately high suicide rate at Paremoremo prison commencing at about the time the changed hospital admission criteria was initiated. In particular, we wanted to find out whether there was a correlation between the two.

We were told that at any given time there were between 22 and 30 prisoners in the Assessment Block and the Assessment Unit at Paremoremo. We were concerned to be impartial in drawing conclusions from our own observations at Paremoremo and in weighing up the evidence presented to us. We arranged for an independent Assessment Team to visit Paremoremo. That team was chosen after we had consulted with kaumatua in

Auckland and South Auckland. It comprised:

Dr Phil Brinded	Consultant Psychiatrist Christchurch
Mrs Betty Goodwin	Community Worker Mangere
Dr Douglas Wilson	Consultant Psychiatrist Hamilton
Mr Hohua Tutengaehe	Tutor Christchurch
Mr Warren Brookbanks	Barrister and Solicitor Auckland

Dr Brinded and Dr Wilson have a special interest in forensic psychiatry.

Mrs Goodwin and Mr Tutengaehe are widely known and respected in the Maori community. Mr Tutengaehe is an Official Visitor at Sunnyside Hospital, Christchurch.

Mr Brookbanks has a special interest in mental health legislation.

Our brief to the Assessment Team (Mr Brookbanks excluded) was as follows:

"We request that you examine all prisoners in the Assessment Block and the Assessment Unit at Paremoremo Prison to ascertain how many (if any) of those prisoners should be dealt with pursuant to Section 42 or Section 43 in accordance with the criteria which, as psychiatrists, you would commonly adopt. We are concerned as to whether the so called "Oakley criteria" is appropriate."

Mr Tutengaehe and Mrs Goodwin were invited to be equal partners in that assessment process and to apply their

special skills and expertise, particularly in assessing the impact of Mate Maori (Maori sickness).

Mr Brookbanks was invited to examine the medical and prison files of the 13 Paremoremo

One inference that could be drawn is that... the Oakley/Carrington psychiatrists had adopted an "accommodation" test rather than a "psychiatric" test.

inmates who had suicided since 1983 and to give an opinion as to whether the high suicide rate was attributable to the change in admission criteria. Our brief continued:

"Basically we want to know, in respect of each suicide, whether, prior to each suicide, there was information available to prison or medical staff either of a psychiatric or other nature which would have justified committal or transfer pursuant to Section 42 or Section 43. If such information was available, why was a Section 42 or Section 43 Order not made?"

Mr Brookbanks was asked to confer with the other members of the Assessment Team in evaluating the information given to him.

After visiting Paremoremo prison four members of the Assessment Team met with a group of psychiatrists at Carrington Hospital on 17 February 1988.

We now set out the following:

1. The report on the Assessment Team's visit to Paremoremo Prison 1-5 February, 1988:

2. Clinical Report on 13 of the 17 Paremoremo inmates examined between 1 - 5 February 1988:

3. Report of meeting between Assessment Team and Carrington Psychiatrists, 17 February, 1988:

4. The Paremoremo suicides - Report by Warren Brookbanks.

ASSESSMENT TEAM: REPORT ON VISIT TO PAREMOREMO PRISON: 1 - 5 FEBRUARY 1988

This Report is compiled from information given to the Committee of Inquiry by the Assessment Team. It has been edited to ensure confidentiality. The Report has been checked by the Assessment Team who have confirmed its accuracy and the findings and views contained therein.

The Report follows:

Our instructions required us (inter alia) to carry out a psychiatric examination of all prisoners in the assessment block and assessment unit at Paremoremo prison and to assess the impact, if any, of *mate Maori* (Maori illness) in respect of Maori prisoners.

We were briefed as to the history of the institution and were then taken on a tour of inspection. We were shown the normal cell block areas and D Block. In D Block the men are under very intensive scrutiny. We were then taken to the psychiatric observation unit and shown the Assessment Unit and the Assessment Block. The Assessment Unit is a four-bed, closely supervised area and the Assessment Block is a cell block housing some 23 or 24 prisoners who are regarded as emotionally and

psychologically too vulnerable to be contained elsewhere in the prison.

The Superintendent and his Deputy gave us a list of men whom they regarded as psychiatrically disturbed in some way. They went to some trouble over that procedure after consulting staff and after excluding the names of several of the inmates actually housed in the Assessment Block and in the Assessment Unit because they were well enough to be transferred in the near future to a normal cell block.

Initially the medical members interviewed several men jointly. The interviews went well in that we found our techniques and views to be in accord so that subsequently we were able to split into two teams to facilitate a more rapid examination of the inmates involved.

It was obvious from the outset that some of the prisoners were very disturbed psychiatrically. We should add that Dr Whittington, who was on leave when we arrived, joined us in the course of the morning and gave us an account of his difficulties in dealing with the psychiatrically disturbed prisoners and particularly the difficulty in transferring them from prison to hospital. We found his comments very helpful. He stressed that he regularly had difficulty in

obtaining transfers of men who had a clear mental illness.

When we started examining the men it became apparent that this was indeed the case and we were able to identify amongst the first three or four men cases of manic depressive illness and schizophrenia which needed treatment in a psychiatric hospital.

Later we shall let you have a Report on 13 of the 17 persons whom we interviewed. It will suffice at this stage to tell you that after seeing all 17 patients we divided them into four groups:-

Group 1:

This group were inmates who fulfilled committal criteria on the day we saw them. There were seven persons in this group.

Group 2:

This group were inmates who were stable on the day we saw them, but who would be clearly committable during the acute phases of what usually had been quite a lengthy illness. There were four persons in this group.

Group 3:

This group showed no evidence of ongoing, psychiatric illness although they were capable of disturbed behaviour. This group is a type which is not unusual in a prison setting. There were four persons in this group.

Group 4:

It is questionable whether the two persons in this group were committable but by any standards they were totally misplaced in Paremoro.

One of the inmates in Group 4 is a Samoan who was convicted of the manslaughter of a child. He speaks no English. He has had a stroke and is hemiplegic. He spends all his day in the prison hospital because he cannot be placed elsewhere. He would be victimised in one of the normal cell block areas. He is mentally subnormal and we were told he spends all his time either watching the test pattern on the television or playing with soft toys or little cars that the prison officers bring in for him.

The other person in Group 4 was seen by us in the Assessment Unit. We believe he was convicted on fraud and car conversion charges. He has shown some instability. He appeared

intellectually slow. We do not know in what range a formal psychological assessment would have placed his intellectual ability. He suffers from persistent enuresis in that he wets himself day and night and clearly, in terms of being a danger to the community, or being capable of violent offending, he poses little risk at all. He is there because the authorities do not know how to cope with his rather eccentric odd fantasizing and the fact that he wets himself all the time. He was placed in Paremoro because of that.

In our view 11 of the 17 inmates whom we saw would be either committable immediately or would certainly be committable during an acute phase of an illness, i.e. they would need to be transferred to a psychiatric hospital. If one were to take into account the other two inmates who were mentally subnormal then 13 of the 17 inmates, in one way or another, were in need of significant psychiatric help.

We would point out that the original list of 17 inmates was drawn up by the prison Superintendent and some of his officers which demonstrates that the layman's perception as to when someone is psychiatrically disturbed in a maximum security prison is a fairly accurate perception. It was also apparent to us that the Superintendent and his officers had used a fairly low threshold when deciding whom we should see. Basically the inmates who were excluded were those showing absolutely no signs of disturbed behaviour.

You have asked us what test we applied in making our assessments under Section 42. You have told us that on several occasions your Committee of Inquiry has been informed that the so called "Oakley team" have adopted an admission criteria which is incorrect and that an accommodation criterion may have been used rather than a psychiatric criterion. You have also told us that the test used by the "Oakley team" is that a prisoner must have an identifiable mental illness which is capable of treatment. You have asked us to comment on that test and in particular to make some observation as to the extent to which treatability should be part of the admission process.

...13 of the 17 inmates...
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help.

We have looked closely at the Oakley admission criteria but cannot agree with it. The test which we used as psychiatrists was whether there was the presence of an identifiable mental illness such as schizophrenia, manic depressive psychosis or some organic mental illness such as a dementia. Put another way, we were looking for the presence of hallucinations, delusions and thought disorder. We were also concerned about helping these people to get appropriate treatment.

We can envisage some mental conditions being treated quite safely in prison but we concluded that most gross mental illnesses could not be safely treated in prison. Although there are psychiatrists available, we were told that there were no trained psychiatric nurses available and of course the prison routine is rather strict and cruel and is not suitable in our view for the management of severely depressed people or someone whose thinking is disturbed by schizophrenia.

We believe that the test we both used was actually quite conservative. We were not liberal in terms of encompassing personality disordered persons, we were looking for things that have already been mentioned, namely, someone who was clearly suffering from a psychotic illness with perceptual abnormalities and thought disorders.

In our view the criteria being used by the Oakley/Carrington staff is negative. They are prepared to examine and assess an individual and we do not think they would disagree with our findings of mental illness. But they then take matters a stage further. They look at the inmate's history, his reliability and other factors and because there is no secure unit at Carrington the inmate is denied admission to the hospital. It is the security aspect of the case which is significant. That was highlighted by one of the psychiatrists at Carrington who was going out fairly regularly to Paremoremo to assess the prisoners. He now refuses to go because he says he is assessing inmates for Lake Alice and not for Carrington because there is no place in Carrington to which the prisoner is able to go.

...the hospital would not take dangerous patients.

All the prisoners in Paremoremo were regarded as dangerous and therefore they could not be admitted to the psychiatric hospital.

You have asked us whether an accommodation test was being applied by the Oakley/Carrington team. After the first day at Paremoremo it became quite clear to us that it is an accommodation test that is being used. We do not try to address why that is so - that is another issue.

We were told that there was an increasing reluctance, and a sense of pessimism by those working in the prison, to refer a prisoner to Oakley/Carrington. We were told that they knew what the answer would be - they would be rejected. The prison staff had also been told that regardless of anything else the hospital would not take dangerous patients. All the prisoners in Paremoremo were regarded as dangerous and therefore they could not be admitted to the psychiatric hospital. It was this kind of circuitous attitude that made the staff at Paremoremo reluctant and pessimistic.

It is obvious that the prison is having to cope by default with psychiatric illnesses. The staff deserve praise for what they have done but it is very difficult for them. The psychiatric facilities and psychiatric treatment available at the moment is sadly lacking. Even if the patients whom we saw were committed to psychiatric hospitals Paremoremo would still be sadly deficient in psychiatric input. There are two psychiatrists employed by the Justice Department, one of whom is there for one day per week and the other attends for two days per week. There are visiting psychologists but no psychiatric nursing staff. There will always be mental illness and disturbances within the prison system but Paremoremo is not equipped to deal with it and certainly it is not equipped to deal with what is happening at the moment.

You have asked us whether there are any other matters which are relevant. The prison staff told us they had been spoilt by the previous arrangements with Oakley hospital. The Justice Department had been allowed to continue on without making any provision whatsoever for psychiatrically disturbed people within the prison because there was such a low threshold for admission to Oakley. Now that

that state of affairs is reversed they acknowledge that they are in big trouble.

It highlights again that the prison authorities should have developed psychiatric facilities to a much greater extent than they have. It looks as if they are now going to address that with a new prison hospital but it is not going to be the whole answer.

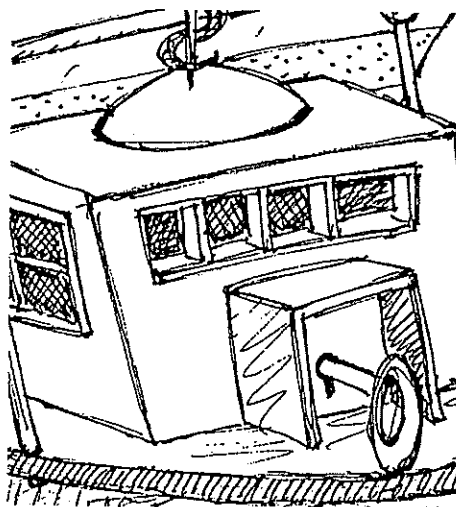
The psychiatric hospital also needs to realise that there are some prisoners who will be coming out of prison into the hospitals and they will have to decide how best to deal with them within the health system. No one has really made provision for this very difficult group of people. The amount of treatment that can be provided in a punitive setting is both limited and distorted.

We doubt whether there would be too much difference between the assessments made by us on the one hand and the assessments made by the Carrington psychiatrists on the other. But of course they have added an extra dimension which is the question of security.

You have asked us whether the patients whom we saw and who are presently committable under Section 42, could properly be contained in Carrington Hospital. Our view is that there are facilities at Carrington which could cope with some of the prisoners but not most of them. Given the present state of the hospital and the morale of the staff, as we understand it, we believe that it would probably be quite difficult, if not potentially disastrous, if most of those prison inmates were placed in Carrington.

Your Committee of Inquiry has been told that the test used by the Carrington psychiatrists is that the prisoner must be suffering from an identifiable mental illness which is capable of treatment before he will be transferred pursuant to Section 42. You have asked us to comment on this. We believe that their use of the word "treatable" conflicts with our use of that term. We think they would more accurately express their view if they were to use the word "curable". A lot of mental illness is not curable.

Some groups of mental illnesses respond to appropriate psychiatric treatment. They are treatable but not curable. For us the test is whether one can ameliorate the condition. Our joint definition of the term "treatable" is synonymous with "ameliorating" or at least amelioration is included in the definition. The most charitable explanation that we can offer regarding the Oakley/Carrington test is that when they use the term "treatable", they are in fact talking about something which is "curable" which is a much stronger term.



We, the two psychiatrists on the Assessment Team are aware of our Maori colleagues views regarding the prison system in general and the mental health of the 17 persons whom we all saw at Paremoremo. We wish to support their statement. We felt, from a European point of view, that there was a tremendous lack of Maori input at Paremoremo. There is a lack of Maori cultural input. There is a lack of spiritual input and there is a lack of educational input and we think it is up to

the Maori people to say how best these needs are to be met. These were needs which we also identified.

We would also want to say that one of the most moving things for us was to see the response of the Maori inmates to Hohua Tutengaehe and Betty Goodwin. That was really striking. The presence of those two people cut through whatever was there and it was striking and a real education to us. There was a Wairua about it. It was something very important to the men. We would also wish to say that from our point of view it was vitally important that we work in tandem with our two Maori colleagues. They were able to make a cultural contribution from the psychological and social point of view that we may not have been able to understand and therefore could not really come to grips with. That method of working together was very much of benefit to us.

We, the two Maori members on the Assessment Team wish to make it clear from the outset that we support the professional views which have been expressed by our two colleagues. From a Maori perspective those views are valid. Our discussions with the men in Paremoremo commenced with karakia. We were interested in the presence of mate Maori and that was a factor which we took into account as the examinations proceeded.

We were pained at what we saw. We were pained by the fact that there was no Maori input anywhere along the line, even in terms of the prison building itself. There was a strong call from the inmates to have kaumatua - a permanent kaumatua - coming in just to see them, just to listen to them. There was also a strong call for a minister of religion or a tohunga to go into the prison. Clearly, from a Maori point of view, the 13 persons referred to by our colleagues should not have been in prison. 13 of the 17 prisoners whom we assessed were Maori. We would have no objection to those 13 patients being treated in a psychiatric hospital. Anywhere outside the prison system would be better. It was clear to us that the mind starts to deteriorate pretty rapidly in prison. The prison officers carry an awful responsibility. They are parents, they are security people, and they are supposed to be psychologists and psychiatrists. They are making that type of assessment daily and we are sure that it affects them as well.

You have asked us whether, from a Maori

We were pained by the fact that there was no Maori input anywhere along the line, even in terms of the prison building itself.

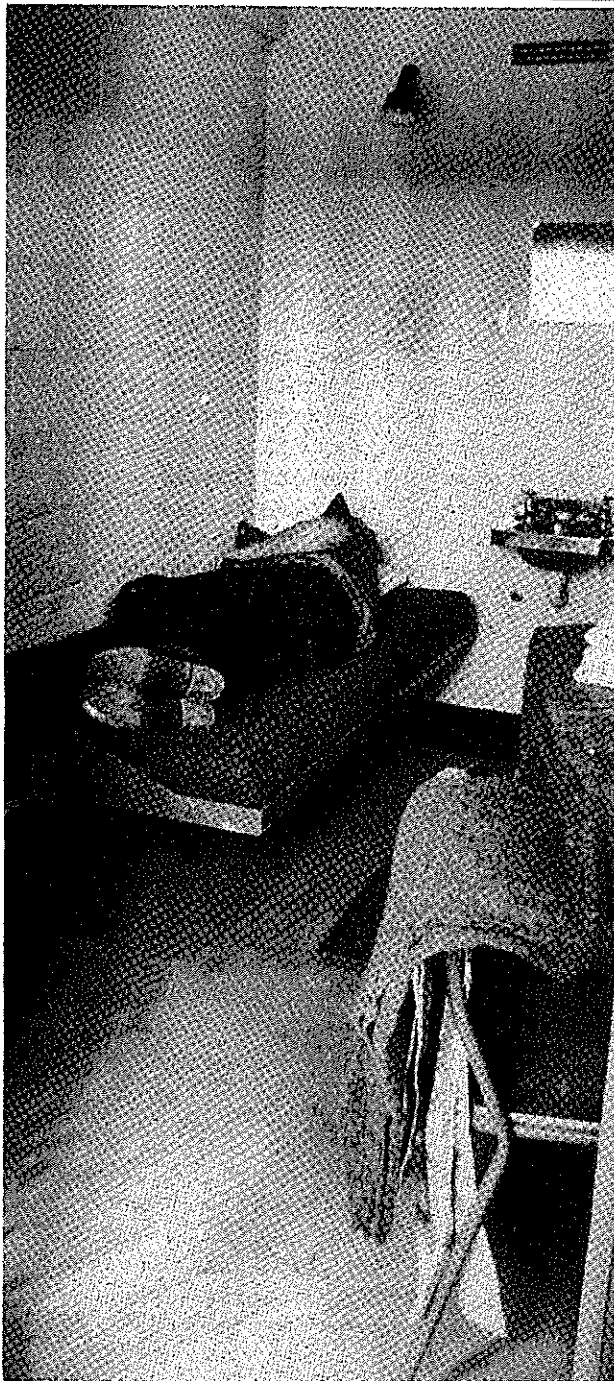
point view, there was anything in the assessments undertaken by our two psychiatric colleagues which would be in conflict with our views as Maori people. Although our two colleagues have not mentioned matters of culture, language and different backgrounds, we would have to say that their views and their assessments are not in conflict with our own views.

We believe that it is important to marry up the professional psychiatric side with the Maori side so that one can get an even balance. There is a part for the Maori and a part for the professional and the two must go together.

You have pointed out to us that in some psychiatric hospitals it is the accepted thing to allow a Maori patient to see a tohunga if that patient or his whanau expresses such a wish. You have asked us to make some comment on that regarding the prisoners whom we saw in Paremoremo. We want to say that in our view, as Maori people, it is very important that the prisoners be allowed to see a tohunga if they so wish. It seems that most of the people whom we saw had that wish.

When we welcomed the prisoners in to meet with us we asked if they would mind having karakia and they all had karakia and it was obvious to us that they were in deep meditation in their whakamoemiti. It was also obvious that they were grateful that people whom they regarded as kaumatua and kuia were there to listen to them.

**ASSESSMENT TEAM:
REPORT ON THIRTEEN OF SEVENTEEN PRISONERS EXAMINED AT
PAREMOREMO MAXIMUM SECURITY PRISON
1 - 5 February 1988**



We begin with the inmates in the Assessment Unit.

A: He has a long history of mental illness and psychiatric treatment. He was diagnosed some years ago as having a manic depressive illness and has received treatment from many people including the Department of Psychiatry at the University in Auckland.

He had returned from Lake Alice some three months before we saw him. He had been in Lake Alice for three months after becoming ill in prison. He was certainly viewed by the prison staff as being much better on his return. However, there was also evidence in his notes as to some disquiet by Dr Frank Whittington, the prison psychiatrist, that A had in fact been returned too soon.

A was serving a sentence of preventive detention following four convictions for rather sadistic rapes. When we examined him he was very ill. He was clearly psychotic as evidenced by grandiosity, thought disorder, delusion thoughts and perceptual abnormalities.

I believe him to be clearly committable under Section 42 of the Mental Health Act.

B: He is a young man with no previous history of psychiatric illness who had become unwell while serving his prison sentence in Mt Eden. He had been transferred to Paremoremo prison where staff had had major difficulties controlling him and had sent him to the Assessment block. Here he had displayed an increasing tendency to withdraw from his fellow inmates, becoming more and more quiet and wanting, as he described it, "to keep out of peoples way." This would progress to his being somewhat vacant and unresponsive and sometimes exhibiting bizarre behaviour.

This was followed by an event where he

suddenly lost control of himself, persistently hitting his head on the cell wall and opening up a large gash. This was sewn up by the prison Doctor. The inmate then repeated this event, pulling the stitches out and then also insisted in trying to mutilate his penis. He succeeded in doing this. Eventually the staff could only subdue him with what they termed physical restraint, that is by numbers, and also by tying him into what they call the crucifix position on his bed, with belts.

B said that when he gets like that he can't think, that he just goes mad, that he doesn't want to get on with people, that he wants to get out of their way and that he feels an increasing need to mutilate himself and that having done so he feels better and he feels a release of anxiety. At the time of this last event he said that he felt that he was a spirit, that his body was just a shell, that he had become an angel. He now says that he thinks that "it was a bit mad".

My impression was that his mental state, although stable on the day we assessed him, showed at the time of his extreme distress, clear signs of psychosis. He remained a high suicide risk and was clearly an inmate who needed urgent psychiatric treatment on the occasions he became unwell although at present he remains in a stable if brittle condition. Clearly then whilst not being committable on the day we saw him, he would certainly be committable under Section 42 of the Mental Health Act during the acute phases of his illness..

C: This young man has a past psychiatric history including admissions to Cherry Farm Hospital in 1979 for three months and then again for six months and admission to Tokanui in 1981 for a month on psychiatric assessment from the prison.

He was in the Assessment Unit because of his constant references to suicide and his tendency to self mutilation. Six weeks previously he had apparently tried to hang himself in his cell although the prison officers stated that in their view this was certainly not a serious attempt and even if he had not been discovered they doubted very much whether the method he used would have resulted in any injury. He stated to us that he used psychiatric symptoms to get his own way and that being in psychiatric institutions was better than being in prison. He

was serving a seven year sentence for armed robbery.

He had been diagnosed as suffering from Hodgkins Disease some 2 1/2 - 3 years ago. That was apparently in remission. When we saw him he showed no evidence of formal psychiatric illness but obviously had a very disordered personality and came from what could only be described as a very deprived background. He was one of these individuals who rather than being rehabilitated needed to be habilitated although we did not see any evidence that he needed acute psychiatric treatment.

We move now to the inmates in the Assessment Block

D: He has a history of a very deprived upbringing. He was sent by his mother, who is Samoan, to Samoa to stay with relatives at a very early age. On returning home, when he was still of pre-school age, he was unable to speak the language and did not recognise his own parents. Soon after this he developed meningitis and was severely ill. When he eventually attended school he still had some neurological damage with mobility and speech problems.

Since then he has proved to be an eccentric young man with a very low intelligence. He has a very rich fantasy world in which he lives and at times people find this difficult to cope with. He told us, for example, that his mother was half German and half Samoan which may well be true but that his father was a Navajo Indian which clearly is not true. He also told us that the only reason he had come to gaol was for the purposes of the gospel. He felt that prisoners could be helped and therefore he had got himself arrested. There is ample information in his notes to suggest that this was not the case. In fact he is a petty recidivist offender. His presence in Paremoremo is something of a mystery. The only rational explanation seems to be that his rather unusual behaviour, constant fantasizing and the fact that he is also persistently incontinent led the other prisons to feel that they couldn't cope with him and he was therefore sent to Paremoremo.

I did not see any evidence of formal psychological testing but I believe that his intellectual

retardation is probably secondary to brain damage from his meningitis at an early age. He also shows persistent enuresis, which is unusual in a 22 year old man, and a sad absence of social skills. This leads me to believe that on a basis of mental retardation he would be committable under Section 42 of the Mental Health Act. He would certainly be more humanely and better helped in a psychiatric institution or penal institution of minimal security but with access to adequate psychiatric advice particularly given that he poses little or no security threat.

E: He is a young Maori who has a right hemiparesis following a stroke in 1972 when he was in his mid-teens. He has suffered from psychiatric illness since then and was first diagnosed as suffering from schizophrenia at the age of 15 one year after his stroke. He has received intramuscular medication for this condition ever since.

Intellectually he now appears very slow with defective speech. He has had several admissions to Oakley Hospital and was committed there for some years. He is considered potentially violent and dangerous and was serving a sentence for being an accessory to a murder committed by his brother. He has rape convictions. When he becomes unwell he suffers from both visual and auditory hallucinations and can become quite aggressive and violent. Although his mental state was stable on the day we assessed him, it is quite clear that at times within the prison he has been psychiatrically quite ill, that he has been psychotic and that this psychosis is what we would term a chronic organic psychosis probably secondary to brain damage caused by his stroke. He was not committable on the day we saw him. There is no doubt that during the acute phases of his illness within the prison he has certainly been committable under Section 42.

F: He told us that he was 19 months into his six year sentence for child molestation. He had been convicted of child molestation in 1985 and then faced another 19 charges, on which he was convicted, in 1986. He was in the Assessment Block partly because of the nature of his offences and partly because he had also threatened to self-mutilate. He was feeling under

pressure when we saw him as his divorce was pending the next week and he was very bitter about that. He had not seen his daughter for nearly two and a half years and that also made him bitter. He complained that he had no one to talk to about his problems in order to help him deal with them. He gave a very sorry history of a deprived upbringing with an alcoholic father and a violent mother. He married at the age of 16 1/2 and his wife was killed in a motor vehicle accident seven months later.

He remarried again and now has a child by this marriage who will be four years old next month. It is this marriage that is now dissolving.

F spent a long time telling me of his bitterness towards his wife. He accepted that he was homosexual and had been convicted of breaking the law by molesting underage children. He said that his wife and his brother had also been involved but had not been charged. Overall whilst he was very angry he was not significantly depressed and he denied being suicidal. I could find no evidence of acute psychiatric illness in this man and under present circumstances he was certainly not committable under the Mental Health Act.

G: He is a young man sentenced to preventive detention in November 1986. He told us he was due to come up before the Parole Board in June 1993. He was in the Assessment Block as he had become extremely angry following his sentence of preventive detention and he had tried to hang himself three times whilst in custody. Each of these attempts would appear to have been very serious and he had only survived them due to the diligence of prison staff. He told us that at the moment he was sleeping and eating well but that at times he gets extremely depressed. His mood gets so low that he does not want to continue living. During these times he says that he will not eat for weeks.

He is a man with a long history of deprivation as a child. He had spent some time in a Boys Home and had been subjected to physical violence. He has had multiple psychiatric admissions to Kingseat, Oakley and Carrington and from 1972 - 1979 he was in Alice Maximum Security. All of these admissions resulted from his sexual offending. He states that he feels

hopeless about his sentence and at the moment feels very vulnerable. He showed no acute signs of psychiatric disorder though clearly he would be considered to have a personality disorder. He has a very volatile mood and when we saw him he would not have been committable under Section 42 of the Mental Health Act. It would appear that his suicide attempts have been based upon hopelessness due to his sentence accompanied by bouts of depressive illness.

H: He is a 25 year old man who has served 3 years of a 6 year sentence for rape. He had shown suicidal behaviour within the prison on several occasions and told me this had happened because he felt he was being used as a scapegoat to keep the gaol settled. He then went on to tell me how he believed his food and cigarettes were poisoned or drugged, that his wife was being turned against him by people outside, that officers came into his cell at night when he was in a drugged state and would rape him and that this had happened time and time again. He also said that he could hear inmates talking and whispering about him although they would never do this to his face. He was receiving no psychiatric treatment at the time I saw him.

He had no previous history of psychiatric illness but it had been noted within the prison that his feelings had increased in intensity. He felt very bad about himself and upset that he still had a considerable amount of time to spend in prison. He actually requested us to see him regularly if that was possible.

I believe his symptoms to be clearly consistent with a paranoid psychosis which may well fit the description of prison psychosis but certainly it was a state that required treatment. Interestingly the staff within the Assessment Unit had vacillated somewhat about this man, feeling that he was just being "awkward". Increasingly, as his fears and accusations remained persistent, the staff themselves began to feel that he was unwell.

I believe that on the day I saw him he was committable under Section 42 of the Mental Health Act in view of his psychotic illness.

J: He is a 23 year old man serving a life sentence for murder.

He told me that he had been in Oakley Hos-

pital three times and in Lake Alice twice during the course of his illness. He had, however, no prior psychiatric history before coming into prison. When he became unwell he suffered from auditory hallucinations. This began in 1981. He hears voices talking to him and talking about him. They tell him to fight and the first time he went to Oakley was because he hit a prison officer. When he gets in this state he becomes acutely frightened and to use his word was "horrified". He said that the voices persistently tell him something terrible is going to happen to him and that he is going to die in a physically terrible manner. During one of these episodes he has tried to cut his wrists and states that the voices drove him to do that. He states that he frequently has auditory hallucinations and that in December 1987 he became acutely paranoid and suicidal with some clear evidence of depressive symptoms as well. He was sent to Lake Alice, who disputed his diagnosis with Dr Frank Whittington, and he was sent back unmedicated. I note there was a letter on the file from Dr Whittington to Lake Alice telling them that their assessment and treatment had been less than adequate.

My interview with J would lead me to concur with Dr Whittington. I believe that he becomes acutely psychotic when he does become unwell and at those times would clearly be committable under Section 42 of the Mental Health Act although on the day that I saw him his mental state was stable.

K: He is aged 40 years and is serving a five year sentence for rape. This man had tried to hang himself in Mt Eden. That was a very serious attempt. He had no previous history of psychiatric illness before going into prison. He told us that he was absolutely mortified by his offence, it had upset him, it had upset his family and had caused great upset for the victim and her family.

He said he had something on his mind, an episode that happened to him within his cell, that he ought to talk about but felt that he could not do so. On talking to staff we were told he often approached staff in that manner also. I was unsure whether something real had happened to him, such as homosexual rape, or whether in fact this was all part and parcel of his condition. He showed clear signs of a major

depressive illness with psychomotor retardation, depressed mood, so softly spoken that he was barely audible, sleep disturbance and suicidal behaviour. He also showed clear signs of psychosis by virtue of thought disorder and auditory hallucinations. Throughout my interview with him he was extremely vague, distracted, perplexed and confused. My view was that on this examination K was in urgent need of psychiatric treatment. I noted that he was receiving some medication including an anti depressant but in view of his psychosis I would have felt that this level of anti depressant treatment was actually inadequate for his condition. He was clearly committable under Section 42 of the Mental Health Act.

L: The next person was seen in very distressing circumstances. He was a young 23 year old Pacific Islander. He was seen in the observation cell since he had attempted, successfully, to mutilate himself with a razor blade the previous night. He had inflicted serious wounds to his throat and right arm and we noticed his left arm was grossly scarred with wounds that he had inflicted on himself a couple of months ago.

This person was suffering from auditory hallucinations and passivity phenomena. He believed that his thoughts could be read out aloud and that we could read his mind. He was clearly suicidal and still threatening to cut himself. He stated that during these times he loses his mind and that the self-mutilation makes him feel better. He was suffering from delusions about the mafia and had ideas of reference feeling that he was responsible for other suicides throughout the prison. He was serving a 4 year prison sentence for wounding with intent.

This man has a very long history of schizophrenic illness and psychiatric treatment. There was no doubt in my mind that he was psychotic, in desperate need of psychiatric treatment, and was committable under Section 42 of the Mental Health Act.

The next two patients were seen in the hospital wing of the prison. The first was:

M: He is a 29 year old man who had served four years and four months of a seven year sentence. He was a man who, throughout his term in prison had been prone to cutting himself and also to suicidal behaviour. He stated, and this was confirmed in the notes, that he had tried to kill himself 28 times in hospital including a self inflicted throat wound that rendered him in a coma for 2 months and in hospital for 3 months. He is really a shadow of his former self. He told us that he had previously weighed 13 1/2 stone whereas he would now weigh barely 8 stone. He has lost a great deal of his hearing secondary to antibiotic treatment after his terrible throat wound and he also has quite severe eyesight problems due to some scarring of the cornea of both eyes which occurred while he was in his coma. He has clearly had what we would term cerebral anoxia in that the blood supply to his brain must have been significantly impaired after he cut his throat and he now suffers from a degree of brain damage.

This man has also had epileptic fits since the age of 16 but was not medicated prior to coming to the prison. It may well be that he has also suffered a degree of brain damage because of this. He has suffered from alcoholism which may have further damaged his brain and has also been heavily into the drug scene in Australia. He was in the hospital because the day before he had had an epileptic fit on the Assessment Block and had fallen and cut his head. Although he denies it the hospital staff are sure that he did not injure his eye during that fall. They say that following his admission to the hospital block, and whilst in his bed, he inflicted a severe injury to his own right eye which necessitated treatment in Auckland Hospital. When we saw him it was not certain whether he would regain his vision in that eye. At the time he could not see out of it and it was barely light sensitive.

From his own description M at times becomes very depressed, does not eat, loses weight, has sleep disturbances, has a very poor mood and rather extreme self mutilation and serious suicidal behaviours. On the basis of his clear depressive illness, his tendency towards severe self-mutilation and suicidal behaviour and his terrible physical condition, I believe M to be committable under Section 42 of the Mental Health Act.

N: This man is a Samoan who speaks no English. He was brain damaged at birth and suffered a spastic hemiplegia and speech defect. He is also epileptic. He is intellectually subnormal and behaves many years below his chronological age. He is illiterate and can only count to ten.

He was convicted of manslaughter after being left in charge of a young baby whom he slapped and eventually killed. He was sent to Mt Eden where he suffered continual intimidation and subsequently set fire to his cell. He was then sent to Paremoro where he again suffered intimidation from other prisoners even on the Assessment Block and was therefore placed in the hospital where he has remained. In the hospital he sits all day in his room talking with himself in Samoan or playing with his soft toys, toy soldiers and small cars that the prison officers bring in for him. His notes show that the other inmates from Samoa knew him in Samoa and they say quite clearly that he is a mental patient. He has been known to ask that Samoan officers in the prison beat him up because he

hates himself so much.

There have been attempts by members of staff to move him from this inappropriate placement. One officer, writing in the notes in November 1986 said that he should not be there because he cannot protect himself. The Charge Nurse in the hospital stated in January 1987 that "this poor unfortunate needs more than we can give him here, he needs a more suitable placement." However it is clear that a more appropriate placement has not yet been found for him.

I believe, on the basis of mental subnormality, that this unfortunate man is clearly committable under Section 42 of the Mental Health Act and despite his serious conviction would clearly be more humanely and appropriately dealt with in a psychiatric institution. I feel some concern about his conviction and wonder to myself how he could have been found fit to plead. It is also distressing to note that he has family in Auckland who visit him very rarely and who seem to support his present placement.

**ASSESSMENT TEAM:
REPORT OF MEETING BETWEEN ASSESSMENT TEAM AND
CARRINGTON PSYCHIATRISTS - 17 FEBRUARY 1988**

On 17 February 1988 the Assessment Team met with several psychiatrists at Carrington Hospital for the specific purpose of discussing their admission criteria and the Paremoremo suicides.

One of the psychiatrists gave background information leading up to the present situation. He described the awful conditions at Oakley M3. He said there had been 70 patients of a heterogeneous group who had occupied M3. The main function of the ward was security which seriously compromised any attempts at treatment. In his view there was probably no other ward like it in Australasia because of the level of security it provided within a psychiatric hospital setting.

It was felt that the mess of M3 should not be allowed to perpetuate itself and the psychiatrists saw the closing of M3 as one of their main aims. The Auckland psychiatrists also saw the closing of M3 at Oakley as a major aim. We were told that unless M3 Oakley closed the Carrington psychiatrists could foresee another Oakley Inquiry.

They then went on to tell us about the facilities that were to operate following the closing of M3, i.e. the facilities within Carrington to deal with some of the patients formerly dealt with in M3. They indicated quite clearly that they were not going to take the same type of patients because they saw the security aspect as being inappropriate within the hospital setting.

They emphasised that the type of case which had predominated in Oakley were persons who had either developed a prison psychosis, that is a mental illness in relation to their imprisonment, or people with behavioural disorders and people who were malingering. That was their emphasis. They again inferred that it was inappropriate to take these people into a psy-

chiatric hospital. They said that these people would no longer be wanted.

They talked for some time about the people who used to be admitted to M3 and commented that in many cases the prisoners who were admitted were malingerers. One psychiatrist then said that having dropped the numbers down at M3 and having set an arbitrary figure of 25 as the maximum, the next aim, as he put it, was to stop that type of patient coming back into the hospital situation.

They also spoke about the inappropriateness of having secure facilities within the hospital setting. One psychiatrist said that when one was pushing for an open hospital situation, and pushing for care in the community, then having a security provision within the hospital was somehow reversing the whole process

and the two did not sit together.

They also spent a lot of time telling us that they could not be seen in a treatment role and a custodial role at the same time. A lot was said about prisons and the obnoxious influence of prisons. The clear inference was that if they went ahead and helped within the prison system then perhaps what they were really doing was maintaining a poor system. One psychiatrist said that perhaps what they should have done was to withdraw their help altogether and just tell the Justice Department that it was their problem and they should deal with it. I think that the phrase used was:

"Perhaps we should have pulled everything out and just let the place blow up."

They also pointed out that the Justice Department had never really developed any psychiatric facilities within the prison so that when Dr Savage left the scene in 1982, and the criteria changed, as the psychiatrists readily admitted it did, then the Justice Department was sud-

**"Perhaps we should have
pulled everything out
and just let the place
blow up."**

denly in trouble because it had difficulty getting their acutely ill people out of the prison and into the hospital setting.

They said that four units had been proposed to alleviate some of the problems when Oakley closed. One of those units was the National Security Unit at Lake Alice which would operate in much the same way as Oakley M3 until such time as the Justice Department developed its special prison. There was also going to be a closed structured living environment at Carrington and an open structured living environment. These two units would be used for personality disordered people in particular. One of the units would have a greater degree of security than the other. The fourth unit was to be the intensive care unit. The psychiatrists said that only one of these four units was operating in the manner that they had anticipated.

They also pointed out that the intensive care unit at Carrington was not operating in the manner they had anticipated. We were told that it operates on a very strict admission criterion. It will not take people who are behaviourally disturbed and will only take people who have a demonstrable psychosis which is not accompanied by behavioural disturbance. In fact, if anyone does become difficult within the intensive care unit, he/she is transferred out of that unit to the acute area. We could see what they meant when they said it was not operating in the manner they had expected because one would expect an intensive care unit to operate the other way.

It can therefore be seen that the intensive care unit at Carrington is not a facility providing security and that it operates in a manner that precludes the admission of any patient requiring restraint or confinement.

Our collective view is that this state of affairs is irresponsible. The staff are really saying that they will take patients if the hospital has the facilities but because the hospital does not have the facilities the staff cannot admit the patients. That seems to be a clear statement that they do not want these people in the hospital system.

"The fact is they do not want these patients and they thought the Justice Department should create its own institution to take its own mental patients. ...This attitude is inconsistent with the law."

You have asked us as to the test which the Carrington psychiatrists adopt when deciding whether someone should be transferred out of the prison and into hospital pursuant to Section 42. The psychiatrists repeated their statement about the presence of a treatable mental illness and they were non-plussed when we told them we had found seven or eight people at Par-emoremo with a very clear definable mental illness who were not malingering and who were not personality disordered. They made no comment.

The fact is they do not want these patients and they thought the Justice Department should create its own institution to take its own mental patients. That is really what they were saying. This attitude is inconsistent with the law and that test does not have regard for what is required of a doctor in the management of people who are in distress or ill.

One of the psychiatrists made a statement about distress. He said:

"Whatever you want to diagnose these people as, they are clearly in distress."

His own distress seemed to be that there were no appropriate facilities available so what was he supposed to do. He asked how was he supposed to help. He saw his responsibility as going into the prison and assessing and trying to help but he asked what he could do because there were no facilities provided. He felt that he was powerless to change that.

The psychiatrists basically avoided the issue of suicides. They emphasised that there had been an increase in prison musters and they tried to explain the increased suicide rate on that basis. As we see it, if there was a blockage to getting help for distressed prisoners, then those prisoners suicided because that help was not available and not because the musters were high.

At two points during our discussions our team made direct reference to the tragedy of men hanging themselves quite regularly - Maori men in the majority - whilst people were setting new criteria and arguing. We made the point

that there was a great deal of distress and that it should have been a humanitarian duty to somehow deal with that. They just kept quiet. The very clear impression we gained was that their own stated criteria was not being adhered to.

Our conclusion has to be that the Carrington admission test is an anomaly. It is used by the hospital authorities to prevent people from coming into the hospital whom they feel they cannot handle. So whatever the criteria which they describe, the underlying agenda is that which was pointed out to us, namely, that having emptied M3, they then had to stop patients we have previously referred to coming back into the hospital. Therefore, they stopped everyone. That has been the effect of it because in the past few years there have been only four people who have been admitted from Paremoremo to Carrington/Oakley.

You have asked us for the reaction of the psychiatrists when we told them that as a result of our examinations we had found seven people who required treatment immediately in a psychiatric hospital and that possibly there were 13. They looked embarrassed and then changed the subject. They did not comment. There was

Our conclusion has to be that the Carrington admission test is an anomaly.

little evidence of their feeling responsible in any way to try and treat these people. There was a very clear theme coming through that prisoners are the responsibility of the Justice Department, that they did not want them and that Carrington just did not have the facilities.

Some criticism can also be levelled at the Justice Department. The psychiatric facilities and services at Paremoremo are inadequate. Staff at Paremoremo commented that Head Office seemed to think that they have adequate facilities and as a result prisoners from other parts of the country are transferred to Paremoremo for treatment. That belief seems

to stem from the days when there was ease of admission to Oakley M3. What is happening now is that since M3 has closed, and since there has been a change in admission criteria by the Auckland psychiatrists, the Justice Department is still continuing to act in exactly the same manner as if nothing has changed. They are actually making the situation worse. We believe that pressure would need to be brought to bear on the Justice Department too so that those people responsible are made to realise the folly of what they are doing. They are inflaming an already difficult situation by transferring people from other parts of the country to Paremoremo.

He poroporoaki aroha ki te rangatahi, i tuku ia
Ratou ki te mate, i nga wa i papouri ai, o
Ratou ngakau.

KO TE WEHI KIA IHOWA TE TIMATANGA OTE MATAURANGA
I WHAKAMAUA AI TANA RONGOPAI KI TE MATA OTE WHENUA,
KO TE AROHA TE TANGATA TETEHI KI TETEHI

Rangaranga te murihau ka tutu nga ngaru
Ote moana,
I whakairia ai nga kapuatu ki, runga inga
Tihi tapu o tonganui.
I taraia ai te marama ki te ao me
Nga whetu ki te rangi.
I tangihia ai te whenua,
I tangihia ai te tangata
Aue aku kurupounamu ka riro, ki tua
O paerau, ki te huinga ote kahurangi,
Ki te atata o taku raukura ka riro.

Haere e tama ma nga uri o wo koutou tupuna.
Ko te poroporoaki mamae, moumou
Koutou kia mate. Oti ra ma ratou koutou
Hai powhiri. Ko te Whakapae a wo koutou
Matua na te nanakia o nga ture, me te
Matao o nga manawa o nga mana, ka
Tuku koutou ia koutou ki te anu makato.
Nana i homai nana i tango atu, kia whakanuitia
Tona ingoa ite ao, ite po, ite oho, ite moe,
Ite tika, i roto ano hoki ite he.

No reira.

Hikohiko te uira ki runga o Paremoremo,
Papa te whatitiri ki runga ote wharepaia,
Waipuketia te kupu, ka riri -
Ko ngungunu ko ngangana ko aparangi
Ko apiti hono tatai hono,
Koutou te hunga kua okioki ki tua
Ite rauwharangi o paerau, ki te Wairuatanga
Ote tangata, ki a koutou.
Apiti hono taitai hono
Matou te hunga ora hai whare korero mo
Koutou.

Noho mai ra i raro ite aroha me te mana
Ote Ariki

ASSESSMENT TEAM : THE PAREMOREMO SUICIDES

REPORT BY WARREN BROOKBANKS

The writer visited Paremoremo Maximum Security Prison on approximately nine separate occasions.

During these visits I was given free access to all relevant inmates records and spent many hours reading through the often substantial individual files in order to gain an overview of the psychiatric and behavioural make up of the inmates concerned. In addition I spoke informally with a number of staff members at the prison including prison officers, psychiatrists, a departmental psychologist, welfare officer and teachers.

I wish to record my sincere thanks to the prison staff for their full cooperation and helpful responses to my many queries. In addition I would like to thank the members of the Assessment Team, especially Dr Phil Brinded and Dr Douglas Wilson, for their helpful comments on the occasions that I met with them.

In offering my observations on the individual suicide cases, my comments will necessarily be limited primarily to the immediate context of events preceding the inmates deaths in order to answer the question posed by the Committee as to whether there was information available to prison or medical staff of a psychiatric or other nature which would have justified committal or transfer pursuant to Section 42 or Section 43.

The survey deals with 13 suicides since the beginning of March 1983. I have not considered the case of an inmate who died of accidental electrocution. It was not regarded as a suicide.

1. A.

This inmate, who was described as one of the most dangerous prisoners ever housed at Paremoremo Prison, while locked in his cell in D Block, wrapped himself in newspaper and a sheet, and set fire to the material. He died from self-inflicted burns covering more than 70% of

his body at 11.50p.m. on 26 March 1983 some 6 hours after to his transfer to Auckland Public Hospital.

A came from a deeply disturbed background. His only sister committed suicide subsequent to admission to a psychiatric hospital and both parents had histories of suicide attempts. Between March 1976 and March 1983 he was admitted to psychiatric hospitals on three separate occasions and had been variously diagnosed as an aggressive psychopath, hypochondriac and schizophrenic. However an assessment in February 1980 by a physician, neurologist and psychiatrist concluded that while he had no organic pathology, he suffered from psychiatric disorder that was "probably unmanageable in prison".

Following his transfer to Oakley Hospital in December 1982 he was assessed as suffering "gross disorder of thought form" expressing delusion of "hypochondriacal" nature, and was diagnosed as schizophrenic.

However, A was returned to Paremoremo on 22 March 1983 heavily sedated, on the basis apparently that he was no longer suffering from any formal thought disorder. On the day prior to his death he self-inflicted wounds to his throat and wrist and was placed on quarter hourly observations, signifying that he was a highly suicidal risk.

The decision to return A to prison was criticised in the report of B H Blackwood, District Court Judge, dated 4 August 1983 and prepared for the Secretary of Justice.

Judge Blackwood concluded that although it was doubtful whether A intended to kill himself on 26 March 1983, (he had seemed surprised that the fire grew as big as it did), he was mentally ill and needed to be detained in a secure psychiatric hospital and not a prison.

I would concur with that judgment. I believe it to be highly likely that A still suffered symp-

toms consistent with mental disorder on his return to prison. This probably contributed to his suicide. In my opinion there was information available that would have justified his committal or transfer pursuant to Section 43. At the very least it can be said that he was sent back to prison prematurely.

2. B.

B was a 30 year old Maori, married with three children. He died on 23 April 1983 at Auckland Hospital following his transfer from Paremuremo on 14 April 1984 where he had been found unconscious in his cell with a shoelace tied around his neck. At the time of his death, he was on half hourly observations to reduce the risk of:

- (i) self damaging acts and
- (ii) assault from other inmates.

His former membership of the Black Power gang may have been instrumental in his death in that he had been 'dropped' by the gang and during his current sentence had been twice beaten up by former Black Power associates.

In addition, he had allegedly been disowned by a friend for whom it is said he had started the 1982 Lake Alice riot. He was evidently feeling the hostility and rejection from his old associates, and, it seems, his family.

It should be noted, however, that in the period from September 1974 to March 1983, B was admitted on transfer to psychiatric hospitals on at least six separate occasions, although he was never found to suffer from psychosis or major depression. His behaviour was characterised by bizarre conduct (throwing himself about, head banging and swallowing foreign objects), while refusing medical treatment for swallowed objects which had caused serious medical ailments.

Some twenty minutes before he was found in his cell with the shoelace around his neck, B had commenced banging his head against the cell wall. He desisted from this conduct but was soon after seen eating matches and "something" from the toilet. The use of a mechanical restraint was considered by the officers on duty at the time but was apparently decided against.

It seems clear from his history that B had some form of personality disorder. His conduct immediately prior to his self-strangulation was

bizarre but essentially no different to what had characterised his conduct during previous sentences. He was under observation at the time and there is nothing to suggest that the officers were neglectful in the decision not to employ a mechanical constraint.

Granted the fact that there was no psychiatric assessment done during the last sentence, it is impossible to say whether the suicide was related to a psychiatric illness that was treatable. The question of a possible committal/transfer does not appear to have been considered during the most recent sentence.

Perhaps the best that can be said is that B's behaviour may have been more settled or manageable if he had been in hospital rather than in prison.

3. C.

This inmate's difficulties appear to have started to manifest early in October 1984 when the Classification Committee refused to recommend his transfer out of maximum security. From that time onwards, C continued to express his concern that other inmates were trying to "set him up" and that he felt he was going to be killed.

By 19 October 1984 he was described as being "extremely nervous" and continued to express fears that someone was going to kill him. Although he denied being suicidal when questioned by the Acting Superintendent on 19 October 1984, he complained of his inability to sleep in D Block, requesting a transfer out of the Block. At about this time he handed the Acting Superintendent a paper which he said was his Will. This may have been an early indication that he was contemplating taking his own life, given his overall anxiety. That afternoon he spoke to the departmental psychiatrist, Dr Maule, who noted that he appeared taciturn and self-controlled but did not consider that he was mentally disordered.

On 21 October 1984, three days before his death, C was placed on half hourly observations signifying that he was regarded as either suicidal, unsettled or mentally unstable.

There is no information which suggests that C suffered from psychiatric illness prior to his current sentence. However, on the day prior to his death, a departmental psychologist noted

that she was "immensely concerned" by his condition including paranoid concerns that his life was in danger, that unnamed persons were trying to poison him and that L.S.D. was being put into his food. The report concluded that at the end of the interview, C showed "many signs of an acute psychotic episode".

Arrangements were made for C to receive further psychological counselling but this was not actioned before he died. He committed suicide by hanging himself in his cell on 24 October 1984. There is no information about his behaviour on the day of his suicide.

In C's case I do not believe that prison staff can be criticised although there was an apparent breakdown in communication. When it was realised on 23 October that he may be suicidal steps were taken to place him under observation. However, there seems to be fairly clear evidence that immediately prior to his death he was suffering from some form of mental disorder which, assuming the psychologist's observations to be accurate, would at least have warranted his assessment pursuant to Section 43. It is extremely unfortunate that these observations having been communicated to senior personnel within the prison, appropriate procedures were not activated immediately.

At that time there was apparently no access to a psychiatrist for the purposes of an urgent assessment or transfer to hospital which may have prevented the suicide occurring.

4. D.

This inmate was serving a two year sentence on two counts of indecent assault on a female. He had been transferred from Mt Eden to Par-emoremo prison on account of his disturbed unmanageable behaviour.

His early background was unspectacular with no early evidence of disturbed behaviour or attitudes. Indeed, his development appears normal until the time he left school when he became involved in mixed drug abuse. From the age of 20 in March 1980 until his death, D was admitted to psychiatric hospitals on five occasions. The most common diagnosis on these occasions was schizophrenia although this diagnosis was challenged when D was assessed on 30 January 1985 by a team of visiting psychiatrists from Oakley Hospital. The assess-

ment followed an attempt to castrate himself and bite off his thumb.

The assessment concluded that although he complained of bizarre symptoms, (believing he was Satan, has a milkshake lolly stuck in his brain), which superficially appeared "mad", and although anxious and unhappy, he had a good grasp of the purpose of the interview and his contact with reality was not tenuous. At the end of the interview "no marked disturbance was noticeable and the reason elicited for the bizarre presentation was that D was becoming increasingly frustrated and wished to go to Oakley "to get his head sorted out".

The diagnosis on that occasion was that he was "suffering from a personality disorder of the borderline type, which is characterised by features of identity, confusion and impulsivity".

It was concluded that there were insufficient grounds to commit him under Section 42, it being felt that there would be little purpose in transferring him to a psychiatric hospital at that time. No mention was made of a possible Section 43 transfer; although retrospectively it has been suggested that a Section 43 assessment might well have been appropriate.

D committed suicide approximately one week later following his transfer to the Classification Block.

It is impossible for me to challenge a competent medical diagnosis based upon interviews with the deceased. Appropriate criteria were presumably applied in making the analysis. However, given D's recent psychiatric history of admissions and the previously prevailing diagnosis of schizophrenia, and having regard to his gross self-mutilation, a transfer under Section 43 for a period of observation may well have been appropriate, even if he was not at that time legally committable. Regrettably, that option was not pursued.

5. E.

E was serving a life sentence for the murder of his wife. He can only be described as a deeply disturbed person whose aggressive conduct was a constant threat to his own safety and the safety of those around him. However, there is no documented history prior to imprisonment of personality features or psychiatric state. Soon

after the commencement of his sentence in July 1977 E began to complain of being disturbed by visions and voices. During the period December 1978 to June 1983 he was admitted to Oakley on four separate occasions usually following suicide attempts.

During his first two admissions, E presented what have been described as "clear acute psychotic symptoms" which were relieved while he received appropriate medication, suggesting that he may have suffered from a "major functional disorder". Generally his behaviour while in hospital was more settled, apparently on account of the effects of the medication he was receiving.

However, in the period of 8 months prior to his death, E began to regularly refuse his medication, and from 1 October 1984 indications of strange behaviour and a general deterioration in his conduct were noted. By 19 March 1985, two weeks prior to his death, he had ceased taking all medication.

In the view of one of the departmental psychiatrists, E was a chronic schizophrenic who should have been in hospital. However, because of lack of confidence in the willingness of Oakley Hospital to be involved in committal proceedings, no steps towards obtaining his committal were taken.

6. F.

F was serving an 18 month sentence for burglary at the time of his death. He died two months before his expected release from prison. There is no psychiatric history prior to the current sentencing although he was described by one psychiatrist as a disturbed, inadequate person.

In the month prior to his death, F had become agitated and aggressive and requested the stopping of his medication. During this period he was also the subject of a misconduct report after he threatened to hang himself and cut his right forearm with a razor blade. Two days later he ripped the sutures out and repeatedly removed the bandages. His action on this occasion was evidently not suicidal but rather an act of solidarity with another inmate whom they felt had been unfairly refused a cigarette.

At about this time F expressed fears about the prison being "spooked" and possessed by

evil spirits. His attitude was described as "contrite, abject and guilt-ridden".

A medical file note on the day of his death indicated that he was very depressed, saying he "wants to end it all". The nurse giving him his medication noted that F was crying and talking in a slurred voice. Although he was on half hourly observations at the time F was found hanging in his cell approximately half an hour after the conversation with the nurse.

F was seen three times by a psychiatrist during his imprisonment. Although he complained about anxiety and insomnia, he did not appear depressed and at no stage was he referred to a psychiatric hospital. The last psychiatric note concluded that while he was unstable and unable to handle the stress of Paremoremo, his suicide was unexpected.

While there is no evidence on file that F was mentally disordered immediately before his death, he was evidently emotionally disturbed and at risk. There were clear indications that F was contemplating suicide. The failure to activate Section 43 transfer procedures was presumably related to the failure of the medical professionals who assessed him to appreciate the seriousness of his conditions, or that it warranted more intensive observation.

7. G.

The file on this man suggests that he experienced multiple problems from an early age. G had been in contact with psychiatric services since 1979 for assessment following self-destructive and suicidal acts. In 1984 he was admitted to Dunedin Public Hospital following a drug overdose and over the years had complained of depression, substance abuse, being influenced by spirits, and inability to control his temper.

Earlier assessments suggested disorder of personality rather than definable mental illness although the possibility of schizophrenic disorder was also raised.

In recent years G complained of occasional auditory hallucinations, and expressed fear at voices which warned or suggested that he destroy himself. A psychiatric report prepared for the Court prior to G's trial dated 4 March 1986, concluded that while he suffered from a grossly disordered personality and showed a

number of persisting abnormalities in his state of mind, he did not show the features typical of any recognised mental disorder. The report concluded that he was neither insane in terms of Section 23 of the Crimes Act 1961 nor mentally ill in terms of the Mental Health Act.

An observation made when G was seen on 27 June 1986, a week before his death, suggested that he was keen to get medication to dull the pain of his existence although there were no indications that he was seriously contemplating suicide.

G committed suicide at approximately 1.00a.m. on 2 July 1986. He had evidently planned the event and had clearly indicated his intentions to a fellow inmate. He was not on observations at the time of his death and there was nothing in his behaviour at the time that suggested that he was a serious risk of suicide. There is no evidence on file to say that he was suffering from any psychiatric disorder justifying committal in terms of Section 42 and there appears to have been nothing about his immediate behaviour or attitudes that would have justified consideration of a Section 43 admission.

8. H.

This inmate's death was the subject of a special inquiry conducted by a Senior Inspector of prisons. The report concludes that H's suicide was preventable if the duty officers had used more initiative in checking H who had completely covered his cell front with towels and screens. Had the officer actually made an effort to see into the cell, H's death may have been prevented.

However, H does not appear to have been seen by the prison psychiatrist during his imprisonment. In any event there is no extant psychiatric assessment on file. He was not evidently regarded as an "at risk" inmate although disruptive.

I must conclude that he was not known to be psychiatrically disordered at the time of his death so that the use of Section 42 or Section 43 procedures would have seemed inappropriate to the prison staff who may have been able to assist H at the time.

9. J.

J was transferred from Wellington prison following an assault on an officer. He was received at Paremoremo on 23 October 1986. He was initially placed in Detention Block and later segregated in D Block.

An earlier psychologist's report written while J was an inmate at Wellington prison described him as an intelligent person "most likely crippled by a severe personality disorder". However, in addition it was suggested in the same report dated 26 September 1986, a month before his reception at Paremoremo, that there were symptoms suggestive of psychotic thinking which suggested 'serious psychopathology'.

In the six weeks prior to his death, J saw a departmental psychiatrist on at least one occasion and the view was expressed as late as 21 November 1986 that his mental state was a cause for concern and that a placement in classification would be appropriate with a view to possible placement in the Assessment Unit.

J was duly transferred to classification on 1 December 1986 becoming a day patient in the Assessment Unit from 10 December 1986. Perhaps ironically he was made a full-time placement in Assessment on 19 December 1986, the day he hanged himself.

Although the prison authorities were evidently concerned about this man's mental condition, his death would seem to have been wholly unexpected. There does not appear to have been a comprehensive psychiatric assessment since his reception and although he was described as "odd" and "unsettled", there were apparently no overt indications that he was depressed or suicidal prior to his death. It is unlikely that he was committable in terms of Section 42, although a thorough psychiatric examination may have raised concern suggesting the appropriateness of a Section 43 transfer.

10. K.

This inmate was transferred to Paremoremo from Christchurch Prison following assaults on staff and generally disruptive behaviour. He had been serving a 21 month sentence for possession of an offensive weapon and related charges.

K may have suffered from brain damage at birth and his high propensity for violence with low tolerance level were the most notable features of his personality. He had earlier been assessed as a danger to himself and a serious danger to others.

In addition to the violence which he often externalised K was a notable self-mutilator, on one occasion at Paremoremo self-mutilating six times within a three day period.

In a report prepared by a psychiatrist while K was at Christchurch prison, it was noted that while psychotic symptoms had not been heard or observed, he continually presented with a paranoid obsessional neurosis bordering on a paranoid psychotic state.

However, in a report by one of the Paremoremo psychiatrists dated 22 December 1986 in anticipation of K's half date release on 4 January 1987, it was noted that there had been an amelioration of K's depressive component and an improvement in his demeanour and overt behaviour, including a determination to relinquish his dependence on drugs. However, when the District Prisons Board met on 17 February 1987 it was decided to defer a decision about K's release for two months on the grounds that he was not ready to be released.

K committed suicide by hanging in D Block early on Friday, 6 March 1987. He was not on observations at the time of his death. It was suggested following an internal inquiry that K's death might have been preventable if the officer in charge of the landing at the time had been more diligent in checking individual cells.

However that may be the real question would seem to be whether K should have been in prison at all. On one view his capability of extremes of violence and self-violence was in itself a depressive phenomenon, and there would seem to be evidence to suggest that K was sufficiently depressed on earlier occasions to have been committed under Section 42. But for whatever reason no consideration seems to have been given to the possibility of committal in the period immediately prior to his death even though he was seen by a prison psychiatrist three days before he died. This would seem to be a case where the prison authorities failed to fully appreciate the seriousness of his mental condition and accordingly the issue of committability prior to his death did not arise.

11.L.

This man's history is by now well known to the Committee through the submission of First Officer G P Price. His transfer to Auckland Maximum Security Prison followed his assault on a female in Mt Eden Prison.

Early in his stay at Paremoremo he was seen as a high suicide risk with paranoid ideation related to his fear that people were trying to get him. Details of his disturbed mental state are adequately set out in Mr Price's submission.

There can be little doubt that his underlying paranoia was exacerbated by his high basic anxiety level and the claustrophobic conditions of his confinement. There were numerous occasions when L could have been committed prior to his death and the failure to do so was evidently not on account of any insufficiency of indication of mental illness, but rather management decisions to keep him within the prison system when his committal should have been actively sought. I am satisfied that he was committable in terms of Section 42 at the time of his death.

12.M.

This inmate had a traumatic childhood, having been physically injured by his mother at the age of four and regularly beaten as a child.

Although described as suffering from a personality disorder, he had a long standing obsession with being a slave of Satan and having to make a 'sacrifice' for him. He was deeply concerned with ultimate issues of life and death and his disturbed thinking (as manifest in his prolific writing) portrayed an ongoing preoccupation with the battle between good and evil, being worked out in his own experience.

His time at Paremoremo, from 13 June 1985 when he was transferred from Christchurch Prison, alternated between Classification, Assessment and 'time out' units, and the Detention Block where he was located at the time of his death.

During his period at Paremoremo M developed a paranoid fixation about one of the nurses whom he believed had put a Black Magic spell on him. This nurse had spent considerable time prior to his death, counselling M and was physically present when M took his life.

It is suggested that acceleration of the work to modify the ventilator grilles in the Detention Block may have prompted M to take the ultimate step before the 'exit' was closed to him. It would also appear that he intended the nurse to witness his death.

M had been placed on Category One observations three days prior to his death following the discovery of suicide type letters. Although there were staff in attendance at the time the manner of his death was apparently carefully planned, including ensuring that the cell door was jammed hereby preventing access to him.

However, as there was no evidence on file as to any recent psychiatric assessment, it is impossible to say whether he was legally committable immediately prior to his death.

13.N.

N was at Paremoremo a little over one month before he committed suicide. Although he requested segregation soon after his arrival in the prison because of difficulties in settling in, there were no indications as late as 18 December 1987 that he was either depressed or at risk. Nor was there anything in his previous behaviour to suggest that he was a possible suicide. However, in an early interview while still at Christchurch Prison, N had expressed a fear of being 'taken over' by spirits and feeling 'bottled up' inside.

However, he was not psychiatrically assessed upon his transfer to Auckland and his suicide was considered to be a 'complete shock' to all staff since there had been no observable signs to indicate the need for concern. There is nothing on the file to suggest that he was committable immediately prior to his death.

COMMENT

Of the 13 suicides considered in this survey, four (A,C,E and L) would have been legally committable at the time of their deaths. Given the acute state of their mental disturbance immediately prior to the taking of their own lives, they should not have been in jail. Of the remainder, a further four (B,D,F and K) might in other circumstances have been committed but were cases where management decisions had been taken by the prison staff to maintain the inmate within the prison environment without invoking specifically psychiatric measures. In each of these cases there was express concern about the state of the inmate's mental health but the indications were not such that immediate assessment or committal was deemed necessary. The remaining five, (H,G,J,M,N) were probably not committable immediately prior to their deaths, although each apart perhaps from N was evidently emotionally disturbed prior to their deaths.

However, in terms of the Committee's immediate concerns as outlined in Judge Mason's letter of 11 January 1988, it is not possible to attribute responsibility for the failure to activate the Section 42 or Section 43 transfer procedures to any decision of a receiving hospital, at least directly. In only one case (D) was an assessment done by a visiting assessment team which concluded that there were insufficient grounds for a committal. In no other case did the issue directly arise.

For the sake of completeness I wish to record that in my view the staff at Paremoremo had little or no confidence in the Oakley team approving a transfer from prison to Oakley/Carrington pursuant to Section 42.

It is therefore not surprising that they chose to maintain the inmates within the prison environment and manage as best they could.

In other circumstances, it is likely that 8 of the 13 prisoners who suicided, being committable, would have been committed and their deaths in all probability prevented.

THE AFTERMATH : OR IS IT THE BEGINNING?

22 March 1988:

John Papalii appeared for trial in the High Court at Auckland. He pleaded not guilty on the grounds of insanity to two charges of murder and two charges of wounding with intent to injure.

Three consultant psychiatrists gave evidence that at the time of the offences Papalii was suffering from paranoid schizophrenia to such an extent that he was rendered incapable of knowing that his actions were morally wrong.

The jury found him not guilty on the grounds of insanity. He was then committed to Carrington Hospital as a special patient.

1 April 1988:

Mr Ian Campbell appointed Acting General Manager, Auckland Hospital Board. He subsequently appoints Dr A.L. Honeyman as Acting Director of Health Policy and Miss Murphy as Acting Associate General Manager.

Mr Campbell notes that the State Sector Act requires the General Manager to act independently of the Board in respect of staff appointments.

Monday 11 April 1988:

A Jury in the High Court at Auckland found Manuel Charles Williams guilty on 10 counts of sexual violation and one charge of attempted murder. At his trial evidence was given that Williams had been refused re-admission to Carrington Hospital one week before the alleged offences had been committed. At the trial psychiatric evidence was given that Williams was medically and legally insane at the time the offences occurred. The Jury rejected William's insanity plea. He was found guilty as charged and was sentenced to life imprisonment.

Wednesday 13 April 1988:

The media reported that a man who had decapitated his baby son had wandered to a nearby school and had several times visited a nearby shop after having recently been committed to Kingseat Hospital for insanity. Kingseat has no secure wards.

Thursday 14 April 1988:

Brian Christopher Jane was found guilty by a Jury in the High Court at Auckland of the murder of his father. Two psychiatrists gave evidence at his trial that Jane was a paranoid schizophrenic and was insane at the time of the commission of the offence. Jane's plea was rejected by the Jury. He was convicted and sentenced to life imprisonment.

Thursday 14 April 1988:

A male patient in the Whare Paia unit for Maori patients at Carrington Hospital was allegedly attacked by women nurses for previously attempting to rape a nurse. He sustained head injuries and received hospital treatment before being transferred back to Carrington. The Acting Medical Superintendent, Dr Peter McGeorge, reported the incident to the police after having consulted the Board Chairman Sir Frank Rutter.

Thursday 14 April 1988:

The Minister of Health called for an urgent meeting with the Chairman of the Auckland Hospital Board to resolve problems in housing potentially dangerous psychiatric patients.

Monday 18 April 1988:

The Auckland Hospital Board voted unanimously to:-

1. Provide a 10 patient Safe Care Unit at Carrington for dangerous psychiatric criminals.
2. Prepare an admission protocol making the duty doctor solely responsible for accepting or refusing a patient.
3. Call to task the Maori Health units at Carrington, making them accountable to the Board.

Sir Frank Rutter is reported as saying:

"I do not believe we can delay any longer...the public has been seriously alarmed and concerned about incidents with patients requiring safe care since the old Oakley Ward M3 closed in August 1987. The ward has housed dangerous patients and no secure substitute has since been provided in Auckland."

The Board's Acting General Manager, Mr Ian Campbell, was given 14 days to provide the Board with firm proposals for a secure unit at Carrington.

Sir Frank Rutter also said:

"The Maori Health units, the Whare Paia and

Whare Hui, have tended to become isolated and independent, they appear to be unwilling to be subject to hospital management, control and audit. They must acknowledge they were departments of hospitals, subject to management decisions and visits by members of other departments. If the units cannot accept this Board policy then the Board will have to look elsewhere for advice on Maori psychiatric help."

Monday 2 May 1988:

Auckland Hospital Board informed that a 10 bed safe care unit at Carrington Hospital would take six months to complete. Delay criticised by media and some staff.

Monday 9 May 1988:

Auckland Hospital Board proposes to build a 10 bed safe care unit at Kingseat Hospital within three months. That proposal is subsequently adopted by the Board.

Tuesday 24 May 1988:

Minister of Health announces that he has asked the Director of Mental Health, Dr Basil James, to work with and assist the Auckland Hospital Board to solve the psychiatric services in its region.

"I do not believe we can delay any longer...the public has been seriously alarmed and concerned about incidents with patients requiring safe care since the old Oakley Ward M3 closed in August 1987. The ward has housed dangerous patients and no secure substitute has since been provided in Auckland."

– Sir Frank Rutter

COMMENT

"It is only with the heart that one can see rightly.
What is essential is invisible to the eye".
Antoine de Saint-Exupéry

INTRODUCTION

The status of those people who offend against the law, and who also labour under some sort of mental disability, has been a contentious issue in New Zealand for a long time. As offenders, if sentenced to a term of imprisonment, they clearly come under the jurisdiction of the Justice Department which is responsible for their incarceration and care. At the same time, because they are people who are psychiatrically disturbed or mentally ill, they also come under the responsibilities of the Department of Health, and of the various Hospital and Area Health Boards which administer health services in the region.

Understandably, some of these people have not been very welcome in the institutions of either service; in the prisons run by the Justice Department, or the hospitals administered by the various Hospital Boards. The result has been that, on many occasions, inmates have been shuffled from the criminal justice system to the health system, and vice versa. Attempts to resolve the issue have created problems for both services, especially in the Auckland area.

On 1 April 1988, the State Sector Act 1988 came in to force. One of its effects was to abolish Hospital Board Executive groups and to replace the triumvirate with a General Manager. The comments below relate to events up to 1 April 1988.

We have no wish to recount in detail the unhappy history of Oakley and Carrington hospitals since 1971. Our starting point is the Gallen Inquiry 1983. That Inquiry saw the future of Oakley hospital as having an emphasis on forensic psychiatry, an emphasis which would be reflected in the establishment of a remand unit, and a secure unit for the treatment of psychiatrically disturbed prisoners. The Inquiry also confirmed what, to many, was a self evident truth, namely, that the Auckland Hospital Board and the Oakley administration had persistently failed to provide adequate facilities and services and to implement recommendations of the several Inquiries since 1971, especially those of the Hutchinson Inquiry. Inevitably, this resulted in the development of inferior standards of care and treatment for patients.

If ever there was a period in the history of the Auckland Hospital Board when it needed to confront the criticisms, then that period arose immediately following the Gallen Report 1983. As Mr Campbell, the Chief Executive, has correctly pointed out, the Board was keenly aware of the shame of past events at Oakley, and wanted to ensure that there was an improvement.

We believe that, since January 1983, the Board has responded to the criticisms, but in the process it has disgraced psychiatry, it has failed to comply with its legal obligations, it has demonstrated a poverty of concern for its psychiatric patients, an insensitivity for the feelings of the general public as to safety, a disregard for the views of hospital and prison staff and, not least, a lack of commitment for the welfare of those psychiatrically disturbed prisoners who were denied the dignity of appropriate treatment. In some cases, prisoners were even denied the dignity of being allowed to survive.

Haere nga mate, haere nga mate, haere nga mate.

During the course of this Inquiry, we heard from many individuals and organizations regarding the activities of the Auckland Hospital Board.

No useful purpose would be served by traversing the evidence in detail. Suffice it to say that we were impressed by the integrity and concern shown by those individuals and organizations who were critical of the Board. It would be fair to say that much of the criticism was vehement, but we did not detect any self-serving interest in any submission presented to us. On the contrary, we are satisfied that, without exception, the critics were motivated to ensure that psychiatric patients, whether from within or without the justice system, be given a better deal than they appeared to be getting in Auckland. If, in the process, public and staff concerns on the issues of safety and security could be resolved, then so much the better.

Later, we shall comment on the attitude and actions of members of the Auckland Hospital Board. At this stage we want to comment on some of the individual submissions presented to us.

Prison Staff

We express our admiration for the work being done by Dr Whittington, Dr Maule and the superintendents at Paremoremo and Mt Eden prisons, as well as others associated with those two institutions. In our view, they are working under circumstances, and in an environment, which prohibits effective treatment of those prisoners who are grossly mentally disturbed. That most of them are trying to manage such people in the absence of nursing training, and in a non-therapeutic environment, is a tribute to their concern, persistence and patience.

We note the anger and frustration of prison officers who, since 1983, have found it difficult to transfer persons whom they regard as mentally sick in to psychiatric hospitals in Auckland. That anger is well founded. Our Assessment Team has already observed that experienced prison officers are usually fairly perceptive when it comes to deciding whether a prisoner is mentally ill. On that basis alone, the overwhelming evidence from staff at Paremoremo and Mt Eden justifies their anger, frustration and disillusionment with those responsible for deciding when an inmate will be admitted to hospital - i.e the so-called "Oakley team". However we look at the evidence, the "Oakley team" was only prepared to admit, if at all, those patients whom they regarded as manageable. Later, in the absence of a secure facility at Carrington, they allowed people with psychiatric disorder to remain in gaol or, in the alternative, they transferred them to the National Security Unit at Lake Alice.

We believe it is expecting too much of prison officers to be both nurse and warder. The primary function of a prison officer is to contain people. Sick people should be cared for by health professionals; that is what they are trained to do, and if some degree of security in some cases is called for, then that also is the responsibility of the health professionals.

We adopt the submission that those who are grossly disordered should not be in prison, which is a totally untherapeutic environment. Dr Maule and others have acknowledged that some prisoners can be treated in prison, but certainly not those who are seriously mentally ill. We agree.

Academic Staff

Professor Werry has told us that he is an outspoken critic of the Auckland Hospital Board. We should add that Professor Werry, Associate Professor Wright and their colleagues suggested that we should not accept their criticisms of the Board at face value, and that we should seek other opinions. In our view, the evidence they presented was balanced and objective.

We accept the submission that, as a result of the Board's short-sighted policies,

Auckland is now stuck with the worst of all possible worlds; i.e. high imprisonment rates, low hospitalization rates, bad conditions for psychiatric patients within the community, and demoralization of the hospital services. We acknowledge that other factors, apart from the activities of the Board, are mainly responsible for the high imprisonment rates.

If, as has been suggested, there had been a "holding operation" and consultation following the Gallen Inquiry, then it is likely that this present Inquiry would have been unnecessary.

We accept that the Board attempted some improvements and consultation with interested groups, but, in our view, these were token gestures only.

Nurses and P.S.A.

We now comment briefly on several features of the evidence presented by nursing staff and PSA representatives to whom we spoke.

It was suggested to us that some nurses and PSA members were more interested in their own welfare than in that of their patients. It would be naive to believe that nurses and PSA members do not regard remuneration and terms and conditions of employment as important elements in the employer/employee equation. It is entirely to be expected that, on occasions, furthering their own interests may result in disagreement with their employer – even to the extent of so-called "industrial action". We are aware, for example, that the rates of pay and allowances at Oakley Hospital were higher than those at Carrington Hospital. The closure of Oakley would necessarily result in staff being required to work in a non-secure facility at Carrington and, as a consequence, their remuneration levels would fall. Prima facie, therefore, nurses and members of the PSA had a vested interest in ensuring that Oakley, or at least a facility which performed a similar function, remained in operation. Whether that was the "secret agenda" which the Board "did not want to inflame", we do not know. The Board did not tell us of the so called "secret agenda", despite our request for that information. But if that be the "secret agenda" referred to by Sir Frank Rutter, then we reject it.

We have had the advantage of meeting with many nurses and PSA members throughout New Zealand. Nurses are the backbone of the psychiatric service. They hold a unique position in the provision of inpatient care in relation to other health disciplines. Whilst not denigrating other groups, we believe that psychiatric nurses are in the forefront of provision of care. They provide continuous 24 hour a day, 7 day a week care and treatment. They are uniquely charged with the responsibility for ensuring the safety of residents in the hospital setting. Furthermore, nurses are the one group, often reluctantly, who deal with physically violent patients who require to be restrained. It is a role which they accept and, as a corollary, their views should not lightly be dismissed.

In any organization, as in any society, there will always be individuals who may step outside the norm of acceptable behaviour for some ulterior or personal purpose. The careless exercise of power is also a characteristic of human behaviour which is not unknown in New Zealand. These observations do not apply, on both a national and local level, to the nurses and PSA representatives whom we met. We were impressed by the care which nurses and PSA members throughout the country demonstrated towards their patients. In many cases, they were fulfilling the role of patient advocate. That concern was evident amongst nurses and PSA members in the Auckland region. We accept unreservedly that the actions of nursing staff prior to, during, and subsequent to the PSA ban of 15 March 1985 were motivated out of concern for their patients. We dismiss any suggestion that the PSA ban and events subsequent thereto were prompted by some self-serving need.

We have already noted that one group of nurses felt disgraced by the standard of care they were able to offer. We believe them. We find it difficult to understand the

criticism which Miss Murphy made of those nurses, when she said she was totally opposed to any nursing staff who try to use patients for their own ends. The nurses whom we saw were distressed at their powerlessness in being unable to offer more to their patients. We believe that an acknowledgement of the plight in which the nurses found themselves, and a stronger resolve to encourage and assist them, would have achieved a great deal more.

We accept the PSA evidence that the 1985 ban was only intended to be a short-term holding action while discussions were held with the Board as to the resolution of serious health and safety issues. The ban lasted for two years. Ultimately, a joint PSA/Auckland Hospital Board Task Force was established to look at the provision of facilities and other matters covered by the ban. We have been told by the PSA that, pending a final report by the Task Force, the Board had formally requested, and obtained, from the PSA an assurance that its members, mainly volunteers, would continue to nurse patients in Oakley M3 after its closure. Although Oakley M3 was to be degazetted as from 17 August 1987, it was agreed that the building would still remain in use, but under a new designation, i.e. Carrington M3. It should be noted that the volunteers who agreed to continue nursing in the proposed M3 Carrington did not seek the higher Oakley allowances which had been paid to the former Oakley staff.

On 17 August 1987, staff working in Oakley M3 were asked to remove the patients to the open structured living environment – M7. That request was put to staff by Miss Murphy and Mrs Quinlan. By 11 o'clock that morning, the transfer of patients had been completed. The nursing team designated to work in the open structured living environment (M7) were instructed to present themselves at that ward to care for the patients who had been transferred there. We were told that the staff refused on the grounds that the former Oakley M3 patients were outside the agreed area covered by the ban. They also pointed out that other patients had previously been selected to move in to the open structured living environment (M7) and that the ward had been designated for their use. It should also be noted that, prior to the transfer of the patients from Oakley M3 to M7, the clinical teams had already decided that the admission of M3 patients to other wards in the hospital was inappropriate.

The PSA met with management, and management accepted responsibility to nurse the former Oakley M3 patients. Ultimately, M7 became known as the Whare Paia. We have been told that the PSA has never received a rational explanation as to why Oakley M3 closed in breach of the agreement between it and the Auckland Hospital Board.

The PSA view is perhaps best summed up by Marney Ainsworth who says:—

“We would argue that nurses did not walk out. We argue that the Auckland Hospital Board removed those people from responsible nursing care in an agreed environment and that the Auckland Hospital Board itself created the situation that developed.”

The PSA have told us that they attempted to resolve matters with the Auckland Hospital Board on 17 August 1987 but were unable to do so. It is our view that good communication and sensible negotiation could have resolved the problem there and then. Regrettably, the PSA did not at that time have access to those persons in the Board with whom the problem could have been discussed and perhaps resolved.

When we spoke with representatives from the Board we were simply told that the nurses refused to nurse the patients from M3. No further explanation was forthcoming, despite our invitation to elaborate.

We do not know whether the so-called refusal to nurse was also part of the “hidden agenda” which the Board did not “wish to inflame”. In the absence of further

explanation from the Board, we can only comment that, after having seen and heard nursing and PSA representatives, we see no reason why their evidence, as outlined above, should be rejected. In our view, they were credible witnesses.

AUCKLAND HOSPITAL BOARD

During the course of this Inquiry, we spoke to only two persons who were uncritically supportive of the Auckland Hospital Board. The first was Dr Felgate, a one time member of the interim Oakley management group which also included Dr Honeyman and Miss Murphy. Dr Felgate is also the psychiatrist in charge of the Whare Paia, which is the Carrington bicultural health unit. The second person was Mrs Quinlan, Principal Nurse at Carrington Hospital. (She resigned in May 1988). She was supportive of the Board's "open door" policy and its admission/assessment criteria following the Gallen Report, but critical of the lack of funding for community facilities and services for psychiatric patients.

On December 3 1987 we met with Board members and officers. They were:
 Sir Frank Rutter, Chairman;
 Mrs Bassett, Deputy Chairperson;
 Mr Campbell, Chief Executive;
 Dr Honeyman, Medical Superintendent-in-Chief; and
 Miss Murphy, Chief Nurse.

Later, that group was joined by Mrs Harawira, the coordinator at the Whare Paia.

It is our firm belief that, if the recommendations of the Gallen Inquiry had been adopted by the Board, there would have been no need for our Inquiry. It is fair to say that many of the 79 recommendations of the Gallen Inquiry were implemented by the Board. What cannot be overlooked, however, is that the major recommendations, those which would have initiated a new era in forensic psychiatry, were deliberately rejected by the Board - with disastrous consequences. We acknowledge that the Board was entitled to adopt that approach, but it must be said that all three members of the Gallen Inquiry were knowledgeable, experienced and respected. Their views should not have been lightly dismissed. We find it difficult to believe that the Gallen Inquiry would propose a major recommendation which Dr Honeyman later described as "ill-founded".

In our view, the appointment by the Board of a special committee, devoid of any planning function, in lieu of a Board of Control as recommended by the Gallen Inquiry, was nothing more than a facade, which gave the appearance of a new direction but which ensured that decision-making remained in the hands of the Board. That one act, more than any other, immediately ended the prospect of a new and better regime for forensic psychiatry in the Auckland area.

We do not accept the comment by the Executive group of the Board that, ... "the special organizational provision (the Board of Control) proposed by the (Gallen) Committee" was "unclear and ambiguous".

What needs to be noted is that the Board's own organizational structure for Oakley had been considered and rejected by the Gallen Inquiry and yet it was precisely that structure which the Board resorted to when it rejected the Gallen recommendation. The fact of the matter is that the Board wanted its own way - and it got it - at a price.

By 17 November 1983 the special committee was seriously considering its own dissolution. Ultimately it sank into oblivion, but not before it had been advised by Dr Honeyman that, so long as it continued in existence, Carrington and Oakley hospitals would not amalgamate. On 17 August 1987 Oakley hospital closed. An amalgamation of Oakley/

Carrington was never achieved.

Other events compounded to ensure that the most important Gallen Inquiry recommendations would not be implemented. Firstly, a Director of Forensic Services was never appointed. Secondly, Dr Honeyman was appointed interim Medical Superintendent. He then became responsible to himself. Thirdly, Miss Murphy was appointed interim Principal Nurse and fourthly, a new remand unit at Oakley was never established. We endorse the view of Professor Werry and his colleagues that the responsibilities of Dr Honeyman and Miss Murphy were such that they "should have been looking after the system as a whole without trying to run the most difficult spot in the system, i.e. Oakley/Carrington".

The Gallen Inquiry, in recommending the establishment of a Board of Control, obviously envisaged that a wide range of skills, expertise and scholarship would be applied so as to steer forensic psychiatry in a new direction. The nature of the proposed structure would ensure that the Hospital Board maintained a continuing responsibility for the mental health of prisoners and remandees.

Dr Honeyman, Miss Murphy and Mr Campbell (at least since December 1985 when he was appointed Chief Executive), were the Executive group which were the Board's principal advisers. All three are intelligent people. If, as we have been told, decision-making at Executive level is achieved by agreement, then the Executive for the time being must be held collectively responsible for the policy, planning and administrative decisions of the group subsequent to January 1983.

What can be said with certainty, is that the Executive countenanced a lowering of security at Oakley/Carrington and the introduction of a more stringent test for admission from prison to hospital. It misinterpreted or misunderstood the Gallen Report. Its interpretation was that all prisoners who were mentally ill should be admitted to the new Oakley. The Gallen Inquiry referred to "all prisoners ... who have psychiatric problems requiring hospitalisation". The Board then spent over \$500,000 on M3 which resulted in the security level being lowered to that of a "closed ward". The evidence of Dr Taylor, which we accept, shows that admission and discharge policies changed following the Gallen Inquiry, and that security was lowered. Having deliberately achieved a low level of security, the Board then decided that Oakley M3 could only function as a service for the short-term care of severely disturbed committed patients, and limited short-term care for some psychiatrically disturbed prisoners. Having then ensured that it did not have suitable facilities to provide an adequate forensic service, the Board then shifted the problem to the Minister of Health and the Minister of Justice. That shift ultimately led to the 1984 Working Party.

With the advantage of hindsight, we find it difficult to understand why the Ministers of Justice and Health allowed themselves to be manoeuvred into establishing the 1984 Working Party. After it had disregarded the major recommendations of the Gallen Inquiry, for reasons which have not been satisfactorily explained to us, and after it had run down security at Oakley so that it was virtually ineffective, the Board then attempted to sidestep its obligations and throw those on to the Health Department and, more particularly, the Justice Department. It seems to us, with respect, that at the Ministerial meeting on 2 March 1984 the Board should have been informed bluntly and clearly that it had a legal obligation to provide care for psychiatrically disordered offenders and remandees, and that it should fulfill that obligation. Had that course been followed, we suspect that the Board would have been left with little choice but to adopt the principal recommendations of the Gallen Inquiry.

The Working Party reported in November 1984. The Board has told us that,

when the Mt Albert Borough Council turned down the Justice Department application to convert Oakley M3 into a special prison, that immediately created a three year gap which the Board was trying to fill. We were invited to accept that the Board's planning was predicated on the basis that a special prison hospital would be available to provide the type of security required for mentally disordered prison inmates. We reject that explanation, and in that regard we refer to recommendation 6.5 and paragraphs 2.10, 3.6, 3.17 and 3.18 in the 1984 Working Party report, which clearly spells out a residual obligation on the part of the Board to provide facilities and care for prisoners with mental disorders.

We hasten to add that not all the blame for the intolerable state of affairs which subsequently arose rests with the Board. However commendable the actions of the Justice Department in upgrading facilities in Paremoremo and Mt Eden prisons for psychiatrically disturbed prisoners and remandees, the simple fact of the matter is that progress towards the establishment of a special prison in Auckland went into limbo once planning approval had been declined by the Mt Albert Borough Council. There also appears to have been a lack of liaison between the Justice Department and the Board in order to resolve the problems which were then emerging.

The Board knew, well before 17 August 1987, that a special prison would not be built and that the type of security which it envisaged would not be available. Nonetheless, it went ahead and closed Oakley.

We now comment on the attitude of the Board towards its legal obligations under Sections 42 and 43 Mental Health Act 1969. Both Sir Frank Rutter and Dr Honeyman have assured us that it is the policy of the Board and its staff to obey the law. Dr Honeyman has told us that it is his responsibility to ensure that staff comply with the law. We accept that the Board's policy is as stated. We are satisfied, however, that, since January 1983, the Board has not implemented that policy, nor has it any attention of doing so.

On the evidence presented to us, we are forced to conclude that the Board's efforts have been targeted towards discarding and rejecting those patients whom it saw as an embarrassment, namely the criminal justice patients, which it regarded as the responsibility of the Justice Department. We invite you to read the evidence of Dr Honeyman earlier in this report in this regard, and give two examples to demonstrate the point.

Dr Honeyman told us that if an order is made by a Judge under Section 42 or 43 then the Board is obliged to comply with it. He had earlier told us that if a Section 42 certificate is made out the patient will be admitted,

"where it is clinically appropriate" and that,

"...the Board will accept people it is capable of handling".

He commented that the PSA ban was all that had stopped patients being admitted. On our assessment of the evidence, the true situation is that the Executive had run down the security at Oakley to the stage where it could no longer safely contain some prison inmates. Having created that state of affairs, it is hardly surprising that the PSA, on 15 March 1985, decided to ban "Oakley-type" patients. As one nurse correctly pointed out to us, the advent of "Oakley-type" patients into a less than secure ward would have been an open invitation for confrontation between patient and patient, and staff and patient, and the resultant disruption to effective nursing care which that would have created. In our view, it is quite unreasonable and unrealistic to expect nursing staff to care for dangerous, or potentially dangerous, patients in an open or non secure ward. We find

difficult to believe that the Board would countenance the care and treatment of such people in an open or less than secure ward, and yet that is the only rational alternative to the PSA ban. If, however, we are wrong in that view, then we ask why prisoners, who, in ordinary circumstances, would have been admitted to Oakley or Carrington, were instead transferred to Lake Alice. It is clear to us that it was not the PSA ban which stopped inmates being admitted to hospital, but rather the failure of the Board to provide a secure facility which would safely contain those psychiatrically disordered offenders requiring security. Had the Board provided such a facility, as public pressure compelled it to do on 18 April 1988, we have no doubt that the ban would have been lifted.

We have no wish to appear unduly cynical, but we are left with the very distinct impression, after meeting with the Executive, that it was in the Board's interests to allow the ban to continue for as long as possible. That at least enabled it to blame the PSA, nurses and others, whilst at the same time ensuring that it discarded its responsibilities towards criminal justice patients, and that it completed the run-down and eventual closure of Oakley.

In our view, nursing staff were justifiably apprehensive when dealing with patients whom they regarded as a danger either to themselves, to other patients or to staff. They believed that in such situations the dangerous, or potentially dangerous, patient should be kept apart from other patients by being placed in a secure facility. When the patient was assessed as being no longer a danger, transfer would be to a less secure facility. But it seems to us that, when the secure facility did not exist, the hospital staff were placed in a Catch 22 situation. We fail to see how nursing and medical staff, under those circumstances could make an assessment as to whether a patient should be in a secure or less secure facility, when one option which should have been available to staff was removed from consideration.

We hasten to add that nurses to whom we spoke acknowledged the inadequacies of Oakley M3. They did not wish a return to the pre 1983 regime, but pointed out that some of the M3 functions, from the security aspect, were necessary. We agree.

We believe that, in the Auckland area, nursing and para-medical staff have done their best to alert the Auckland Hospital Board to the need for services which will meet the needs of psychiatric patients, including those who are commonly referred to as criminal justice patients. On occasions, their efforts have been described as radical, and in that regard we again mention the PSA ban of 15 March 1985. It is clear to us, and it should have been equally clear to the Auckland Hospital Board, that, even at that early stage, nursing staff envisaged the development of a safe care type facility within psychiatric hospitals that would ensure treatment for people who would otherwise be unacceptable in an ordinary open psychiatric hospital. Those people would include the special patients who are the subject of this Inquiry.

We say clearly and emphatically that nursing and para-medical staff have been motivated out of concern for their patients, and that the Board has been dismissive of those concerns.

We believe that the attitudes of the Executive, and others who occupied positions of authority at Oakley/Carrington, made it virtually certain the PSA ban would be almost incapable of resolution. Miss Murphy made it clear to us that nurses with appropriate skills could provide "safe care", in which event it would not be necessary to resort to locked doors and seclusion — even in respect of the so-called dangerous patients

admitted to the hospital under Sections 42 and 43 Mental Health Act. Miss Murphy is totally opposed to seclusion.

Mrs Quinlan, the (then) Principal Nurse at Carrington, held similar views. She said that a psychiatric hospital is not a place for containment. Dr Honeyman and Dr Felgate also told us, in no uncertain terms, that prisoners should be treated in the community with which they were familiar, i.e. the prison community.

Interestingly, Dr Felgate is one of a group of psychiatrists involved in the assessment of prisoners at Paremoremo prison. He was the only psychiatrist, in our experience, who did not understand the meaning of the term, "forensic psychiatry". He suggested that forensic psychiatry was all about dealing with difficult people that nobody really wanted to be bothered with.

More than two years before Oakley closed, nurses were asking for a safe care facility to contain "Oakley type" patients. At least a year before Oakley closed, Dr Radcliffe and several of his colleagues expressed concern that a safe care unit be ready for occupation by the date of Oakley M3's planned closure. The Board did nothing. One month before Oakley closed, the Board accepted the obligation to provide a safe care facility within its institutions. The Board accepted that obligation in response to a Ministerial inquiry. We believe that the (then) Minister was misled, as no such facility existed at the date of the Oakley closure, nor does it exist down to the present day. As late as 3 December 1987, when we met the Board, we were informed by Mr Campbell, the Chief Executive that,

"... when the Board looks more closely at the issue of safe care facilities it may find that there are actually enough facilities but that the pressure on them may need to be eased."

We express concern at that observation. It seems to us that Mr Campbell, as a member of the Executive, and as one of the three persons actively involved in planning Board facilities, should have been well aware of the nature and the number of safe care facilities available to it. After all, Dr Radcliffe, nurses, the PSA and the general public had been vocalizing the need for such facilities over a period of some years, and it can hardly be said that Mr Campbell and other Executive members were unaware of the concerns being expressed.

For example, when we inquired of Miss Murphy as to the reason for the PSA ban of March 1985, her response was:

"I would love to know."

At a later stage, Miss Murphy somewhat reluctantly acknowledged that:

"... the PSA could well have said that there were insufficient staff and that there was insufficient accommodation"

By necessary implication, we were invited to conclude that the Executive, and thus the Board, did not know why the ban had come into being. We decline the invitation.

We are satisfied that the Executive was well aware as to the reasons for the ban, a continuation of which conveniently slotted in with the Board's plan regarding criminal

On the principle of collective responsibility, each member of the Executive must be held accountable for the judgments, decisions and action of the other and for the collective advice given to the Board.

If a further example of the Board's attitude is required, we need only refer to its relationship with the Wanganui Area Health Board. That latter Board is responsible for the management of the National Security Unit at Lake Alice, near Marton. From time to time, the Lake Alice Review Panel will recommend the transfer of maximum security patients from Lake Alice back to the hospital area from whence the patients came. In Dunedin, we met with a special patient from the Coromandel area who had been a patient in one of the Auckland psychiatric hospitals prior to his transfer to Lake Alice. When the Review Panel recommended his transfer back to Auckland, the Auckland Hospital Board refused to accept him. Had it not been for the good offices of the Otago Hospital Board, he may still be languishing in Lake Alice hospital. The human tragedy of that episode is that a patient from the Coromandel area, who should have been resident in an Auckland psychiatric hospital was transferred to a psychiatric hospital at Cherry Farm in Dunedin, and, in the process, he was therefore deprived of the close supportive links from his friends and whanau which he could reasonably have expected had he remained in the Auckland area.

On other occasions, we were told of, and spoke to, patients from the National Security Unit who were denied readmission to Auckland hospitals despite the fact that a transfer to the Auckland area had been recommended by the Review Panel. In the result, those patients were forced to remain in the National Security Unit when their clinical condition did not justify that course. In some cases, patients have remained in the National Security Unit for periods in excess of a year following the recommendation of the Review Panel.

The Auckland Hospital Board says that it has no facilities to contain such patients. Expressed more bluntly, the Board has decided that it will override the Lake Alice Review Panel with its own set of values. The fact that its set of values may cause distress to patients, and problems for the Wanganui Area Health Board, appears to have been of minor significance. In fairness, we should record that at one stage the Auckland Hospital Board offered to pay for "its" patients to remain in the Wanganui area, and for certain costs in relation to family visits to be met by the Board. No further comment is called for.

We wish to say that the criticisms we have expressed of the Executive members do not apply to the Board Chairman, Sir Frank Rutter, and the Deputy Chairperson, Mrs Bassett. We believe that they were concerned to be truthful and balanced in their views. We do not doubt the integrity of their evidence, although we reject some of their conclusions. For example, Sir Frank Rutter told us that one of the recommendations of the Gallen Inquiry was that Oakley be closed. Sir Frank has repeated that comment publically on several occasions. He is incorrect, and his view demonstrates a complete misunderstanding of the situation. The Gallen Inquiry recommended an amalgamation with Carrington.

In commenting on the evidence given by Professor Werry, Associate Professor Wright and their colleagues, Mrs Bassett observed that personalities and personal antagonisms had coloured the evidence given by the senior academic staff, and that the philosophical outlook of Professor Werry and his colleagues was very similar to that of Miss Murphy and Dr Honeyman. With respect, we disagree.

PAREMOREMO SUICIDES AND PATIENT ASSESSMENT

We now comment on the Paremoremo suicides and the assessment process.

In an article in "Mental health: a Case for Reform" (5 September 1986), Dr Paul Jensen suggests that some of the Paremoremo suicides were, at least in part, precipitated by the sudden introduction of the new hospital policies after the Gallen Inquiry. He also suggests that the increased rate could in part be related to "epidemic" effects. While we do not disagree with that view, we firmly believe that there are four major factors which collectively have caused the increased suicide rate since 1983. They are:

1. the changed admission criteria;
2. the lack of adequate secure facilities at Oakley/Carrington which has directly impinged on clinical assessments;
3. the very limited application of the term "mentally disordered"; and
4. the very limited definition of the term "treatability" adopted by some Oakley/Carrington staff.

We accept that, to a minor extent, inadequate prison facilities and other peripheral matters also contributed to the increased rate.

The Board has informed us that there were two suicides at Oakley in each of the periods 1968 to 1982, and 1983 to 1988. We were informed that the Board was not totally confident of the reliability of those records. Edgar Rout, on whose views we place considerable reliance, has informed us that there were no suicides at Oakley in each of the above periods.

It would be stretching the long arm of credulity altogether too far to conclude that 13 suicides occurred in the five year period (1983-1987) for the reasons advanced by Dr Jensen. Such an explanation is untenable when compared to the single suicide in the fourteen year period from 1968 to 1982. The simple fact of the matter is that prisoners with psychiatric disorders, who needed to be in hospital, were denied admission. Those prisoners whose condition was judged to fall within Sections 42 and 43 Mental Health Act were admitted to the Lake Alice National Security Unit.

Several prison officers at Paremoremo commented that at least half the suicides were preventable. First Officer Price asserts that 10 of the 13 suicides were preventable. All the prison officers to whom we spoke said many of the suicides occurred because inmates could not be transferred to hospital, and, in any event, they had no faith in the so-called "Oakley team". They knew that, in all probability, a request for transfer would be refused. The inmates therefore remained in gaol. The report of Warren Brookbanks, a member of our Assessment Team, speaks for itself. We believe it is cogent and persuasive evidence in support of the views expressed by prison staff and others.

We believe that if Oakley/Carrington had been provided with a secure facility, as suggested by Dr Radcliffe, the PSA, nurses and other groups; if the Oakley/Carrington assessment staff had refused to adopt a very limited definition of the term "mentally disordered"; if that same staff had not adopted a very limited application of the term "treatability"; and if some staff had not compromised their professional integrity, then the lives of many of the persons at Paremoremo who committed suicide would, in all probability, have been saved.

We believe that some prisoners at Paremoremo and Mt Eden have been deprived of their human right to appropriate treatment. The system which evolved between Oakley/Carrington and the prison service was one which evolved for the convenience of the Board. Its evolution was encouraged by some of the Oakley/Carrington assessment

staff. It did not evolve for the benefit of those who most needed to be helped – prisoners with psychiatric disorder. In the process lives were expended.

Mr Rout believes that there is a direct relationship between the Board's policy of returning inmates more quickly to prison and the increased suicide rate at Paremoremo since 1983. He gave as an example the case of patient 1A which is referred to in the report by Warren Brookbanks. He shares that belief with many others.

We do not intend commenting at length on the meeting between the Carrington psychiatrists and our Assessment Team. We allow that report to speak for itself. All five members of the Assessment Team carried out their duties in a professional, compassionate and responsible manner. We accept responsibility for their reports which we endorse.

We are unaware as to the names or numbers of Oakley/Carrington psychiatrists who have participated in the assessment of prisoners at Paremoremo since January 1983. We accept that, in general terms, the psychiatrists at Oakley/Carrington are men and women of skill and devotion, and it would therefore be unfair to criticize that group in toto because of the stance taken by a few.

It must have been very clear to the psychiatrists, on many occasions, that they were dealing with psychiatrically disordered prisoners. The findings of our Assessment Team at Paremoremo provides cogent proof of that fact. A secure facility did not exist at Oakley/Carrington. That was known to the psychiatrists. It follows that if a secure facility did not exist, then the psychiatrists were confronted with a situation which was unworkable. In effect, a prisoner who, in ordinary circumstances, would be admitted to hospital, was denied admission because secure facilities did not exist. That in turn necessarily resulted in mentally ill prisoners being transferred to the National Security Unit at Lake Alice or, alternatively, remaining in gaol.

The evidence satisfies us that some assessment psychiatrists regarded prisoners as the responsibility of the Justice Department. As "Oakley-type" patients they were not wanted at either Oakley or Carrington. The admission of all inmates was therefore denied – excepting four who were admitted between 1983 and 1987.

The Oakley/Carrington assessment staff wanted only those patients who were "manageable". What seems to have been overlooked is that health professionals have an ethical and moral duty to care for psychiatrically disordered people, whether they be manageable or unmanageable. Management has a corresponding obligation to provide the facilities which enables that duty to be carried out.

We are not prepared to accept that prisoners from Paremoremo were denied admission to Oakley/Carrington because they were malingerers, or because they had developed a prison psychosis, or because they were persons who suffered from personality disorders. Some prisoners may have come within one of those categories, but it would be a nonsense to believe that that was the main reason why admission to hospital was denied.

In our view, the administrative and management decisions of the Board or its Executive after January 1983 were the major factors which influenced clinical teams into denying admission of inmates to Oakley/Carrington. We are satisfied that clinical

teams on occasions must have modified their clinical decisions to deny admission because to do otherwise would be to compromise the Board. It is both unethical and illegal to refuse admission simply in order to reduce hospital numbers. We cannot escape the conviction that the modification of clinical decisions to harmonize with the policy of the Board has exposed the modification for what it is, i.e. nothing more or less than a convenient device to ensure that the Board did not have to care for patients whom it regarded as being the responsibility of the Justice Department.

As an aside, we comment that the manner in which the Assessment Team carried out its duties demonstrated that well-intentioned Maori and non-Maori people can easily work in a spirit of cooperation and goodwill in the field of mental health. Neither non-Maori health professionals nor Maori experts possess an exclusivity when it comes to assessing, diagnosing and treating those who suffer from psychiatric disorder. That each member of our Assessment Team had a keen appreciation of the others' skills and expertise, and was prepared to utilize those skills in the interests of patient care, is an approach which we commend.

THE HOSPITAL BOARD AND ITS EXECUTIVE

We have commented on, and been critical of the planning and administrative decisions of the Board and, in particular, its Executive group.

Between 1983 and 1988, and particularly from March 1985 onwards, events in the Auckland psychiatric hospitals and the two major prisons in the region attracted considerable, and generally adverse, media comment. The Board must have been well aware, if only from media coverage, of the concerns being expressed about the inadequate psychiatric facilities in gaols and the inadequate security facilities in the hospitals. Staff and community concerns were also prominently highlighted, especially in relation to security. That all was not well would be an understatement.

If, on the other hand, it was unaware as to the action plan of its own Executive, then we can only wonder why it did not become more inquisitorial, and insist upon the Executive supplying it with more information and explanation; and, if it was thought necessary, why it did not instruct the Executive as to how the continuing problems could best be resolved. If the Board did not proceed as we have suggested, then it cannot escape blame by default. After all, the Executive exists to serve the Board. The Board does not exist to rubber stamp the wishes of the Executive. Media coverage on events since 1983 make it difficult for us to accept that the Board did not know what was happening. Why it did not choose to resolve a long standing PSA ban, and to deal with other pressing problems regarding forensic patients, remains a mystery.

We have no hesitation in concluding that, at least since 1983, the blame for events at Oakley/Carrington lies squarely at the feet of the policy makers. We want to

emphasize that Mr Campbell did not become a member of the Executive group until December 1985 when he was appointed Chief Executive.

We say bluntly and emphatically to the Auckland Hospital Board, that it is ethically unacceptable for any administrator to extract the huge human cost which has been paid since 1983 in the interests of reducing Hospital Board responsibility and a consequent reduction in expenditure.

1 APRIL 1988 : AND LATER

It seems to us that if the present unhappy impasse between nurses and the PSA on the one hand, and the Board on the other, is to be resolved, there will need to be a greater willingness on both sides to compromise. For example, if recommendations which we make later in this report are adopted, it may mean that the traditional nursing role in forensic psychiatry will alter quite drastically. We envisage situations where nurses may be required to work not just in hospitals, but also in prisons and in the community. That in turn will require a renegotiation of some matters which hitherto have been regarded as inviolate e.g. the four on/two off roster system. In that event, we would expect nurses and PSA members to behave not only realistically, but reasonably and responsibly.

We believe, however, that the greatest need for change must be a change in attitude by the Auckland Hospital Board. Since the Gallen Inquiry, the relationship between the PSA and nurses on the one hand, and the Board on the other, has been one of a continuing dispute. The Board's public and industrial relations have been abysmal. If progress is to be made in future, it will be essential for the Board to consult with, and plan with, nurses and various union groups. Not to do so will be a recipe for disaster.

With the advent of the State Sector Act 1988 on 1 April 1988, the Executive of the Auckland Hospital Board ceased to exist. Mr Campbell was appointed Acting General Manager. He subsequently appointed Dr Honeyman as Acting Director of Health Policy and Miss Murphy as Acting Associate General Manager. The present position is that, although a triumvirate managerial system should no longer exist, all three members of the former Executive continue to occupy the three most important positions in the managerial hierarchy. We can reasonably assume that from time to time there will be discussion and an exchange of ideas on Board policy and the practical implementation of that policy amongst the three.

We are satisfied, however, from the lessons of recent history, that their future involvement in that regard (the provision of psychiatric services and facilities in the Auckland area) would be undesirable....

We respectfully draw your attention to Section 5, Hospitals Act 1957. That Section refers to the powers of a Minister to give directions to a Hospital Board. The Section is directory and grants to the Minister a broad discretionary power to give,

"...any Board such direction, not inconsistent with this Act or with any other regulations thereunder as he considers necessary or expedient for the purpose of this Act."

Although the powers in that section should be used as a last resort, we respectfully suggest that the Auckland Hospital Board be reminded of its implications.

Later in this report, we shall be making certain recommendations regarding the provision of regional medium secure units, regional minimum secure units and an

expanded community psychiatric service. We shall also be making recommendations regarding the funding of those facilities and services and the appointment of a Commissioner who will act on your behalf to ensure that tagged funding is spent for the purposes for which it is allocated.

In respect of psychiatric services and facilities in the Auckland Hospital Board area we have one recommendation to make.

RECOMMENDATION

We recommend the appointment of a Commissioner to oversee the establishment, efficient management and administration of all psychiatric services and facilities in the region for a period of at least 3 years. That Commissioner will report to and be directly accountable to you. The Commissioner should possess administrative, management and financial skills and ideally will have had some association with medical or psychiatric services. The Commissioner must be possessed of aroha and interpersonal skills. He/she would be expected to consult with all interested groups in the psychiatric service and to liaise closely with the Director of Mental Health. The Commissioner would be empowered to coopt such individuals or organizations as he/she thought appropriate. In simple terms, the Commissioner would be an interim General Manager for psychiatric services in the Auckland Region.

We would hope, notwithstanding our previous comments, that the Commissioner would see himself/herself as a facilitator to work with the Board with the objective of establishing a psychiatric service which will be innovative, refreshingly beneficial and enjoyable for both staff and patients and one in which the Board may have justifiable pride.

We would hope also that the Commissioner would find it unnecessary to recommend to you the exercise of your powers under Section 5, Hospitals Act 1957.

We note that on 24 May 1988 you authorized the Director of Mental Health to work with and assist the Auckland Hospital Board to solve the psychiatric service problems in its region. We envisage a somewhat similar role for a Commissioner but extended as to content and duration as outlined.

PART 2: THE REGIONS : INCLUDING AUCKLAND

This part of our report deals with the forensic psychiatric services available in the various areas referred to in our Terms of Reference. We discuss in general terms the administrative and clinical procedures and criteria by which decisions are made in the psychiatric hospitals we visited, the law relating to those procedures and criteria and finally we comment on the service as we see it. Our recommendations then follow.

THE LAW

Our Terms of Reference have been explained earlier in this report. The comments below should be read as part of that explanation.

In this Section of our report the terms "Section 21", "Section 42", "Section 43" and "Section 47" refer to the Mental Health Act 1969.

The terms "Section 121", "Section 115" and "Section 118" refer to the Criminal Justice Act 1985.

SECTION 121

Section 121 is a remand provision which is designed to make psychiatric reports more specific and also to ensure that psychiatric examinations for remandees are carried out in psychiatric hospitals only when all other possibilities are clearly inappropriate. An order cannot be made under Section 121(2)(b)(ii) unless a psychiatrist has certified or given evidence that it would be desirable if the psychiatric examination was to take place in a psychiatric hospital. Where no such specialist is available, a medical practitioner may so certify or give evidence to that effect.

One psychiatrist told us that, in practice, it would rarely be necessary to admit an alleged offender to hospital for examination. He suggested that in most cases the diagnosis, or lack of it, would be apparent. Exceptions occurred when there were doubts as to a diagnosis, in which case an inpatient examination would be recommended.

He said that more defendants than were strictly necessary tended to be admitted under Section 121 (2)(b)(ii) because some Judges did not ask a specialist psychiatrist to perform the

pre-admission examination, and because some psychiatrists had an imperfect knowledge of the law.

He also commented that the adequacy of facilities in psychiatric hospitals for an examination under Section 121 (2)(b)(ii) depended almost entirely upon the availability of psychiatrists charged with this responsibility. He said that only rarely would special facilities be required by a psychiatrist for an examination and report since most psychiatric examinations relied upon good observation and clinical skills rather than special facilities. He suggested that the limiting factor on inpatient examinations was the availability of psychiatrists, and not the availability or adequacy of the facilities.

SECTIONS 42 AND 43

On the expiration of a prison sentence, a patient admitted under Section 42 will automatically have a change of status to that of a committed patient under Section 21. A patient admitted under Section 43 will automatically become an informal patient on the expiration of his/her sentence.

Inmates admitted to hospital under Sections

42 and 43 may be granted leave on the authority of the Minister of Health if two medical practitioners, appointed by the Minister, certify that they are fit to be allowed to be absent from hospital. The Minister may impose such conditions when granting leave as he thinks fit. The power to grant leave under Section 47(1) shall not be exercised in respect of any person who is serving a life sentence or a sentence of preventive detention.

SECTION 115

Reclassification procedures differ for patients under Section 115(1)(a) and Section 115(1)(b) as follows:

Section 115(1)(a)

Patients under disability are subject to a "maximum period of detention as a special patient" for 7 years from the date of the making of the order where any offence is punishable by life imprisonment or preventive detention; or a period from the date of the order equal to half the maximum term of imprisonment for which the defendant was liable on conviction.

If, at the expiry of either term, a patient is no longer under disability, a certificate under Section 116 (6)(a) of the Criminal Justice Act 1985 from two medical practitioners to this effect, and a report supporting this, is sent by the Director of Mental Health to the Attorney General. The Attorney General will either direct that the patient be brought before the appropriate Court or direct that the person's status be changed to that of a committed patient.

If no such certificate is given, the Attorney General will direct that the patient be held as a committed patient under Section 116 (6)(b) of the Criminal Justice Act 1985.

The Attorney General may give similar directions in respect of a patient before the expiry of the maximum period of detention if supported by a certificate under Section 16 (4) of the Criminal Justice Act 1985 stating that the patient is no longer under disability.

Patients under disability may also have a status change to that of committed patient under Section 116 (5) Criminal Justice Act 1985 if the Minister of Health, with the concurrence of the Attorney General, is satisfied that the order is no longer necessary.

Section 115 (1)(b)

Patients acquitted on account of insanity may have a status change to that of committed patient or be discharged under Section 117 of the Criminal Justice Act 1985 if the Minister of Health is satisfied, on the recommendation of two medical practitioners, that the Court Order is no longer necessary.

After a patient has been reclassified from special to committed status the subsequent discharge of the patient is the responsibility of the Superintendent.

Several psychiatrists complained that the time taken to reclassify a patient was far too long and that it was not unusual for the process to take three months and sometimes up to six months to finalize. They considered this to be unreasonable but acknowledged the political nature of the process even though the criterion for reclassification was essentially clinical in nature.

SECTION 47

Applications for first short periods of leave under Section 47 (4) (i.e. leave not exceeding 7 days exclusive of departure and return) for special patients under Section 115 and Sections 42 and 43 must be approved by the Director of Mental Health. Thereafter the Superintendent of a hospital may be delegated authority to grant leave.

Periods of long leave for Section 115 (1)(b) patients and Section 42 and 43 patients may be granted, on certain conditions, by the Minister of Health.

The granting of leave to special patients is tightly controlled. The first leave must be approved in advance by the Director of Mental Health who requires considerable detail before granting such leave. Subsequent leave of up to, but not exceeding seven days, is at the discretion of the hospital Superintendent. The granting of leave to committed patients who, immediately before becoming committed patients were special patients, must at present be considered on the same basis as any other committed patient who acquired that status under some other provision of the Mental Health Act. As one Superintendent described it:

"They have, as it were, served their time and must not be penalized any further any more

than a prisoner would be".

Another psychiatrist expressed his view this way:

"For patients whose status has recently been changed from special to committed patients, I don't consider that there should be legal restrictions on the granting of such leave. If there is then the change of status has no meaning".

SECTION 118

A person ordered to be detained under Section 118 has the same legal status as a patient committed under the provisions of Section 21 and is therefore to be treated, granted leave or discharged in accordance with the procedures adopted in individual hospitals. If that is left to the discretion of the psychiatrist in charge then that person will generally have regard for the public interest which will sometimes outweigh the private interest of the patient. It would seem that there is no way in which the balance of

public versus private interest can be quantified in any satisfactory way and thus this judgment must be left to the professional expertise of the individual psychiatrist or clinical team responsible for deciding the issues of discharge or leave. One psychiatrist told us:

"It would still be my view that if a Court decides to make a committal order under Section 118, then the responsibility for decisions about leave, discharge etc. are passed entirely to the hospital staff. Any prudent hospital staff will be aware of public sensitivities and of the patient's past behaviour in all such cases. I do not favour giving the Court some right to restrict discharge from hospital in such cases. After appropriate treatment the patient's situation may be quite different in a few months and an order restricting discharge may be quite inappropriate. I would have grave fears that the situation could be abused if the Courts were given a right to restrict discharge".

THE REGIONS

OTAGO

Cherry Farm is the main psychiatric hospital in the region. The Otago Hospital Board provides a centralized psychiatric assessment service for the courts which usually involves no more than three to five psychiatrists at any one time.

Most of the people referred for assessment under Section 121 Criminal Justice Act have alcohol and drug abuse and dependency as part of their problems, and many have personality disorders.

In 1982, 50% of all remandees were assessed while on bail, or in prison. The remainder spent part of the remand period in Cherry Farm hospital. Following discussion and negotiation between the Medical Superintendent and the Judges in the region the percentage of remandees being assessed on bail or in prison increased to 75% in 1984.

Since the introduction of the Criminal Justice Act 1985, the request rate for psychiatric

reports has dropped from a steady 160 - 180 per year, to 100 per year; 90% of remandees are assessed on bail or in prison.

The Medical Superintendent told us that in any 100 referrals she would expect to find approximately 1 or 2 people with schizophrenia, approximately 10 to 12 people with a depressive or manic illness, and approximately 8 with a sexual disorder. Some 70 would be either substance abusing or substance dependent, and about 30 would have antisocial personality disorders.

Thus, in any 100 referrals, perhaps 15 would have a treatable illness, and most of these would receive treatment in the normal way, i.e. as if they had been referred by a General Practitioner.

There have been very few inpatient remands since the Criminal Justice Act 1985 came into force. The majority of these have been men, and few have presented any real management prob-

lems as inpatients. They are admitted to an acute ward at Cherry Farm hospital which is for men and women, and which is not locked. Full multidisciplinary assessment and treatment is provided as for any other patient.

Special patients under Sections 42 and 43 of the Mental Health Act are accepted at Cherry Farm hospital. Section 42 patients usually come from Dunedin or Invercargill prisons, and comprise those patients who have become so ill while in prison that they cannot be safely managed except in hospital. If the patient returns to normality, he is returned to the originating prison, but a small number serve their sentence at Cherry Farm and become Section 21 committed patients.

Section 43 patients are only accepted after considerable negotiation with the originating prison, and usually only near the end of sentence. Dr Faed, the Medical Superintendent, said that she preferred to offer an assessment period of 6 - 8 weeks in the first instance although some Section 43 patients have required continuing psychiatric treatment. Usually they return to prison just before the expiry of their sentence so they can receive the benefits of the appropriate supervision terms if they are released on parole.

There has been only one special patient admission under Section 115 Criminal Justice Act at Cherry Farm since January 1986.

The care and treatment of special patients is the same as for any patient in the hospital except that:

(a) the special provisions of Section 47 of the Mental Health Act are strictly applied; and,

(b) every special patient is reviewed annually by a panel which now includes the senior Dunedin District Court Judge.

It is this panel which decides whether or not a request for a change of status from special patient to committed patient should be applied for through the Director of Mental Health. The panel reviews the clinical care and legal status of all special patients within the hospital. Of necessity this really involves those patients who are more long term than special patients who

are admitted for assessment and/or short term treatment.

At the time of our visit there were two patients at Cherry Farm who were under disability. All other Section 115 patients had been reclassified to committed patients. When a special patient has been reclassified to committed patient the Medical Superintendent requires staff to notify her of any plans for leave, or trial leave, especially if the patient has been a sexual or violent offender. She believes that Cherry Farm has a continuing responsibility to ensure that the safety of the public is not placed at risk. She also believes that it is in the best interests of all special patients if the rate of reoffending is kept as

low as is humanly possible, because the public outcry after an ex special patient reoffends is so extreme that there is often a prolonged socio-political effect on all other special patients.

CANTERBURY

At the time of our visit, there were nine special patients detained in Sunnyside hospital and 10 former special patients who had been reclassified to committed patient status.

There are several penal institutions within the catchment area of Sunnyside hospital, including the main female prison for New Zealand. We were told that an excellent working relationship existed between the hospital and prison services and personnel. Because of this relationship few difficulties were experienced in transferring prisoners to hospital under Sections 42 or 43 where the inmate's clinical condition deemed that to be appropriate. A similar relationship existed between the hospital staff and Justice Department staff. Remandees under Section 121(2)(b)(ii) caused few problems.

We were told that, until 1982, the system of review for special patients detained in hospital was confined to discussion between the consultant psychiatrist responsible for the patients care and the Medical Superintendent of the hospital. There was no direct communication with the patient concerned, unless it was intended to recommend a change of patient status

Cherry Farm has a continuing responsibility to ensure that the safety of the public is not placed at risk.

to the Director of Mental Health. As a result, patients were usually unaware of their status being under review.

In 1982 it was decided to set up a Special Patients Review Committee in order to share the responsibility for difficult and worrying decisions, such as leave, change of status, discharge and follow-up care of special patients.

The Committee first met in September 1982. The aim of the Committee was to standardize hospital procedure in order to ensure regular review of special patients and former special patients, especially regarding their after care. At that time, September 1982, there were 22 special patients detained in Sunnyside. Of this number, 14 had been charged with murder. From that time on the Committee met on a regular basis (monthly) and, where necessary, coopted medical and nursing staff who had been closely involved with the patients. Patients did not attend the meetings. Regular entries were made in case notes. Full written assessments were requested from senior staff. The results of the review were communicated in writing to each patient reviewed.

In September 1985, the Committee was reorganized. The Medical Superintendent, Deputy Medical Superintendent, a Consultant Psychiatrist, the Chief Psychologist and the Principal Nurse were appointed as members. The Deputy Medical Superintendent accepted responsibility for the ongoing organisation and recording of the work of the Committee.

It was decided that special patients being reviewed would attend for interview and that medical and other staff would be coopted where necessary.

Since 1985 the scope of the Committee has been further broadened to include not only special patients but also those patients who may present a danger to themselves or to the general public whilst in hospital or upon discharge. A number of patients who had committed or would be seen as likely to commit some form of sexual offence or physical assault have since been reviewed by the Committee.

it was decided to set up a Special Patients Review Committee in order to share the responsibility for difficult and worrying decisions

We were told that patients are now much more aware of the regular review as to their circumstances and the fact that they have the opportunity to express their own views to the Committee is something they value.

Discharge of a patient under Sections 42 and 43 of the Mental Health Act is also considered by the Committee. Each person is reviewed at least annually through written reports submitted by those who have continuing clinical contact with the patient.

Reclassification and discharge under Section 115 of the Criminal Justice Act is another function of the Committee. The special patient is interviewed by the Committee during this process.

Leave under Section 47 of the Mental Health Act is granted by the Medical Superintendent who is the Chairman of the Committee. He receives the application through the clinical team respon-

sible for the patient's treatment. Leave for former special patients is granted by the clinical teams responsible for their treatment. Rehabilitation plans for this group of patients are submitted to the Committee for consideration. Each former special patient whether in hospital or on trial leave is reviewed at least annually by the Committee.

Relatives or friends of special patients may apply for leave. Leave will not be granted to a special patient detained pursuant to a temporary reception order.

When the initial request for leave is received and has been discussed and recommended by the Special Patients Review Committee, the Medical Superintendent then recommends to the Director of Mental Health that leave be granted. After receipt of that first approval from the Director of Mental Health, the Medical Superintendent may then grant leave as he sees fit. The special patient is not allowed out of the hospital grounds unless accompanied by the person who signed the leave form or by a hospital staff member. In either case, the person accompanying the patient is responsible for the special patient throughout the entire period of leave and until the special patient is returned to

the hospital on due date and time.

The discharge of persons under Section 118 of the Criminal Justice Act is the responsibility of the clinical teams. However, the Special Patients Review Committee is presently considering an extension to its current activities to include the continuing review of this group of patients in addition to the others previously referred to.

The Special Patients Review Committee was originally formed to spread the thinking and analysis of a patient's past, present and future over a wider group of disciplines, backgrounds and experience. The final decision must still be taken by the Medical Superintendent but his recommendation now results from information gathered in a systematic way so that his recommendation is now more likely to be accurate and unprejudiced.

Sunnyside hospital has reasonably adequate facilities for dealing with remandees for psychiatric reports pursuant to Section 121(2)(b)(ii).

WEST COAST

There have been no special patient admissions to Seaview hospital in Hokitika since the appointment of the present Medical Superintendent in May 1986. There have been a few such patients over the years but their numbers have been limited by the lack of secure facilities in the hospital. The Medical Superintendent told us that he had had no direct experience in the management of special patients and therefore had no comment to make about the procedural matters in this respect. Seaview occasionally receives remand patients pursuant to Section 121 (2)(b)(ii) Criminal Justice Act but they have presented no problems in terms of procedure or management. In 1987 two such admissions were made.

NELSON

Unlike all other regions (excepting the West Coast), the Nelson region is not served by a prison. It is not surprising therefore that there are no special patients in Ngawhatu hospital. We were informed that persons from the Nelson region who came within that category would be accommodated at Porirua hospital near Wellington as there are presently no secure

facilities at Ngawhatu to accommodate such patients.

We were informed that occasionally assessments are requested pursuant to Section 121. There is a close rapport between the Medical Superintendent and his staff at Ngawhatu and the local Judge. Because of the small numbers involved, the infrequency at which such requests are made and the short distance between the hospital and the court, it is usually not too difficult for the assessment to be undertaken either in the precincts of the court or alternatively by remanding the defendant to the hospital. There are two rooms available at the hospital to contain patients for whom a modest degree of security may be required. However in the normal course of events a patient admitted pursuant to Section 121(2)(b)(ii) would be placed in the usual admitting ward.

WELLINGTON

Porirua hospital near Wellington is the main psychiatric hospital in the region. In the two year period between 1985 and 1987, there were two admissions and two discharges under each of Sections 42 and 43 of the Mental Health Act. In the same period, there were 34 admissions and 31 discharges under Section 121 (2)(b)(ii) of the Criminal Justice Act. There were six admissions and three discharges under Section 115 of the Criminal Justice Act and five admissions and one discharge under Section 118 of the Criminal Justice Act.

At the time of our visit, there were four men in hospital under Section 115 of the Criminal Justice Act, one of whom had been received on transfer from another hospital. There were also three people in hospital under Section 121 (2)(b)(ii) who subsequently became Section 21 patients. Four patients were in hospital under Section 118 of the Criminal Justice Act. No patients were on leave under Section 47 of the Mental Health Act.

The facility used for Section 121(2)(b)(ii) patients depends on the degree of mental disturbance and the need for safe containment related to that person's offence. In practice, people who are not too disturbed and who are not regarded as an absconding risk, will be admitted to the normal admission ward for the geographic area in which they live. Thus the

patient's conditions will be that of any other person admitted to an admission ward. Those who are regarded as a danger to themselves or others, or who are too disturbed to manage on an admission ward, are admitted to Craig A unit for men or Awhina wing of Lomond villa for women. These facilities are secure and safe, but spartan. Both occupy a wing of the main ward and have single bedrooms, ablution facilities, sitting room and dining facilities. Both areas are staffed more intensively than other areas of these wards.

Section 115 patients are managed in the accommodation most appropriate to their clinical state. Treatment of a person with an active illness is less of a problem than the care of a person who is considered at risk of absconding. Porirua hospital does not have a safe care unit specifically for this group of people.

Subsequent psychiatric care is provided, for those who continue to live in hospital, through the usual services, that is, the admission wards, the rehabilitation programme and, if necessary, slower rehabilitation in long stay wards. The usual mental health professionals are available, although the hospital does not have adequate numbers of psychiatrists or fully trained psychiatric nurses, psychologists, social workers or occupational therapists. Patients who require closed accommodation, but are not acutely disturbed, are cared for in Craig B for men, and Aratika wing at Lomond for women. One of the Section 115 patients, was in Craig B, as was one of the Section 118 patients at the time of our visit. If the patients' clinical state improves and he/she has complied with parole and other conditions, a shift to another ward may result. One Section 115 patient was currently in an admission ward, where he had been for two years, on an active programme. One Section 118 patient was in Lomond and another in an admission ward. The other two Section 115 patients were in long stay male wards.

In addition, Porirua hospital had two people who were previously held under Section 115 (1)(b), Criminal Justice Act. Both became Section 21 patients in 1986. One was in a long stay ward, and the other had been tried in a variety of community placements - and had been transferred to another of these placements just before our visit.

Outpatient assessment is available by hospi-

tal staff. One hospital psychiatrist has a separate appointment with the Justice Department and does assessments at Mount Crawford prison. Arohata prison receives services directly from Porirua hospital staff.

Porirua hospital has established a review committee within the hospital which does regular formal reviews of special patients and may also review, on request, patients whose psychiatric situation is complicated by behaviour likely to bring them in to conflict with the law or those who have a history of criminal offending, in particular for sexual offences or serious assaults or arson. The review committee is augmented by the doctor and ward charge for the patient. These people provide written reports to the committee and the opinions of other consultants may be sought for the purpose of the review. The patient's progress and functioning over the previous period is discussed. Any suggestions by the clinical team for a change of programme or placement are considered. If a difficult medico-legal problem arises the District Inspector of the hospital may be asked to see the patient concerned and invited to express an opinion.

The Medical Superintendent informed us that it was her intention to consult with the District Inspector whenever a change of status was being considered for a special patient. She also said that follow up arrangements for such patients are made very carefully with a view to providing adequate support, and sufficient reporting of the person's state, and ensuring use of the services described above.

WANGANUI

Lake Alice Hospital - (excluding National Security Unit)

Persons are admitted under Sections 42 and 43 if this is recommended, with supporting evidence, by a specialist psychiatrist and if an admission bed is available. Most referrals come from Wanganui (Kaitoke) prison, where the Medical Superintendent held a monthly clinic and was also available for crisis intervention. A few referrals come from Manawatu (Linton) prison, and are recommended by a specialist psychiatrist from Manawaroa psychiatric unit in Palmerston North. On admission patients are

assessed and treated in the least restrictive environment possible, depending on their mental state and staff available. If a patient is received from Kaitoke, the prison staff are kept up-to-date with his progress during the Medical Superintendent's monthly clinic. Patients are reviewed at six monthly intervals by the Lake Alice Special Patients Review Group comprising the senior psychologist, senior social worker, a senior nursing officer, the Medical Superintendent and another consultant psychiatrist.

Persons are admitted under Section 121 2(b)(ii) if this is recommended to the Judge by a specialist psychiatrist, and an admission bed is available. Referrals vary widely from place to place and over time. The statistics show that most inpatient referrals emanate from the New Plymouth District Court. Patients are assessed in the least restrictive environment possible and a report prepared by one of two psychiatrists who have a forensic interest and experience.

Persons admitted under Sections 42 or 43 are returned to the prison of origin when treatment is no longer considered necessary in hospital and after consultation between prison staff and the referring psychiatrist. Delays are sometimes experienced in obtaining the necessary authorization from the Director of Mental Health in the case of Section 42 patients and we were told of the difficulties sometimes experienced on the ward by the activities of prisoners whose condition had improved. Such persons often became very disruptive. Patients under Sections 42 and 43 are not discharged from hospital except back to prison. If their sentence ends and they become informal (Section 43) or committed (Section 42) they will be discharged at the discretion of the consultant psychiatrist responsible for their care. Reports are provided by the consultant psychiatrist to the Parole Board regarding remission of sentence. Persons admitted under Section 121 (2)(b)(ii) are returned to Court by the police once the Court report has been prepared. The time taken to prepare the report varies from 24 hours to 4 weeks. Such patients are not discharged except back to the Court.

The reclassification of persons detained under Section 115 is on the recommendation of the Lake Alice Special Patients Review Group referred to above supported by the views of the

consultant psychiatrist responsible for the patient. The subsequent discharge of the patient is the responsibility of the consultant psychiatrist, but he/she may refer back to the Review Group, the psychiatrists as a team, or the Director of Mental Health.

Leave for special patients under Section 47 is requested from the Director on the recommendation of the clinical team responsible for the patient, usually with charge nurse, social worker and consultant psychiatrist involvement. When special patients become committed patients, their leave is the responsibility of the clinical team, although the Review Group may make recommendations at the point of reclassification, or the team may refer the matter back to the Review Group if there are ongoing concerns.

Patients committed under Section 118 are treated in the same way as Section 21 patients, and their discharge is the responsibility of the consultant psychiatrist involved, although he/she will often seek advice from the Review Group and others.

National Security Unit

Although the Wanganui Area Health Board staffs and funds the National Security Unit, admissions and discharges are made by the Director of Mental Health, on advice from the National Security Unit Review panel. This panel comprises four psychiatrists (including the Justice Department's psychiatrist from Paremoremo, Dr Frank Whittington), two medical superintendents from other psychiatric hospitals and a District Court Judge.

WAIKATO

Tokanui hospital is the main psychiatric unit in the Waikato region. It is situated near Te Awamutu and is about five kilometres distant from Waikeria prison which is the largest in New Zealand.

Regrettably many of the complaints which we heard from prison officers in Paremoremo and Mt Eden were echoed when we met with the Superintendent and some of his staff at Waikeria prison. They believed that psychiatrically disturbed prisoners were being inappropriately detained in prison. Prison officers acknowledged that some psychiatrists from To-

kanui were readily accessible and one psychiatrist in particular was praised for his time and effort in trying to treat such people in prison. Criticism was directed at the Medical Superintendent for his apparent reluctance to admit psychiatrically disturbed prisoners to the hospital.

One senior prison officer summed up the views of those present when he said:

"In the past we have had quite a good rapport with Tokanui hospital in that we have been able to refer prisoners to them for assessment. If the assessment showed that psychiatric intervention was needed, they would be admitted to Tokanui and treated. In due course they would be returned to this institution. However in the recent past, there has been a reluctance by Tokanui staff to accept people whom we consider to be psychiatrically disturbed because they feel that these people can be treated inside the concrete of this prison. That is absolute rubbish because we do not have the resources, we do not have the therapeutic personnel here to deal with these people and we do not have skills to cope with the complexities of a psychiatric illness. We do our best to treat these people but it is impossible in this place.

Currently we have three people in this gaol whom I would classify as psychiatrically disturbed and who really need to be treated in a hospital. Some psychiatric treatment is underway and this has been organized by our medical officer in association with one of the psychiatrists from Tokanui".

Another senior officer told us that in any one year there would be about 60 inmates who required psychiatric treatment, some of whom, about 12 in his opinion, needed to be detained in a psychiatric hospital. He was adamant that the latter group would be quite beyond any treatment regime which could be instituted in the prison.

Another prison officer expressed a similar

view when he told us:

"I think it is fair to say that we do not experience problems in arranging for someone from Tokanui to come over and provide an assessment and indeed we get tremendous cooperation from certain staff members in the hospital. I would have to say however that it is now virtually impossible for a prisoner to be transferred to Tokanui hospital and if my experience means anything, a prisoner transferred there would not last very long - he would simply be returned to this place. In the majority of cases we now don't even try to arrange a transfer. We try to battle on with our own limited resources".

Another prison officer, whilst agreeing with his colleagues, looked at the difficulties from a slightly different perspective. He told us:

"We probably have a totally different point of view from the people at Tokanui. Tokanui staff have told me about some of the people they receive from this institution as patients. On occasions staff have been assaulted, the prisoners have been

very difficult to handle so from their point of view, they are reluctant to put up with that sort of behaviour. From our point of view, we do not see these prisoners as the responsibility of the penal system and if any animosity has developed between us and the Tokanui staff, it is because we are stuck with them when we feel they need hospital treatment. The Tokanui staff don't want them because they are too hard to handle and Tokanui is not a maximum security psychiatric hospital so if there is any animosity it is based on this conflict of roles and not so much on administrative failures either at Tokanui or at Waikeria".

We also encountered similar criticism from Judges, Justice Department staff and others concerning the lack of cooperation from the Medical Superintendent when dealing with applications under Section 121. For example, we were told that on some occasions Section

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121(2)(b)(ii) patients had been returned to court without prior notification having been given either to the presiding Judge or to court staff. Probation officers to whom we spoke were also critical that some patients had been inappropriately discharged from Tokanui and left to wander the streets. The probation officers acknowledged that in those cases the patients condition may indeed have stabilized but were critical that no appropriate steps had been taken to ensure effective follow-up in the community. We are unable to comment with any authority on the validity of these criticisms but what can be said with certainty is that the criticisms covered a broad spectrum and were directed only at the Medical Superintendent.

We were told that special patients at Tokanui are reviewed by a Review panel several times each year. The panel included two consultant psychiatrists from Hamilton and a Judge although at the time of our visit the judicial member of the panel had not been appointed. The panel would also review patients on request. Although the panel existed in theory at the time of our visit, we were informed that difficulty had been experienced in obtaining agreement as to its exact composition and the form in which reports were to be prepared for the Director of Mental Health. The Medical Superintendent appeared to hold a view different from that of the other panel members with the inevitable result that, because of these inter-personal difficulties, the panel functioned in a sputtering, sporadic manner instead of the very smooth way in which similar panels operate throughout New Zealand.

We have no wish to be unduly critical of the Medical Superintendent at Tokanui - we believe that he was doing his best, but be that as it may, and whatever the merits of his own beliefs, the fact of the matter is that few patients were admitted to hospital from Waikaria pursuant to Sections 42 and 43, the examination of patients pursuant to Section 121 was fraught with administrative, logistic and other difficulties, the review panel did not function as an effective unit and generally there was

considerable discontent as to the service being offered in forensic psychiatry.

From a practical point of view, recommendations as to reclassification leave and other matters which would normally be considered by a review panel were left in the hands of the Medical Superintendent.

Since our visit to Tokanui in the latter part of 1987, we understand that a new Acting Medical Superintendent has been appointed to that hospital. We understand that since then the review panel has been revived and, if it has not already occurred, the Senior District Court Judge in the region will be invited on to the panel. It is proposed that the panel will meet at least twice a year and on demand. It is proposed that the minimum membership of the panel be three, two of whom will be outside consultant psychiatrists and a District Court Judge. It is also envisaged that the hospital consultant would sit with the panel and that reports be obtained from senior nursing staff, therapists, psychologists and indeed all members of the clinical team involved in the care and treatment of the individual patient. The Acting Medical Superintendent has also suggested that the patient being reviewed would be entitled to meet with the panel and would be invited to make any contribution he/she thought appropriate.

The former Medical Superintendent at Tokanui hospital expressed concern to us at certain inappropriate clerical and administrative arrangements which he regarded as a significant impediment in developing and running a smooth forensic psychiatric service.

Whatever the merits of that view it appeared at the time of our visit that the consultative process had failed and that this had resulted in irritation, delays and general dissatisfaction.

We are satisfied that the facilities at Tokanui hospital are adequate enough to facilitate Section 121 (2)(b)(ii) examinations.

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AUCKLAND

We have already discussed in detail, in Part I of this report, the admission procedures in respect of Sections 42 and 43 patients in the Auckland area. No useful purpose would be served by repeating the evidence previously referred to. Some of it is relevant to this part of our report.

We want to deal particularly with the administrative and clinical procedures and criteria in respect of those persons ordered to be detained under Section 121 (2)(b)(ii) of the Criminal Justice Act 1985.

Two different systems operate in the Auckland region:

Auckland District Court

A Judge sitting in the Auckland District Court is first required to obtain a preliminary psychiatric assessment (the mini assessment) before remanding a defendant to a psychiatric hospital under Section 121 (2)(b)(ii). One Judge described the present situation in these terms:

"As you know I am unable to remand a prisoner to Carrington hospital until a psychiatrist has certified that it would be desirable for the psychiatric examination to take place in the hospital. The fact of the matter is that psychiatrists from Carrington are not prepared to visit the Court to carry out that function and I am therefore required to arrange for a medical practitioner to provide the appropriate certificate.

Some months ago I spoke to the Medical Superintendent at Carrington hospital and was told that the Justice Department should arrange for the police to take the patients to hospital for assessment. I said that it was the responsibility of the psychiatrist to come to the Court. The Medical Superintendent disagreed with me and I then asked if he would supply me with a list of experienced medical practitioners whose assessments would be acceptable in lieu of an assessment

given by a specialist psychiatrist. I would point out that in the Auckland area there are several senior medical practitioners who regularly visit the cell block in the Court and who are usually available at fairly short notice. The Medical Superintendent was adamant that no person other than a psychiatrist was suitable to undertake the mini assessment. I compromised and the present situation is that a defendant who is being considered for a Section 121 (2)(b)(ii) order is now transported from the Auckland court to Carrington hospital by the police, the mini assessment is undertaken by a Carrington psychiatrist usually over a 2 or 3 hour period and the defendant is then returned to court the same day accompanied by a mini assessment certificate. If a more formal psychiatric examination is required in hospital I then make the appropriate order".

Another Judge expressed surprise that there were no medical practitioners in the Auckland region whom the Carrington psychiatrists regarded as being suitably qualified or able to carry out a mini assessment.

Another witness commented:

"Let us be frank about it. The people at Carrington do not want violent people in the hospital. They want the remandees in the prison and they would rather go to the prison a couple of times over rather than have remandees in hospital, especially a hospital which has no secure facility".

The several Judges to whom we spoke commented that the major advantage of the mini assessment was that it enabled a speedy return of a remandee back to court.

The Police perspective is best described by the Police spokesman who met with us:

"Section 121 of the Criminal Justice Act creates some difficulties for the police, particularly in Auckland where the practice has been for District Court Judges to obtain a

"The Medical Superintendent was adamant that no person other than a psychiatrist was suitable to undertake the mini assessment."

mini assessment from a psychiatrist at Carrington hospital before exercising their powers in terms of Section 121 2(b)(ii). What happens in practice is that the police make an application under Section 121 but before the Court will exercise its powers under this Section, it requires what is commonly known as a mini assessment. This means that front line police are usually required to transport the person out to the hospital and wait while the examination is carried out. As a consequence, front line police are taken away from their normal duties for a minimum of two to three hours at a time. If the Court makes an order in terms of Section 121 2(b)(ii), the police are involved in transporting the person back to hospital. As can be seen, the police are performing a function which many regard as a Justice Department responsibility. This situation comes about principally because Carrington hospital staff will not, as a rule, accept a prisoner for assessment unless one of their psychiatrists has carried out the mini assessment in the first instance. The police do not usually experience the same sort of problems elsewhere and in most instances, the Courts will act on the basis of a doctor's certificate".

We asked Dr Honeyman why, if the Carrington psychiatrists were unavailable, they would not allow a medical practitioner to undertake a preliminary examination and if necessary provide the appropriate certificate. He replied that in his opinion, the law was intended to ensure that, wherever possible, the assessment should be carried out by a psychiatrist and that reference to "another medical practitioner" in the law was an "escape route" to be used in those cases where it was impossible for a remandee to be seen by a psychiatrist. He did not believe that any person should be admitted to a psychiatric hospital as a remandee unless first seen by a psychiatrist.

We suggested to Dr Honeyman that yet again another Catch 22 situation had arisen. Carrington psychiatrists who were unavailable to undertake mini assessments in court were not prepared to act on a mini assessment under-

taken by another medical practitioner because the spirit of the law required that the assessment be carried out by a psychiatrist who was not available. We asked for an explanation. Dr Honeyman told us that in his opinion, it was not their (the psychiatrists) job in the first place. He said that psychiatrists at Carrington were not on hire to examine persons caught up in the justice system. He made it very clear that he believed the law to be incorrect. He said:

"There is the law that says they (remandees) may be sent there (to hospital) to be seen by them (a psychiatrist). The new law, Section 121 is written that way but I believe that people who write the laws without righting the system whereby the law may be implemented should be asked questions and with respect I believe that it is not just the Auckland Hospital Board that should be asked that question the Auckland Hospital Board's position is clear. We will do what we can, what we feel we are able to do within our power at specialist level or at the

registrar level but the fact of the matter is that the constraints in the service that we provide to our own people at this point in time make it extremely difficult for us on the other hand I am sure you will accept that our system for the examination of outpatient remands is in fact efficient, effective and readily available".

We believe that the mini assessment process which presently operates out of the Auckland District Court is inefficient and causes a waste of valuable judicial, police and administrative time and energy. We acknowledge and agree with the view expressed by Dr Honeyman that consultant psychiatrists in the Auckland area are a scarce and valuable resource whose time should not be spent in travelling to and from the Auckland Court as and when required in order to undertake mini assessments. Such a situation would be unfair to the Auckland Hospital Board, Carrington management and to the psychiatrists concerned if only because it would be virtually impossible for psychiatrists to be rostered on duty with any degree of certainty that they would in fact be able to attend to their hospital duties.

We suggested to Dr Honeyman that yet again another Catch 22 situation had arisen.

Otahuhu District Court

The procedures outlined above do not apply in the District Courts at Otahuhu, Papakura and Pukekohe all of which are in the catchment area of Kingseat hospital. As has previously been mentioned in this report, Carrington and Kingseat nurses imposed a ban on all "Oakley-type" patients on 15 March 1985. As a consequence of that ban, Kingseat management decided that there needed to be a closer working relationship with the Justice Department, the police and the judiciary. They therefore arranged for a senior psychiatric nurse to be employed full time in the Otahuhu Court as a coordinator of psychiatric services. Since the initial appointment in September 1987, the service from Kingseat hospital has been expanded by the appointment of an additional nurse who carries out similar functions in the courts at Papakura and Pukekohe.

We were told that initially hospital management envisaged that the coordinator would undertake a preliminary assessment (the mini assessment) in court in respect of any prisoner for whom a Section 121 order was contemplated. The result of that mini assessment would then enable the Judge to decide the most appropriate manner of dealing with the defendant.

We have been told that during the six months ended 16 February 1988, the Otahuhu coordinator undertook 94 written assessments and figures which have been supplied to us indicate very clearly that the workload since then has increased in volume. We met with the coordinator involved in this pilot project. He is a man of considerable experience in psychiatric nursing. He clearly enjoys the confidence of Kingseat management and the psychiatrists working in that hospital and our discussions with the Otahuhu Judges left no doubt that they also regard the service as efficient, effective, time-saving and one which did not require busy consultant psychiatrists to leave the hospital ward. The Otahuhu Judges emphasized to us that they also had implicit faith

in the clinical expertise of the court coordinator.

From a practical point of view, the system is defective in that the coordinator is unable to certify the need for an inpatient assessment. To do so would have been in breach of Section 121 (2) (as amended by S3 of 1986 No. 83). Under these circumstances it is necessary for one of the local medical practitioners at Otahuhu to provide the appropriate certificate. We cannot avoid the obvious comment that the coordinator is skilled in psychiatric nursing, he is well able to make a judgment as to whether inpatient examination is required and he enjoys the confidence of management to the extent that they will act on his judgment. Under these circumstances we can see no reason why he should not be permitted to complete the appropriate certificate. We do not regard a formal medical qualification as relevant.

We have no doubt that the service which is now available to the South Auckland courts has proved to be an experiment which needs to be copied. We have been informed from several sources that the court coordinator has been of invaluable assistance not only to the judiciary but also to the probation service, the police, court staff, lawyers and indeed individuals who appear before the court and for whom some psychiatric advice or direction may be necessary.

We asked the coordinator whether he saw a need for a Judge to obtain a mini assessment under Section 121 (2)(b)(ii). He said:

"I think there is. I think it would be sensible to ask for the opinion of a person experienced in psychiatric work and if that person is already available in the court room, then so much the better. The hospital will not place some one in the court unless that person is competent in his/her job and I believe that a person who is experienced in psychiatric nursing is probably in a better position to make a judgment than most general medical practitioners. There are some very competent people occupying positions

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similar to mine and I can see no reason why a G.P. or psychiatrist should sign the initial certificate".

We commend the system which operates out of the South Auckland courts and believe that it is one which, with local modifications, could well be adopted in several parts of the country. In the larger metropolitan courts for example we see the introduction of a similar system as providing a rapid service to the courts whilst at the same time saving valuable medical and police expertise which could be more usefully applied elsewhere. We believe that consultation between each Regional Director of Forensic Services and the Executive Judge/s of that region would soon result in agreement as to which courts could usefully and economically be served in this manner.

We acknowledge that in some of the more remote courts it may be quite unrealistic to provide such a service. It is our view however that in such cases the Director of Forensic Services would be under an obligation to consult with local medical practitioners, to explain the nature of the service being offered and to lay down guide-lines as to the various factors to be taken in to account when deciding to certify an inpatient examination. It may be that in some areas an experienced district nurse or any other person whom the Director thought competent and appropriate could fulfil the function of certifying an inpatient assessment. We envisage, in any event, that the person so certifying would first ascertain from the Director whether an inpatient bed was available.

We see no reason why, under some circumstances and particularly emergency situations, the Director of Forensic Services may not give a telephone approval to the Court Registrar since an approval under those circumstances must necessarily be preceded by discussion between the Director and the person who is so approved,

during the course of which the remandee's circumstances, clinical condition and other relevant matters would have been discussed.

During our visits to Kingseat and Carrington hospitals, we examined the facilities available for the examination of remand patients. For reasons which have been explained previously in this report, there have been few remands to either institution since 1985. There is no in-hospital accommodation available for remandees that would guarantee or provide a more secure environment in cases where that was thought appropriate. We believe the facilities to be inadequate.

Removal, discharge and reclassification processes at Kingseat and Carrington hospitals are undertaken by the clinical team responsible for the care and management of each patient. Dr Peter Lamb from Carrington hospital explained how the multidisciplinary teams operate:

"Planning for the future discharge of a patient may start while the patient is being assessed before being admitted, that is the staff begin thinking about the patient's future options. During the interview the full management of that person is considered including the question of discharge.

Reviews are conducted by members of the team but because of the roster system which operates the people actually present at the review of a patient may change from time to time. At each review the team would decide on current management, it would consider whether a patient should stay in the present ward and matters such as possible transfer or discharge would also be entertained".

We were informed that at both hospitals the Medical Superintendent makes the appropriate applications for reclassification, leave or return to prison but only after there has been wide consultation with the clinical teams concerned.

COMMENT

Several significant features emerged during the course of our Inquiry. They were:

1. Forensic psychiatry in New Zealand is poorly disciplined, under-funded and under-staffed. We shall have more to say about this in Part 3 of our report.
2. Psychiatry as a discipline is one of the poorer relations of the medical profession. We were informed that psychiatric patients occupy approximately 40% of hospital beds and receive about 14% of Hospital Board/Area Health Board expenditure.
3. The long standing role conflict between the justice system and the health system as to who should care for mentally disordered offenders is one which has not yet been resolved. In some regions the inability or unwillingness to resolve the conflict has created inter-personal tensions between people working in the prisons and in the hospitals, discontent and ultimately a loss of job satisfaction. Conversely the forensic service operates reasonably well in those regions where there has been a serious and concerted effort by the personnel in each service to understand the difficulties experienced by the other.
4. In most regions there are adequate facilities to examine patients under Section 121 (2)(b)(ii) Criminal Justice Act 1985. The same cannot be said however regarding facilities for non-remand forensic patients. We shall have more to say about that in Part 3 of our report.
5. There is no reason in our view why the preliminary assessment under Section 121 (2)(b)(ii) must necessarily be undertaken by a psychiatrist or any other medical practitioner. We see no reason why this assessment cannot be made by any person approved of by the Director of Forensic Services.
6. There is a need for internal review (and in some cases external review) of all patients in the forensic psychiatric service. Several of the review panels already in existence appear to work well but we believe that the composition and function of such panels now needs to be formalized. Accordingly we propose the establishment of a National review panel and Regional review panels. The details are set out below.

THE NATIONAL REVIEW PANEL

The National review panel will be appointed by the Director of Mental Health and will comprise:

1. two psychiatrists;
2. a District Court Judge;
3. a nurse;
4. a member of another psychiatric discipline;
5. a member of the Maori community;
6. the Director of Mental Health ex officio.

Where a patient of a minority ethnic group is being reviewed, and that patient is a non-Maori, it may be helpful and desirable if a person of that patient's same cultural and ethnic group were co-opted on to the review panel in addition to the persons referred to above.

The functions of the National review panel will be:

1. to review all patients committed or transferred to hospital pursuant to Sections 42 and 43 Mental Health Act 1969 and Section 115 Criminal Justice Act 1985 and to advise on the management of those patients.
2. to review and advise on the management of other patients referred to it by regional review panels.
3. to review and advise on the standards in the regional forensic service and the quality of patient care and service delivery in each forensic region.
4. to inform and advise the Minister of Health (through the Director of Mental Health) about all aspects

of the forensic services in each forensic psychiatric region.

The reviews described above will take place at intervals of not more than one year.

Patients appearing before the National review panel will be entitled to representation by an advocate of their own choosing. It will be the responsibility of the regional forensic service, through the patient's key worker, to ensure that the patient is fully informed and understands the implications of independent advocacy. The National review panel must also be satisfied that the patient understands his/her right to independent advocacy.

REGIONAL REVIEW PANELS

The Regional review panel will be appointed by the Director of Psychiatric Services and will comprise:

1. the Director of Psychiatric Services where he/she is a psychiatrist. If the Director is not a psychiatrist, then he/she will appoint an experienced consultant psychiatrist who is not already part of the forensic psychiatric service;
2. a senior psychiatric nurse who is not part of the forensic psychiatric service;
3. four members of the forensic multidisciplinary team who will be appointed by the Director of Forensic Psychiatric Services. This group must include at least one member of the clinical team responsible for the patient being reviewed;
4. the Director of Forensic Psychiatric Services ex officio.

At intervals of not more than six months the regional review panel must undertake a clinical review of all patients in the care of the regional forensic service including those patients who are in the care of the forensic community service.

The regional review panel will ensure that all patients receive appropriate treatment and that a high quality of patient care and management is maintained. It will also submit patient reports to the Director of Mental Health.

The regional review panel will not have a reclassification function although it may make recommendations to the National review panel, the Director of Mental Health or the Minister (through the Director of Mental Health) as it considers appropriate.

In our view patients under Section 115 Criminal Justice Act 1985 should be subject to the review processes previously outlined. We believe however that the discretion to reclassify Section 115 patients must remain with the Minister. Although clinical decisions will undoubtedly be critical as part of that reclassification process quasi political judgments must also be applied. That latter function is not one which should be undertaken by a review panel either at national or regional level.

It should be noted that although patients under Section 121 (2)(b)(ii) Criminal Justice Act 1985 are designated as "special patients", we believe it unnecessary for those persons to be reviewed by the National review panel or the regional review panel. At most, such persons remain in the forensic service for not more than one month following which they are returned to Court and are then dealt with as the Court sees fit. It is therefore inappropriate that such persons be reviewed.

The law presently provides that patients in hospital pursuant to Sections 42 and 43 Mental Health Act 1969 may be removed to prison on the direction of the Minister of Health and Director of Mental Health respectively. Several submissions drew our attention to the need for an early return to prison once the patient's condition had stabilized. One doctor referred to prisoners:

".....languishing in hospital unnecessarily because the paperwork became bogged down in Wellington".

In our view an immediate return from hospital to prison is essential once a clinical decision to that effect has been taken. We see no reason why a decision to remove a Section 42 patient should remain at Ministerial level. We propose that this authority be given to the Director of Mental Health who may, in his discretion, delegate to the National review panel. That will necessitate a change in the existing law.

We envisage that so far as it is practicable most transfers of Section 42 patients will occur pursuant to a direction of the National review panel.

Circumstances may arise where the Director of Forensic Services requests the removal of a Section 42 patient but that request is unable to be considered by the National Review Panel. For example the request may be made at a mid-point between two reviews. In such circumstances, the Director of Mental Health may, if satisfied that a removal is appropriate, approve the transfer in his capacity as Director. We envisage that under these circumstances the Director would first seek the advice of the regional review panel.

We see no need to alter the present removal procedures in respect of Section 43 patients other than to record that a Section 43 patient should be permitted to return to prison if he so requests. In such cases the Director of Regional Forensic Services may approve the transfer.

RECOMMENDATIONS

We recommend that a National review panel be established by the Director of Mental Health to review each regional forensic service, and certain designated patients therein, at intervals of not more than one year. The personnel and functions of that review panel have been described earlier in this report.

We recommend that a review panel be established by the Director of Psychiatric Services in each forensic region. The personnel and functions of the regional review panel have been described earlier in this report.

We recommend that Section 121 (2) Criminal Justice Act 1985 (as amended by Section 3 of 1986 No. 83) be amended by deleting from SS (2A) the words "a psychiatrist or (where no such specialist is available) another medical practitioner" and substituting therefore the words "a person approved by the Regional Director of Forensic Services".

There will need to be a consequential amendment defining the office of Regional Director of Forensic Services.

We recommend that Section 44 (1) Mental Health Act 1969 be repealed and that the Director of Mental Health in his absolute discretion be authorized to direct the removal of any patient detained in hospital pursuant to an order made on an application under Section 42 Mental Health Act 1969 and further that the Director be authorized to delegate those powers to the National Review Panel.

We recommend that any patient detained in hospital pursuant to Section 43 Mental Health Act 1969 be authorized to request a transfer to a penal institution and that the Director of Forensic Services be empowered in his/her discretion to direct a transfer accordingly.

PART 3 : THE FORENSIC PSYCHIATRIC SERVICE

"A society may be judged by the way it treats its sick and disabled members"
Hyde (1986)

The introduction of electro convulsive therapy in the early 1940's, followed by major tranquillizers some years later, had the overall effect of enabling psychiatric hospitals to take down the bars from ward windows and to unlock the doors.

Thus was introduced the "open door" philosophy which is now commonly referred to as "deinstitutionalization", or community care.

There were, and still are, casualties of this new philosophy, particularly those patients who were regarded as security risks or who were considered to have a propensity to be dangerous or violent. Those persons who did not have a diagnosable mental disorder or who were considered to be untreatable, along with prisoners who developed symptoms of mental distress, also became casualties of the new philosophy.

It is from these categories of patients that have come those for whom "the yawning gap" has opened.

This part of our report is about the bridging of that gap by setting in place a comprehensive forensic psychiatric service.

WHAT IS FORENSIC PSYCHIATRY?

Simply stated, forensic psychiatry deals with people who have both a psychiatric condition and who have in some way been criminally involved in the justice system. Such people need not necessarily have been convicted by the courts but may be on remand for psychiatric assessment. For the most part, forensic psychiatry operates in the context of the prisons, the psychiatric hospitals or the outpatient services associated with the hospitals. It serves as the interface between these institutions.

In more formal language, it has been defined in these words:

"That branch of psychiatry which requires special knowledge and training in the law as it relates to the mental state of the offender, or alleged offender, and training and experience in the assessment, treatment and care - including the care in the community - of persons who have offended, are alleged to have offended or appear likely to offend because of their psychiatric condition."

THE FORENSIC PSYCHIATRIC SERVICE

Throughout this part of the report, the focus will be upon the concept of the forensic psychiatric service. According to Dr Basil James, Director of Mental Health, a forensic psychiatric service should be understood as a definable group of health professionals with an identifiable leader, who share a common philosophy of care. They should be trained and experienced in the psychiatric, psychological, nursing and community or socio-cultural aspects of forensic psychiatry. Such a service should include, or have access to, persons familiar with the ethnic groups from which patients are drawn, and those persons should participate in assessment, treatment and rehabilitation processes.

THE DEBATE OVER RESPONSIBILITY

Forensic Psychiatry as a specialty is, to all intents and purposes, non-existent in New Zealand. A description of the position in this country reads like a catalogue of negatives. The root cause of this situation rests in the failure, or inability, of the justice and health systems to resolve the debate as to which should accept responsibility for both the assessment of remandees in care and for the provision of facilities for psychiatrically disturbed offenders.

During the course of this Inquiry, several groups commented that it was not the responsibility of health professionals to treat persons who required security. Others urged that mentally sick people, whether offender or non-offender, were the responsibility of the health service, whether or not security was a factor. We set out below several views presented to us.

Whose Responsibility - Justice or Health?

"Society, through legislation, gives certain people the responsibility and authority to manage deviant behaviour and to treat mental disorders. The responsibility for the protection of society and punishment of convicted criminals, rests with the Justice Department. The responsibility for the promotion of mental health and the treatment of mental illness rests with the Area Health or Hospital Boards.

"A balance must be struck between the rights of the individual and the rights of society, between the option of treatment and the option of protection or containment. Any service provided cannot be limited to the extremes of the balance, but must cover a range of facilities; but the underlying responsibility is clear-cut. Justice services deal with punishment containment, health services with treatment containment. As we approach the middle of the balance, it is necessary to become more specific.

"If a decision is made by a professional that treatment is a low priority, treatment should

then be available in a Justice Department facility for offenders.

"If a decision is made by professionals that treatment is a high priority, treatment should then be available in a Hospital Board facility where a degree of containment is possible, such as a Safe Care unit. However, when treatment has concluded, the person should be immediately dischargeable, either to the community, or to the prison if he/she is serving a sentence. Such discharge should be at the discretion of the treatment agency.

"Treatment then should be available in a containment facility, and containment in a treatment facility. Anybody who is moderately to severely disordered should receive care and treatment in hospital. People within the prison system who are mildly disturbed should receive maintenance care/treatment within prison. No one department can cope on its own. The dilemma is how best to divide the case load. In hospital, containment should always be subordinate to treatment. However, nurses should maintain the containment role rather than delegate it to others, so it is used therapeutically: that is containment is seen as control of environment and not punishment."

Northern Regional PSA

Health and Justice Complementary

"Clearly, the psychiatric facilities in the health and justice systems must operate in a complementary and mutually supportive way, and it may be that the same medical and paramedical personnel would work in both systems on a sessional basis. The assumption of truly professional responsibility, with no "buck passing" between the systems, will be a priority to ensure that no one who can be helped is deprived of the opportunity. In the process, it is to be hoped that the best interests of the community at large can also be served.

A description of the position in this country reads like a catalogue of negatives

"From any patient assessment and evaluation must follow a management plan. It has to be accepted that, in balancing the rights of the individual patient and the public, there is a continuum from treatment through to containment.

"When a person performs a dangerous action in response to a clearly evident psychiatric illness, it is primarily the responsibility of the health care system to provide some facilities when needs for containment are minimal.

"A variety of programmes and types of community and institutional placement is needed. This is dependent on individual assessment and position on the treatment - containment continuum.

"To place persons in psychiatric hospitals when there is no clearly identifiable psychiatric illness to treat and/or containment is required, seems most unsatisfactory.

"There are obvious conflicts between the role of the therapist who must engage in and build a trusting relationship with a patient, and a warder who, in providing security, is inherently transmitting a message of distrust. The roles are irrevocably opposed."

CR Wareing, et al, Psychiatrist, Carrington Hospital

Joint Responsibility - Hospitals and Prisons

"We cannot accept the view that Justice Department should accept responsibility for most remandees and psychiatrically disturbed inmates.

"While a small number of psychiatrically disturbed inmates may necessarily be held at the new Justice Department's psychiatric facility, the fact is that a prison is a penal institution and its role is too much in conflict with the "therapeutic community" model required to provide adequate care for disturbed persons who are being assessed, or disturbed prison inmates.

"Primary responsibility for providing appropriate facilities lies with the psychiatric hospitals, and this should be recognized as a matter of policy, and in relation to facilities and resources made available by Area Health Boards and Hospital Boards. The Justice Department has a residual responsibility for a smaller group of persons requiring secure prison facilities who have some needs for psychiatric facilities.

New Zealand PARS, Wellington

In January 1986, the Director of Mental Health expressed his concern to Hospital Boards that this question continued to be a matter for discussion.

The issues have been highlighted by a number of Inquiries and Reports made over the last few years, including, in particular, the Donaldson Report of 1981 and the Oakley Hospital (Gallen) Report 1983. The Roper Report of 1987 (The Committee of Inquiry into Violence) is the latest to address itself to the debate. It is now generally accepted that both the justice and health systems have responsibilities of different kinds for different groups of individuals.

THE NEW ZEALAND SITUATION

An efficient forensic psychiatric service has never existed in New Zealand. There are several reasons for this, among them being:

- a lack of trained psychiatric staff working in general psychiatry in New Zealand;
- inadequate funding, which has resulted in the forensic psychiatric service being regarded as the poor relation of psychiatry;
- the reluctance of staff to manage unpredictable and potentially dangerous patients in the absence of adequate facilities and support; and
- the "open door" policy, with the implicit movement away from the provision of security.

SHORTAGE OF FACILITIES

The history of forensic psychiatry in New Zealand has been described as that of a "poorly populated specialty with a minimum of resources". Dr Phil Brinded, forensic psychiatrist at Sunnyside Hospital, said:

"Forensic psychiatry is a poor relation of psychiatry. There is a relative lack of resources allocated to forensic psychiatry".

New Zealand Prisoners Aid and Rehabilitation Society describes the lack as "chronic", while the Board of Health Standing Committee on Mental Health had this to say:

"Far more than any technicality of law or procedure, the lack of adequate numbers of properly trained staff and appropriate facilities limits the effectiveness of treatment and supervision of the potentially dangerous patient within the hospital and within the community."

One of the critical deficiencies in the system lies in the absence of any medium security unit. Dr Brinded informed us that,

"there is no provision for medium security in New Zealand with an emphasis on assessment, treatment and rehabilitation of suitable patients. Many offenders would be more suited to medium security facilities than to be sent to the National Maximum Security Unit at Lake Alice, but would be too potentially disruptive for intensive care units or other minimum security wards in area psychiatric hospitals."

This also affects the treatment of patients held in the National Maximum Security Unit. According to Frances Morgan of the NZ Association of Occupational Therapists,

"lack of medium security facilities results in limited opportunity to prepare patients for open ward living when they come from maximum security."

"Some patients transferring from Lake Alice National Maximum Security Unit have difficulty settling in a less secure ward. They tend to be restless and disruptive and often have to return to maximum security."

Even the one specialist forensic facility in New Zealand is not without its problems:

"the centralization of all New Zealand security beds at Lake Alice is unsatisfactory from a

regional point of view for patients and professionals alike."

There have been some movements recently towards the provision of facilities. The Auckland Hospital Board has begun work, scheduled for completion before the end of 1988, on the provision of a 10 bed safe care unit at Kingseat Hospital in South Auckland, while the Justice Department took urgent steps to develop better psychiatric facilities within Paremoremo and Mt Eden prisons in 1987, and plans to speed up the building of a specialist psychiatric prison at

Paremoremo. However, facilities elsewhere in New Zealand also need to be urgently and significantly improved. The NZPARS stated that

"delays in developing appropriate care for remandees and inmates needing admission to psychiatric facilities are intolerable, and further delay is unacceptable." The Board of Health's Standing Committee on

Mental Health (1987) warns that whilst inadequate facilities for "forensic" inpatients remain, the future of the development of community care practices for all psychiatric patients remains at risk.

forensic psychiatry... a "poorly populated specialty with a minimum of resources"

SHORTAGE OF STAFF

As grave as the absence of facilities is the shortage of qualified staff. The Roper Report states there are only five psychiatrists (only two of them full-time) working in the justice system in New Zealand, despite the fact that they have a special role in dealing with the mentally disturbed offender. Although counselling and various therapies are used by both psychiatrists and other members of the multidisciplinary team, the prescribing of psychotropic medication is the sole responsibility of the psychiatrist. Given the proportion of offenders who are estimated to suffer from mental disorder, the psychiatrists' role is of particular significance in a modern penal system. They are part of the specialist services of the Justice Department and work in collaboration with other disciplines. However, they are not organized as a group and certainly have nothing resembling a service development plan, as do the psychological services, for example.

It is no surprise, therefore, that recruitment into forensic psychiatry is almost non-existent, with the result that the psychiatrists in the justice system are grossly overworked and under excessive stress.

Only very occasionally has the service been staffed by enthusiasts, albeit self-taught. More often than not, staff has been drawn from those psychiatrists with little or no interest in the area, upon whom the forensic work has been thrust for lack of anyone else willing to engage in it.

LACK OF AN ACADEMIC BASE

No creditable service can exist and survive without the help of an academic base involving both teaching and research. In New Zealand, there is an almost complete absence of such an academic and research base, with a conspicuous lack of investigation into areas such as the treatment of sexual offending, arson, and other deviant behaviour. Forensic psychiatry is poorly taught to psychiatric registrars. As a consequence, there is much shallowness of thinking and confusion about basic philosophies of treatment. Dr Peter McGeorge, challenging prevailing attitudes towards the personality disorder, said,

"other outcomes of such processes have resulted in the propagation of myths such as, "people with personality disorders are untreatable," and are therefore not the responsibility of the health system. In the writer's view, this is taking the difficulties of treating people with personality disorders to a ridiculous extreme. Some people with certain kinds of personality disorder are extremely disruptive of hospital routines and may be made worse by undue attention being given to their dysfunctional behaviour. But others may respond very well indeed to a programme which provides an appropriate mixture of limits and support within the context of a long term therapeutic relationship. To simply dispense such people to the justice system without this understanding, simply condemns them and the public to huge expense and suffering.

"Other myths may even confuse concepts of badness and illness to the detriment of proper

patient care. Likewise, while recognizing the risk of incarceration, the myth that treatment can only be carried out in an open environment has dangerous implications for the public and patient alike."

The inevitable consequence of this situation in New Zealand is a poor treatment programme and therefore poor results. In our opinion, it is unthinkable that the current conditions can be allowed to continue.

THE OPTIONS

We have carefully considered the several options presented to us regarding the treatment and care of psychiatric patients who are offenders. We have been told that there are four basic options if we are to find a way forward out of our impasse. These are:

1. that such patients should be treated in a hospital by health professionals who should also be responsible for security should the need arise;
2. that such patients should be treated in a special unit of a psychiatric hospital by health professionals, but with prison staff seconded to provide security;
3. that such patients should be treated in a prison by health professionals but with prison staff providing the security;
4. that such patients should be treated in a "special" prison staffed by warders who become therapists.

In order to find out how similar problems have been resolved elsewhere, and to obtain guidance as to the solution for New Zealand conditions, we visited the United Kingdom. Although there are other forensic psychiatric models in place in other parts of the world, we decided to examine the United Kingdom scene because, traditionally, the New Zealand legal and psychiatric systems closely follow the British model. We were also influenced by the findings and recommendations of the Butler Inquiry which have had a profound effect on the theory and practice of forensic psychiatry in the United Kingdom since 1975.

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THE UNITED KINGDOM EXPERIENCE

In Britain, three dramatic changes or revolutions in care - pharmacological, administrative and legal - dated from the establishment of the British National Health Service in 1948. The Royal Commission on The Law Relating to Mentally Ill and Mental Deficiency 1954-57, and the Mental Health Act 1959, were the culmination of the administrative and legal revolution.

The Royal Commission effected the most significant shift in care of the mentally ill by establishing their right to be cared for in the least restrictive way, limiting committal to a more clearly defined procedure, and segregating care in mental hospitals from the remainder of health care. The Mental Health Act of 1959 was a liberal reform which coincided with the developing "open door" policy.

Before long, it became apparent that there were limitations on the operation of the new policy. There was a group of patients, offenders and difficult non-offenders who required some security, in need of psychiatric care but who could not be coped with within the philosophy of the "open door" regimes of many psychiatric hospitals. Prior to 1959, most of these hospitals had locked wards and thus this group was easily accommodated. From a long tradition of care, medical and nursing staff had acquired considerable skill in managing this type of patient.

The special hospitals (maximum security hospitals) continued to admit committed dangerous and violent offenders requiring treatment and management under conditions of special security, but after 1959 they were obliged to admit those requiring less security, who were now being refused admission to the psychiatric hospitals. This resulted in over crowding of the special hospitals, to the point where judges were impelled to send people to prison inappropriately instead of to hospital. The prisons,

too, became overcrowded.

In 1969, a bill was introduced in the United Kingdom parliament to provide units with security midway between special hospitals and psychiatric hospitals. It failed to get further than the first reading. Administrators from the majority of psychiatric hospitals claimed to have a totally "open door" policy, and argued that hospital regimes would be undermined by providing special arrangements for a relatively small group of patients at the expense of the rest. Many agreed that something should be

done for this group of offender patients - but preferably somewhere else! Overcrowding of mentally ill offenders, both in the prisons and special hospitals, continued. The special hospitals management objected, declaring that, "to detain patients in special hospitals unnecessarily was an affront to their humanity and civil liberty".

In 1972 the Committee on Mentally Abnormal Offenders (Butler Committee) was established by the Government to address these problems, which had now reached the point of crisis. Concurrently, an internal

Working Party, chaired by Dr Glancy, had also been established to investigate the problem.

In July 1974, an interim report was produced by the Butler Committee, which included evidence from the Glancy Report. Both the Committee and the Working Party recommended the urgent establishment of Regional Secure Units (RSUs) in the National Health Service, to "bridge the yawning gap" between the secure special hospitals and open psychiatric wards. These units were to act as centres for the development of forensic psychiatric services, and would provide treatment to offenders and non-offenders alike. Security would be achieved by a high ratio of staff to patients, the treatment regime, and the build-

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ing design. Such units would be situated in centres of population close to other diagnostic facilities, possibly near general hospitals, and provide 50 to 100 inpatient beds each, ideally for short stay patients. Community care was to be established for patients discharged from the units, and psychiatric and general hospital psychiatric units were requested to continue treatment and rehabilitation of special patients who did not require the secure conditions of the regional units.

The Committee stressed the urgency with which these units were required, and, pointing to funding problems as the possible reason for lack of action, recommended a direct allocation of government funds to Regional Health Authorities to allow the immediate establishment of the units.

In its final report in 1975, the Butler Committee expressed disappointment and concern that no progress had been made in the establishment of the units. It was suggested that this may have been because of a lack of funds to run the units in the interim, and the reluctance of the Regional Health Authorities, upon establishment of the units, to divert funds from other areas for this purpose. The Committee therefore recommended that the costs of running the units should also be met by central government funds. The government agreed to this, and consequently, in early 1976, capital funding and recurring revenue were made available.

FORENSIC SERVICES NETWORK BASED ON REGIONAL SECURE UNIT

The Butler Report of 1975 described a comprehensive network of forensic psychiatric services based on the Regional Secure Unit. The services would provide for both offender and civil patients; they would relieve the overcrowding of prisons and special hospitals; provide improved assessment which would aid the courts; and provide reference points from which the probation and after care services could obtain advice. The units would also be involved in training and research, developing a close association with the universities.

The network would include assessment centres to provide assessment for the court, both on an outpatient basis and during remand in custody in the secure unit. Assessment centres would be integrated where possible with the

secure units.

The Butler Committee recommended that forensic services should be established within the framework of the National Health Services at the Regional Health Authority level, and operational centres should be in the Regional Secure Units in each hospital region. Establishment at the regional level would maintain greater administrative flexibility. The organization of the services would be integrated with the existing hospital and the community mental health services of the regions.

Regional Secure Units would be seen as the hospital facility for what would otherwise be a service mainly dealing with patients in the community. Emphasis was to be on forensic psychiatric services including community care and outpatient work.

The objective of the service would be the development of closer links between the National Health Service and prison medical services on the one hand, and between the hospital and general practitioner services and the social services (local authority and probation) in the community on the other.

The fostering of close links with community social services was recommended. Each regional forensic psychiatric service, together with probation and after care social workers, should see themselves as a team and work accordingly.

To this end, members of the prison service and mental health service would spend a period as a member of the interdisciplinary treatment team at the forensic psychiatric centres. All these centres would have a training role.

Links with special hospitals would also be fostered. Patients from forensic psychiatric centres would be granted admission to special hospitals, and vice versa. Special hospitals could also assist in the training of prison and medical personnel.

The Committee stressed the importance of effective liaison among those working in the forensic psychiatric services, the Regional Secure Units, the psychiatric hospitals in the area, the social services, and the remand prisons. Officially recognized coordination through regional committees to advise on planning and policy was also recommended.

Continuity of treatment was seen as important. Forensic psychiatric services would provide the central core for coordination of the

various treatment services, and would facilitate the provision of "through-care", linking treatment in hospitals and prisons with treatment in the community in day treatment units. In the interest of continuity and supervision, the same personnel could thus follow the offender through the various stages of residential and community treatment, with adequate staffing levels allowing for time to be spent in both settings.

They envisaged closer collaboration between the courts and the helping professions.

THE MEDIUM SECURE UNITS

By 1986, 10 of the 14 Regional Health Authorities had developed permanent Medium Secure Units. The units cater for mentally ill offenders who are too disruptive for an open ward; mentally ill offenders referred from courts or prison; and patients transferred from the special hospitals.

The units provide close supervision by trained staff, individually tailored treatment and rehabilitation programmes, and physical security.

They are viewed as a local service for local people, making it easier for families and friends, clerical staff, social workers, and probation and after care, to maintain close links throughout all stages of recovery and rehabilitation. There is ease of readmission, if considered necessary.

Community Involvement

The support of the community for medium secure units was won only after a long and detailed programme of consultation and discussion. Community leaders were involved in this programme, acting as a liaison group. Such community leaders included chairman and honorary secretaries of residents' organizations, local councillors, and members of the Community Health Councils. Informal meetings, where local people could question those responsible for planning and running the unit, were held. In addition, local people were shown around the unit, and this, together with the meetings, helped them become involved with the life of the unit.

Staffing

The staff in the unit includes the forensic psychiatrist, two psychiatrists in training, nursing staff (with a nurse to patient ratio of between 1.5 to 1 and 2.8 to 1), one or two social workers, and a variable number of para-medical staff. Although the units are secure, the emphasis is on the treatment rather than custody of patients, as is evidenced by the presence of multidisciplinary treatment teams.

Results of Evaluation Studies

Service evaluation studies have been completed on many of the Medium Security units in Britain, and the clear results obtained show:

- enlightened and more humane treatment for violent offender patients;
- increased specialization of staff, with improved morale;
- creation of centres for teaching and research;
- better assessment facilities in a social but secure environment, rather than seclusion;
- decrease in all violent incidents; both patient v staff, and patient v patient;
- overall decrease in reoffending and recidivism among discharged patients;
- more rapid relief of acute psychotic illness;
- more efficient use of staff time, with staff in other areas (and institutions) less engaged with crisis intervention and dealing with violent behaviour.

The support of the community for medium secure units was won only after a long and detailed programme of consultation and discussion

Problems Experienced

One of the problems experienced in the establishment of regional secure units was the disagreement among professionals as to what type of patient should be accommodated in the units. Both the Glancy and Butler Reports described the types of patients considered for admission, but medical professionals within the Department of Health and Social services differed both in their interpretation of these guidelines and their conception of patient type. Even the Butler and Glancy Reports differed in

their definitions. The Butler Committee suggested that units should not accept "aggressive psychopaths or dangerous patients", while the Glancy Report frankly stated the difficulty in defining those to be admitted. However, it did declare that the "elderly wanderer", the "severely mentally handicapped", and the "patient difficult only during acute phase of illness", were to be omitted.

OUR CONCLUSION

As previously mentioned, we have carefully considered several options presented to

us as to which service should care for and treat psychiatric patients, both offender and non-offender.

Apart altogether from our collective experience in New Zealand, we have had the advantage of meeting with numerous health professionals in the United Kingdom, and of examining the various units and programmes which have now been in operation for several years. It is our firm belief that the responsibility of caring for psychiatrically disturbed people, whether offender or non-offender, rests exclusively with the health service.

STATEMENT ON PERSONALITY DISORDERS

This Inquiry has again demonstrated the need for some direction regarding the care and treatment of those who have personality disorders.

There are some people who believe that the personality disordered individual is "untreatable". There are others who believe that such people will respond to well structured programmes within the context of a long term therapeutic relationship.

We discuss both sides of the dilemma more fully in Appendix 3 of this report.

We believe that people with personality disorders will respond to psychiatric care.

Under conditions of extreme stress, an individual with personality disorder may demonstrate clear symptoms of mental disorder as defined in Section 2 Mental Health Act 1969. Under these circumstances, committal would be appropriate.

In some cases, a personality disordered individual may not exhibit clear signs of mental disorder but may nonetheless acknowledge behaviour which could be classified as personality disorder. We believe that if, under these circumstances, he/she expresses a wish to change, a willingness to accept psychiatric help and gives an assurance of cooperative participation in treatment programmes, then the care and treatment of the personality disordered individual is unequivocally the responsibility of the psychiatric profession.

OUR PROPOSALS

We propose the establishment of a Regional Forensic Psychiatric Service.
Our proposed Regional Forensic Service will create:

A. A SERVICE TO THE HOSPITALS:

- (i) In the Regional Medium Secure Unit;
- (ii) In the Regional Minimum Secure Unit;

B. A SERVICE TO THE JUSTICE DEPARTMENT:

- (i) In the courts;
- (ii) In prisons;

C. A FORENSIC COMMUNITY SERVICE:

- (i) Outpatients
- (ii) Aftercare

D. A LIAISON SERVICE TO THE GENERAL PSYCHIATRIC SERVICES.

- (i) Psychiatric Hospitals
- (ii) Community Psychiatric Service

We propose that New Zealand be divided into five Regional Forensic Areas, namely:

- Region 1 will be centred on Auckland;
- Region 2 will be centred on Hamilton;
- Region 3 will be centred on Wellington;
- Region 4 will be centred on Christchurch;
- Region 5 will be centred on Dunedin.

It will be noted that our proposed regional forensic service does not provide for a special prison hospital for psychiatric patients.

The strongest supporters for the special prison concept were Dr Honeyman (Medical Superintendent -in-Chief, Auckland Hospital Board until 1 April 1988), Mrs Quinlan (Princi-

pal Nurse, Carrington Hospital until May 1988), and Dr Felgate (Psychiatrist, Carrington Hospital).

Dr Felgate commented that a special prison would not have a leaning towards treatment and would not be based on an illness model as are general hospitals. He said a special prison

would be,

"to provide an environment in which those prisoners [who break down] can be managed during their stay in gaol. The idea of a special prison is not to treat them or make them model citizens, but is a way of managing certain sorts of prisoners who can't manage an ordinary gaol."

Dr Felgate also pointed out that a prisoner is a member of a community, i.e. a prison community, and said that,

"when a prisoner is under stress, it is best to deal with his distress in his own community if possible."

He suggested that the special prison be staffed by warders who become therapists.

The routines and practices in psychiatric hospitals and prisons are totally dissimilar. In the interests of maintaining security, a prison can only function effectively if a military-type routine is adopted. We have heard ample evidence to satisfy us that, if psychiatrically disordered prisoners are required to fit in to that regime, it would lead to ineffective treatment and care. What may not be generally realized is that the presence of even two or three mentally disordered inmates in a prison has a significant detrimental effect on the management of the entire system. The principal function of prison officers is to contain those persons placed in their charge. They should not be expected to take on the role of therapist or nurse. That, however, is not to deny the need for prison officers to acquire skills in those disciplines which will assist in the rehabilitation of prisoners.

We acknowledge that, in some cases, prisoners requiring psychiatric assistance may very well be cared for adequately in prison: but those who are grossly mentally ill can only be treated adequately in hospital. The Gallen Inquiry was opposed to any proposal to construct a prison hospital for psychiatric patients. We agree. We have been informed that the Justice Department intends proceeding with the construction of a prison hospital on a site at Paremoremo. We are opposed to that.

We believe that, if our proposals are adopted, and given the range of services and facilities we recommend, there will be no need for a special prison or prison hospital. Which-

ever term is used, there can be no disguising the fact that a "special prison" or "prison hospital" would still be a prison operating, of necessity, along regimented lines, and therefore the establishment of a therapeutic milieu would become virtually impossible.

Perhaps the last word on the need for a special prison or a prison hospital should be left to an experienced prison officer, who told us,

"it will be a dumping ground for anybody who is a bloody nuisance in any prison in New Zealand. I'll bet my bottom dollar on it." We agree.

For reasons which have emerged during the course of this report, we repeat that the responsibility for caring for psychiatrically disturbed people, whether offender or non-offender, rests exclusively with the health service.

Forensic psychiatric services comprise a range of psychiatric and community services encompassing a variety of psychiatric problems presented by mentally ill offenders and non-offenders alike. It should incorporate both hospital based and community based resources and liaise with colleagues and other professionals working in the field including public, private and voluntary agencies and community people in contact with the mentally ill.

It will be a fundamental principle that patients who come into the forensic psychiatric service should be cared for in the least restrictive circumstances possible. The environment in which patients are maintained, and the nature of the care they receive, must be directed at enhancing their health, and preserving their dignity, wellbeing and rights.

A central feature of a fully coordinated service will be a network of psychiatric services forming part of the general psychiatric service.

This service will be developed under the aegis and control of the Area Health Boards or Hospital Boards, which will be the employing agency.

The Flow Chart on the next page illustrates the type of service we propose.

FIGURE 1

REGIONAL FORENSIC PSYCHIATRIC SERVICE

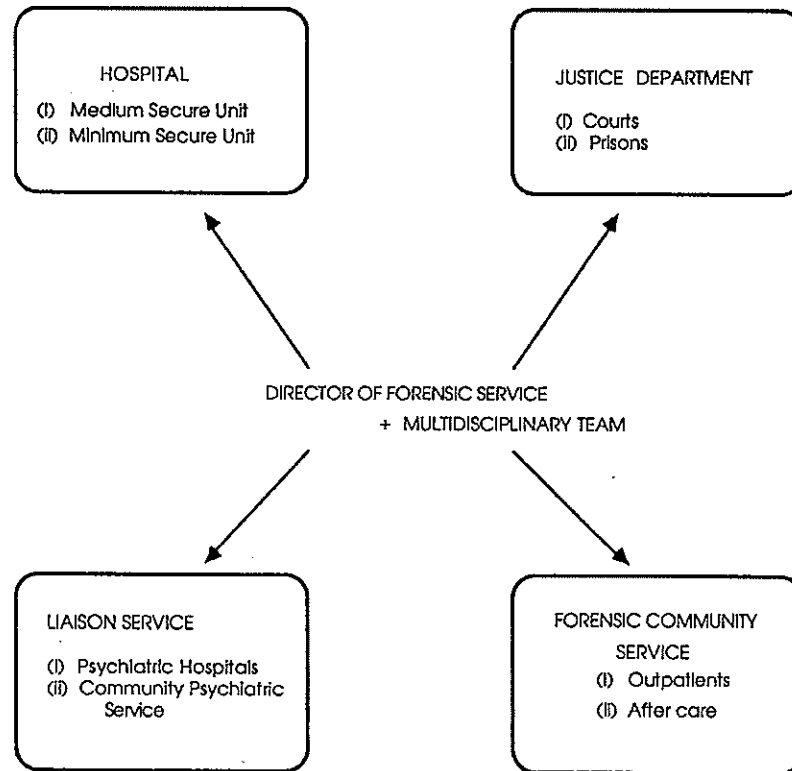
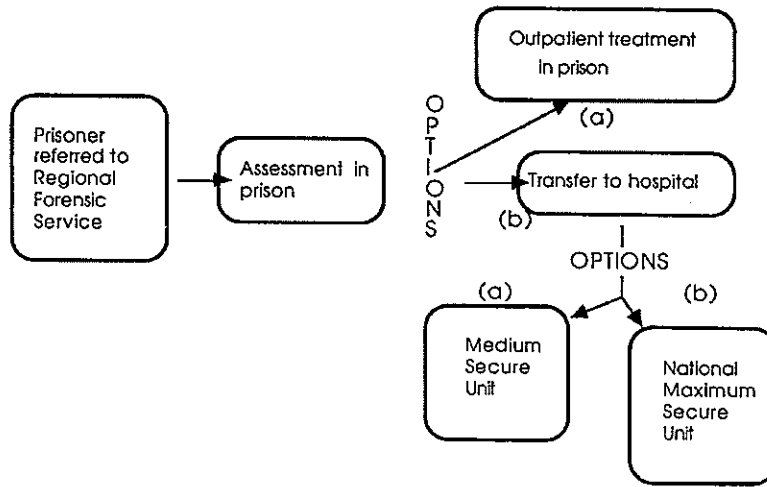


FIGURE 2

MANAGEMENT WITHIN REGIONAL FORENSIC PSYCHIATRIC SERVICE

(i) Admission: From Prison



(ii) Discharge: From Hospital

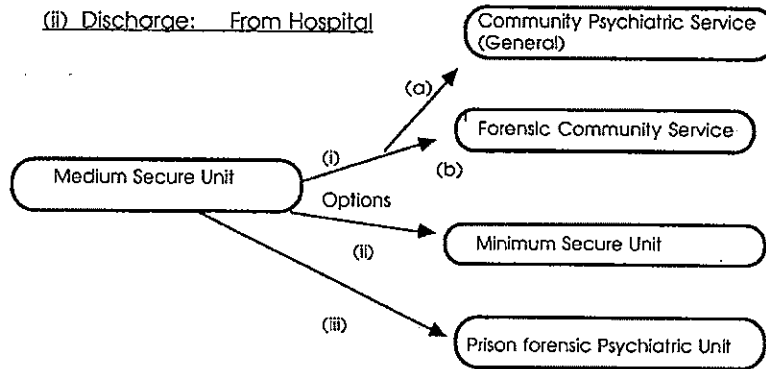
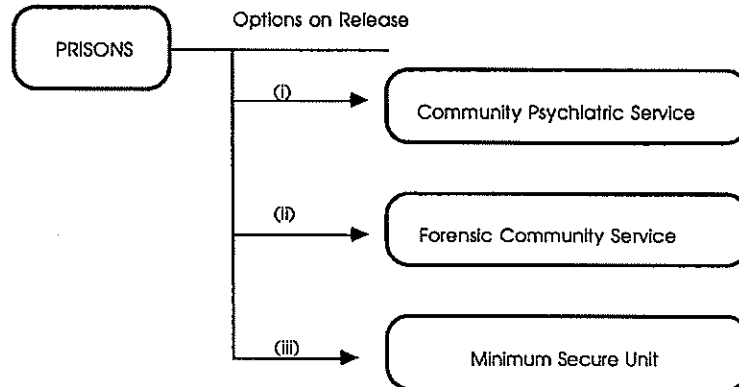


FIGURE 2 CONTINUED

(iii) Release from Prison: (Where in Prison Forensic Service)



THE REGIONAL FORENSIC PSYCHIATRIC SERVICE

Each regional forensic service will be headed by the Director of Forensic Services, who is directly accountable to the Director of Psychiatric Services. His or her responsibility is to establish a multidisciplinary team, including people with professional qualifications in:

1. Psychiatry,
2. Psychology,
3. Nursing,
4. Social Work,
5. Occupational Therapy,
6. Physiotherapy,

and in adequate numbers to provide these services in the various areas described above. In addition, the multidisciplinary team will include people skilled in taha Maori, and other

cultural perspectives appropriate to the population being served. The professional qualification for membership of the forensic multidisciplinary team will include a training in the forensic aspects of the discipline of that particular member. On-going inservice education will be the responsibility of the Director of Forensic Services.

Management of Staff within the Regional Forensic Services

It will be the responsibility of the Director of Forensic Services to ensure that all facilities within the service are adequately and properly staffed by multidisciplinary teams. It is important to note that the stability of each multidisciplinary team will be essential for effective thera-

peutic interventions. We envisage that staff will be on a rotation roster through all sectors of the forensic service to maintain staff skills and interest and to prevent stagnation.

Sources of Referral

Patients will be referred to the regional forensic service from the following sources:

- community psychiatric services;
- general psychiatric services;
- the prisons on the recommendation of the prison medical officer;
- the courts;
- the National Maximum Security Unit at Lake Alice.

A. THE FORENSIC SERVICE TO THE HOSPITALS

(i) THE REGIONAL MEDIUM SECURE UNIT

Why Do We Need Them?

Medium secure units are required for those mentally disordered persons, offenders and non-offenders alike, who do not require the degree of security offered by the National Maximum Secure Unit at Lake Alice, but who nonetheless are not suitable for treatment under the open conditions obtaining in local psychiatric hospitals. No adequate provision is made for these people in New Zealand at present.

The courts sometimes have no option but to impose sentences of imprisonment on offenders who are in need of treatment in hospital but for whom, whether for their own safety or for the protection of the public, secure containment is essential.

In general, the units are required for patients who present severely disruptive or dangerous behaviour, who may be mentally ill or mentally handicapped or for those who suffer from psychopathic or severe personality disorder, whether alone or in conjunction with mental illness or handicap.

The Role of the Regional Medium Secure Unit

The Medium Secure Unit will offer specialized assessment, treatment and rehabilitation to carefully selected patients who:

1. require treatment in varied and adjustable levels of security as identified by each patient's individual needs;
2. will benefit from an intensive and carefully planned programme of care, ranging from several weeks to approximately two years;

3. are not considered to be an immediate danger to themselves or to the general public should they absent themselves without permission.

It should be noted that a medium secure unit is not to be confused with an intensive care unit of a general psychiatric hospital.

The staff will be mixed, and both male and female patients will be accepted.

The service will provide for both offender and non-offender patients.

Eligibility

Whether admission is appropriate can be decided only after clinical assessment, taking into account the circumstances of each individual case. The need for admission to a secure unit should be decided on a multidisciplinary basis. The admitting team would take into account the nature or degree of risk to the patient, other patients, to staff, or to the public, if treatment takes place elsewhere. They would also consider the prospect of response to treatment in a secure unit as opposed, for example, to the prospect of response in an open hospital or penal institution.

No general distinction should be made between offenders and non-offenders on the question of eligibility for treatment in hospital. Offenders are a part of that whole community for which the hospitals are provided. What is important therapeutically is that mentally disordered offenders should be put into the treatment situation which is most appropriate to their needs, with proper regard for the requirements of safety.

The overriding consideration is to provide

the best possible treatment for the patient's mental disorder. All patients should have full access to treatment in the least restrictive environment possible. Ultimately, in individual cases this must depend on clinical judgment. In general, it is hoped that humane counsel will prevail and that consideration of the patient's background will not obscure this basic principle.

In this way, then, it will be possible to meet the identified, long-neglected need of a certain category of mentally disordered patient, offender and non-offender alike, who is being too disruptive in the open wards of a psychiatric hospital, yet unsuitable for life in the community until treated; but is not so disturbed as to warrant detention in prison or in the National Maximum Security Unit.

Assessment and Care Programme

All referrals will be interviewed by selected members of the multidisciplinary team, whose expertise will determine whether the unit can meet the patient's individual needs.

All patients should undergo an intensive assessment to identify their needs and to decide how best these can be met. This should be undertaken in a specially resourced assessment unit, culminating in an individual care plan jointly agreed to by staff and patient, thereby ensuring that an appropriate programme of care is delivered.

It is essential that the central figure in a rehabilitation programme is the patient, whose feelings, aspirations, attitudes and wishes must be taken into account. The idea is to capture the patient's interest at the start. Even a small success at the beginning encourages perseverance.

The development of non-repressive and non-punitive programmes by staff working in the unit will enable the patient to attain better mental health. All caring and treatment programmes in the unit are therefore the outcome of study and conference between patient and ward staff.

A structured daily programme which avoids overregimentation, involves physical relaxation, occupational, educational, social and recrea-

tional periods based on individual requirements, is required.

The ability to accommodate unforeseen setbacks without preventing long-term progress is clearly necessary.

Experienced teachers will be involved in many activities to complement the mental health skills of the professionals. Good team work among all key staff including doctors, nurses, psychologists, physiotherapists, occupational therapists, workshop technicians, social workers and community staff is vital.

The basic aim is to increase independence, to encourage cooperation and, where necessary, sociability. Such plans take account of the age, intelligence, previous education and psychosocial background of the patient, as well as the extent to which his potential has been impaired by mental disorder.

Attention needs to be given to the ethnic and cultural background of the patients. This may require appropriate staff expertise, experience and treatment programmes.

Conventional psychiatry is practised using the usual range of therapeutic techniques. The educational component includes communication, social, occupational, as well as domestic and recreational skills. Regular assessment and reappraisal are essential. Facilities within the clinic include: light industrial workshop, physiotherapy facilities, education department including library and computers, fully equipped domestic training areas, multi purpose hall for sports or drama, and a gardening department. Other recreational or indoor areas include facilities for pool tables, quiet rooms, day leisure areas and reading rooms, television etc.

Design

The design should create a pleasing atmosphere with good use of colours, soft textures and domestic furnishings, with the achievement of a balance between a sense of privacy and the need for observation. We would suggest the employment of professional consultants to accomplish this. As treatment in the clinic will be based very much on therapeutic techniques, excessive or all-pervading meas-

It is essential that the central figure in a rehabilitation programme is the patient

ures of physical security may be counterproductive. With this in mind, physical measures of security need to be planned to be as unobtrusive as possible and the building should form its own boundary.

The unit needs to be secure, but, within the interior, the therapeutic atmosphere should be as free and unrestrictive as possible. These principles should be incorporated into the design of the building.

Security

Patients at the unit will require various levels of security. During the day, staff and patients should be able to move freely through most parts of the building.

Security will be principally based on the high ratio of staff to patients, with a range of 2 to 2.8 nurses for each patient.

We envisage that appropriate architecture and electronic security will complement staff levels.

Staffing

The multidisciplinary team described above will provide care within the Medium Secure Unit.

Additionally, a full range of support staff, including domestics, caterers, orderlies, security, administration, clerical and maintenance staff will be required to ensure the unit functions as far as possible as an independent unit. Food, administration and other services may well be provided from outside the unit.

Size

Each unit will stand alone and will consist of 15 beds, together with two "emergency" beds.

We met with many experienced health professionals during our United Kingdom visit. We visited a 100 bed medium secure unit in Birmingham designed to cater for a population of 5 million. We saw a range of units varying in size and bed numbers.

We were impressed by what we saw in the South East Thames region, which has a population similar to that of New Zealand. Experience in that region shows that, from a clinical, administrative, management and financial point of view, the smaller unit is to be preferred.

We also enquired as to the number of medium secure beds which would be necessary to

serve a New Zealand population of 3.3 million. We were told that the ideal figure would be 70 to 80 medium secure beds and approximately 30 maximum secure beds. It was emphasized that these figures were based on the assumption that sufficient minimum secure beds would also be available for those people whom we shall refer to later in this report. Experience in South East Thames and other regions of the United Kingdom indicates quite clearly that the ratio of beds to population outlined above is adequate to ensure an efficient service without creating expensive facilities which will not be used.

Bearing in mind the close similarities between the health and justice systems in both countries, we believe that a similar bed to population ratio would also apply in New Zealand.

Recommendations

WE RECOMMEND that there be two units in Auckland, one in Hamilton, one in Wellington, one in Christchurch, and, perhaps later, one in Dunedin. Each unit will consist of 15 beds with provision for two additional "emergency beds".

We have no recommendation to make as to the precise location of the units in Auckland, Hamilton, Wellington, and Christchurch. That will be a matter to be considered by the appropriate Hospital Board or Area Health Board. We comment, however, that we see no real reason why the units should necessarily be established contiguous to existing psychiatric hospitals in those regions. For example, in the Auckland region, we see advantages in one unit being sited on or near the existing Kingseat campus, and a second unit being sited on the North Shore. In our view, the facilities at Carrington Hospital are outdated and unsuited for the efficient practice of modern psychiatry. It would therefore be an anomaly if a modern, purpose-built medium secure unit were to be located on that site.

Similarly, in the Hamilton region, we see no reason why a unit must necessarily be established at Tokanui. In our view, that hospital is isolated, and we see advantages in the unit being established in or nearer to Hamilton city.

We understand the Auckland Hospital

Board is presently building a 10 bed secure unit at Kingseat. That is due for completion in August 1988. We want to emphasize that, in our view, that facility must be regarded as an interim unit only. Our experience in the United Kingdom suggests that an interim medium secure unit, and especially one which has been converted from an existing ward, is generally inefficient, ineffective, and ultimately more expensive to run when later converted to a permanent medium secure unit.

These units will fulfill a need for non-offender patients, while advancing the general cause of the "open door" policy in psychiatric hospitals, by enabling the most difficult cases to be treated in more appropriate conditions.

They will result in greater flexibility in placement, which is needed for mentally abnormal offenders; and thereby will bring about early relief to both the prisons and the National Maximum Security Unit at Lake Alice.

Offenders and non-offenders should be treated together; they should share all the facilities of the units without any distinction being made between them.

The offender in need of treatment will be better served not least because of improved assessment, which will also be of immense value to the court in deciding what appropriate action to take.

Such assessment will provide reference points to which the probation and after care service will be able to turn for the advice which they often need.

The units will have an essential role in training and research, for which reason they should be closely associated with the teaching institutions.

Assessments for the courts will be carried out both on an outpatient basis, and on remand in the secure unit.

Assessment centres may also be required in some areas where there are no such secure units.

Regional medium secure units will be the hospital facility of a service mainly dealing with patients in the community. The main emphasis in forensic psychiatric services therefore should be on community care and out patient work.

Area psychiatric hospitals should continue to provide a wide range of facilities for patients including provision for intensive care short of

the security which the regional medium secure units will provide.

Treatment should always be provided as close as possible to the patient's home. It is important to provide continuity of treatment for mentally disordered offenders. The establishment of forensic psychiatric services would provide the central core for coordination of the various treatment services, and would facilitate the provision of "through care", linking treatment in hospitals and prisons with treatment in the community and in day treatment units.

The same diversity of professional groups should be available to provide community treatment and after care as is provided for residential units. In the interests of continuity of treatment and supervision, the same personnel should be available to follow the offender through the various stages of residential and community treatment, with staffing levels adequate to enable time to be spent in both settings. This is especially important where social workers are concerned, because of the particular understanding they have of the offenders' normal environment at home, in the family, and at work.

The Cost

We are unable to be specific as to the cost of establishing, staffing and running a medium secure unit. Because such units do not exist in New Zealand, there is no model upon which a sound judgment can be made. Later in this report, we shall refer to comments made to us by Dr James MacKeith. He told us that in the United Kingdom it is expensive to maintain a patient in a medium secure unit. He estimated the cost at approximately £40,000.00 per annum per patient.

We are convinced, however, that the advantages in establishing such units, and the community services which form an integral part of such units, far outweigh the cost factor. We believe that, in financial terms, to proceed will be expensive, but not to proceed will be equally, if not more, expensive. In human terms, the cost of standing still will be even greater.

(ii) THE REGIONAL MINIMUM SECURE UNIT

We are unable to specify the number of beds in the minimum secure unit, because no similar units have been developed upon which to make a judgment. Experience has shown, however, that wards of more than 30 patients become unwieldy and unmanageable.

The minimum secure unit will cater for the needs of a group of mentally disordered persons, some of whom may not be willing to accept care offered on a voluntary basis but whose conditions may not be treatable except on a very long-term basis and who could not cope adequately if discharged from hospital. They will include some who are personality disordered, sexual offenders, chronic organic brain syndromes and very severely behaviourally disordered people, too disruptive to manage in the community or in the general psychiatric hospital.

They may stay up to ten years, during which time they will be subject to long-term, but active, rehabilitation programmes. Programmes would incorporate pharmacology, behavioural programmes, group and individual psychotherapy, physiotherapy, occupational therapy, living skills and social skills, anger management, sexual counselling, taha Maori and education.

The objective of this active rehabilitation will be to ensure that the regional minimum secure unit does not become a dumping ground.

This group will contain the socially inadequate for whom the concept of "asylum" is still valid and necessary, as these people cannot function effectively without professional care. (See Appendix 3)

Admission into the regional minimum secure unit is at the discretion of the multidisciplinary forensic team and is to be based on clinical grounds.

Though it would be feasible for existing villas within psychiatric hospitals to be converted to regional minimum secure units, we see no reason why such units should not be developed in the community. It will be important to remember that where such facilities are developed in the community, due regard must be had to the provision of security.

We believe that there is a sufficient population and patient base to justify the early establishment of minimum secure units in Auckland, Hamilton, Wellington, Christchurch and Dunedin. Ultimately, it may be necessary to undertake an audit of the potential population to be served by such units, and allow the service to grow from that point onwards. We wish to emphasize that such units must not be isolated either from the general population or hospital services.

B. THE FORENSIC SERVICE TO THE JUSTICE DEPARTMENT

The regional forensic service will provide a service

- (i) to the courts; an initial assessment in court and a formal assessment in hospital [Section 121(2)(b)(i)];
- (ii) within the prisons;
 - (a) assessment and report on remand [Section 121(2)(b)(i)];
 - (b) assessment of prisoners in respect of Section 42 and Section 43 applications; and,
 - (c) treatment within the prisons.

The regional forensic service in the prisons will include:

- pharmacology;
- behavioural programmes;
- psychotherapy, both group and individual;
- alcohol and drug related programmes;
- occupational therapy, social skills, living skills, occupational skills;
- education;
- anger management;
- sexual counselling in respect of incest, sex abuse etc;
- taha Maori.

The service will further provide:

- liaison with the probation service in cases where a prisoner has been, or is still, within the care of the regional forensic service;
- assessment by the multidisciplinary forensic team and the provision of reports while on bail [Section 121(2)(a)];

PRISON FORENSIC SERVICES

General Principles

(a) Forensic psychiatry will be conducted within the prisons by the regional forensic service.

(b) The service will be an "outpatient" one, with patients returning to their prison wing after treatment.

(c) 24 hour "respite beds" will be available in the prison hospital wing for a maximum of three days, after which the patient will be transferred to the appropriate hospital psychiatric facility in the event of longer treatment being required.

Regional Forensic Service Facilities Required in Prison

(a) An administration office.

(b) Individual interview rooms.

(c) Large all-purpose rooms.

(d) Occupational therapy centre; a large room for leisure skills programmes; flat including kitchen, bathroom, toilet and bedroom for living skills.

(e) School room and library.

The numbers and size of each facility will be determined, in the main, by the capacity of the prison.

Staff

The regional forensic service staff to the prison will be additional to any health care staff already employed and will consist of members of the forensic multidisciplinary team and visiting kaumatua and cultural experts. The team will liaise with visiting physicians, general practitioners and the probation service as appropriate to the management needs of each case. Prison officers will be on a rotation roster through the unit to gain experience in forensic psychiatry and in nursing techniques generally.

Regional forensic service staff will also be on a rotation roster through the prison service from the regional medium secure unit in order to prevent "stagnation". The present Justice Department health care staff, e.g. psychologists, where appropriate, may become part of the regional forensic service staff.

Types of Disorder

It is expected that a full cross section of

psychiatric disorders will present in prison from time to time, among them being:

- schizophrenia,
- bipolar affective disorder,
- endogenous and reactive depression,
- personality disorders,
- sexual offenders,
- alcohol/substance abusers,
- borderline intelligence, some of whom will constitute the "inadequates",
- prisoners with cultural distress.

Incentives in Prison

As an incentive to joining programmes, participation may warrant a strong recommendation for earlier release by the regional forensic psychiatric service team to the Parole Board. Some prison staff may view with a measure of cynicism the degree of commitment by some prisoners to programmes with early discharge as an incentive to participation. We do not.

Administration

(a) Prison officers should not be asked to serve the dual function of containment and therapy.

(b) Prison officers should be on a rotation roster through the forensic prison unit to gain experience in the psychiatric area, to promote mutual support of the two work forces through shared experience, and to share skills and facilitate communication.

(c) The prison superintendent controls the prison. Attendance is at the discretion of the superintendent.

(d) Subject to (c) above, the therapeutic day programme should be independent of the prison programme and should be regarded as being part of the regional forensic service.

(e) The regional forensic service is a psychiatric service. Its presence in prison should not restrict or detract from the development of other services, e.g. education, cultural programmes etc.

Discharge and After Care

The regional forensic service will be concerned only with people who have been patients during their prison incarceration.

In its report to the Prison's Parole Board, the regional forensic service may recommend after care on a mandatory basis as a condition of

parole. This may be to the general community psychiatric service or to the forensic community psychiatric service. A range of support would be available, from extensive care, (hostel, day hospital) through to minimal care. The provision of care by the regional forensic services may be shared with that offered by the probation service. The regional forensic service

will have access to general community psychiatric services as necessary.

The regional forensic service may recommend that a prisoner be discharged with no psychiatric follow up.

Alcohol substance abusers could be referred to the appropriate community based service.

C. FORENSIC COMMUNITY SERVICE

Interlock with General Community Service

In our opinion, a regional forensic service must interlock with the community psychiatric service. Wherever possible, patients discharged from the forensic service should use the general facilities available in the community. (Figure 5) This will be of particular importance in areas outside of the cities where regional secure units will be based, as specialized forensic community services will be costly and difficult to mount in all areas.

Good community care has been shown to prevent rehospitalization amongst people with psychiatric disorders. It is a reasonable conclusion that good community care can also prevent reoffending. This was the position taken by the Richmond Fellowship Inquiry in the United Kingdom into Community Care, 1983. It was found that, for the mentally disordered offender, the first year after release is the crucial time, when proper provisions for gradual rehabilitation can reduce the risk of recidivism.

People with experience in both psychiatry and the forensic area told us of the need to have close contacts with community psychiatric services. A small population of mentally ill offenders who were liable to be lost to services run the risk of reoffending unless supported in the community.

A Pattern for Concern

The practice that caused most concern in-

good community care can also prevent reoffending

involved patients who went from service to service and were transferred from one clinical team to another. As each new team took over the care of the patient, it ran the risk of not being given enough information about his/her behaviour patterns. Consequently, the team members may be somewhat relaxed in their oversight of the patient to the extent that they were unable to

recognize the signs which would indicate the onset of a violent episode. Dr Basil James, Director of Mental Health, Professor Paul Mullen of the Department of Psychological Medicine in Dunedin Hospital, and many other clinicians who spoke to us, said that it was important that the after care be managed by the same clinical team which had managed

that patient within the hospital or prison

Specific Facilities Required

Dr A J Taylor, a psychiatrist in Auckland, expressed concern at the lack of community care for mentally ill offenders discharged into the community. His suggestion is that a series of two or more hostels be developed to rehabilitate the more disturbed, socially inappropriate patients on a step by step basis, instead of discharging patients to an inadequate community service. The Richmond Fellowship, in its submission, cautioned us against discharging special patients into community facilities unless the staff in those facilities have been qualified to accept full responsibility for their care.

Forensic psychiatrists in the United Kingdom, told us that outreach into the community

was of paramount importance, and that regional secure units could only function effectively if a comprehensive community care service was also in operation. In the South East Thames Region we asked experienced health professionals to identify the major mistakes in the planning of forensic services. Several commented that the importance of developing community services had been grossly underestimated. Dr James MacKeith probably best summed up the general view when he said,

"we believe we need much augmented, well staffed and sophisticated staff to manage mentally abnormal offenders in the community. Without that our turnover (in the medium secure unit) drops and when our turnover drops our cost effectiveness drops because it is very expensive to keep a patient in this type of unit. If the discharge of a patient is delayed by even a few months, we end up spending real money. It costs approximately £40,000.00 each year to maintain a patient in this unit."

Dr MacKeith and many others firmly supported the concept of community services being developed in conjunction with medium secure units. Dr MacKeith is not only a senior consultant forensic psychiatrist but he has also had considerable experience in the establishment and management of regional secure units. We place considerable importance on his views.

Examples in the United Kingdom

We were able to see two units where a comprehensive community service was provided. The first was the Knowle Unit, in the Southampton region.

This regional secure unit has a comprehensive rehabilitation service developed within the unit. As well as the medium secure service for patients who require containment, it also has a wing which is unlocked, and where patients are given graded parole into the community. After a period of supervision, and escorted excursions into the community, the patient earns the right to go unattended to the local village. The programme includes the opportunity to live in an independent flat (still within the RSU complex) for a period. The forensic team also maintains a community house where patients can live before moving beyond the forensic services to the general psychiatric services. We spoke to

patients who were participating in this programme, and were told of the benefits that they receive. The longer period of rehabilitation, and the intensive follow up, was very supportive. One young man said,

"I have been in and out of psychiatric hospitals for the past ten years, and have always, once in the community, refused to cooperate in after-care programmes because I have not been convinced of the benefits to me. With the quality of care given, and the degree of education given to me, I can now see that it is in my interests to cooperate with this service."

Not all patients from the Knowle Unit went into this service. The unit director, Dr Malcolm Faulk, was very closely involved with the nearby community psychiatric service in Southampton, and many of his patients were discharged to this alternative.

In Cane Hill, in London, a part of the South East Thames service, the regional secure unit staff are closely involved with the local community, with staff of all disciplines going out into the community and supporting patients in an ongoing basis after discharge. Liaison is maintained with the local prisons, and, on a fairly regular basis, staff go to the prisons to conduct treatment programmes and to assess the progress being made by the participants.

The Need for Long Term Forensic Care

Forensic psychiatric staff in the United Kingdom were adamant that the care of unpredictable patients who had offended in the past and who might be expected to offend in the future, should not be left to those services which had been developed for non-offending patients in the community. We were told that, if this happens, there is a real risk of the offending patients receiving a less intensive follow-up than is necessary. There is a need for cooperation and integration between the community and forensic psychiatric services. There is a small population of patients who will be under the care of the regional forensic team within hospitals and prisons, and who will need to remain under the care of the forensic team for prolonged periods. Indeed, it may be that these patients are in the care of those teams for the rest of their lives.

Recommendation

WE RECOMMEND that a comprehensive community service be developed as part of the regional forensic service.

The range of services provided in the community by the regional forensic team will parallel the range of services provided to the wider psychiatric population but on a smaller scale. In some areas, particularly in those areas remote from the metropolitan centres, the forensic staff will probably use the facilities developed in the community for the wider population.

The Key Worker

The crucial feature of an efficient forensic community programme is continuity of care. Each patient will be allocated a key worker who will be a member of the forensic team. The key worker has a responsibility to inform the patient of the support systems which are available to him or her. Home visits and support of the patient, his/her family and networks by member/s of the multidisciplinary team will be an integral part of follow up in the community.

It will be important from the outset that the key worker establish a close and supportive relationship with the patient in the inpatient facility and before the patient is discharged into the community. It is equally important for the key worker to maintain that supportive relationship while the patient remains under forensic community care.

On occasions, it may be advantageous for the patient to return from the community base to participate in day programmes in the regional secure unit which may be of benefit to him/her. We believe that, particularly in the transition phase from inpatient to outpatient care, the option of being able to participate in such programmes will be of significant benefit to the patient.

Recommendation Regarding Hostel Accommodation

We are reluctant to recommend the development of community services specifically for mentally ill offenders, as there is a risk of these being perceived by both the community and

other sectors of the psychiatric service as being services for the bad. Nonetheless, the notoriety of the patients, and the difficulties of follow up outlined above, demand that this delicate problem be addressed. While we believe that, in a large number of cases, discharge of patients into facilities which exist for the general psychiatric population will be not only possible but desirable, it is clear that for some patients alternative services may be necessary.

WE RECOMMEND that the regional forensic service develop hostel places for the rehabilitation of mentally ill offenders into the community.

In the larger cities it may be necessary and desirable to establish one or more hostels especially for, and operated by, the regional forensic service. We see placement in these hostels as a temporary placement only, and a preliminary step as part of an active rehabilitation programme which will ultimately provide normal accommodation.

In some of the more remote areas in New Zealand, it may not be economically viable to provide hostel accommodation because of the small number of patients involved. In those circumstances it will be important for the regional forensic service to develop a close liaison with the community based psychiatric service so that its facilities and services can be utilized to ensure close supervision of forensic patients.

The Principle of Normality

We can envisage that, under some circumstances, it may be necessary to detain a patient in hospital for a longer than usual period to ensure that his/her mental state has stabilized sufficiently so as to enable him/her to be maintained in the more open non-forensic community service.

We want to make it clear that, in all cases, psychiatric patients who move into the community should not be isolated from the general population. All such patients should be accommodated in the most normal facilities possible. We believe that this will be a small but significant step to overcome the ongoing stigmatization and isolation of mentally ill offenders which unfortunately seems to have become an undesirable characteristic of our society.

The crucial feature ... is continuity of care

MANAGEMENT OF PATIENTS WITHIN THE REGIONAL FORENSIC SERVICE

Patients referred to the forensic service will be managed on the basis of clinical presentation and in the least restrictive circumstances possible.

REGISTER

A register will be kept of all patients in the care of the forensic service. That register will record information regarding:

- (a) location of the patient within the service;
- (b) mental state of the patient;
- (c) current management of the patient.

Registration of a patient will occur when he or she is first admitted into the forensic service, and will be updated at six monthly intervals and on those occasions when the patient moves to another locality or facility. For example, if a patient is transferred from the medium secure unit to the community forensic service, an entry to that effect will be made.

Access to the register will be restricted to forensic service staff, the Director of Mental Health and to those persons who are entitled to access through formal legal processes. It is imperative that the register be updated as described above until such time as a patient is discharged from the forensic service.

MANAGEMENT OF PATIENTS IN THE HOSPITAL SERVICE

A referral from other hospital services to the forensic service may lead to a transfer to any of the following:

- (a) the medium secure unit;
- (b) the minimum secure unit;
- (c) the national maximum secure unit at Lake Alice;
- (d) community psychiatric services either forensic or general community.

The forensic service will decide who will be transferred into the medium secure unit or the minimum secure unit. It will also deal with requests for transfer from the forensic service to the national maximum secure unit. In the latter

case, it will assess the patient and advise the Director of Mental Health on the clinical aspects of the case.

An agreed transfer from a more secure to a less secure facility within the forensic service will be on a trial basis for a period of eight weeks. If, during that period, the patient's condition deteriorates, he or she may be returned to the more secure facility. The decision whether to return a patient to a more secure facility will be the result of consultation and negotiation between each clinical team involved in the care of the patient. The objective will be to ensure that the patient is appropriately placed and that this is a collective decision following consultation, assessment, negotiation and review.

A similar eight week trial period and consultation and negotiation process will operate when there has been an agreed transfer of a patient from the National Maximum Secure Unit to a facility within the regional forensic service.

In cases involving an agreed transfer to a facility not forming part of the forensic service, then a similar eight week trial period will apply. In such cases consultation and negotiation will occur between the forensic team and the team outside the forensic service.

MANAGEMENT OF PATIENTS FROM THE JUSTICE DEPARTMENT

(i) From the Courts

Where a Judge is contemplating a remand for a psychiatric report under Section 121 of the Criminal Justice Act 1985, he/she may request an immediate assessment by a member of the forensic team seconded to work in the Court. One purpose of this assessment will be to recommend where the formal psychiatric assessment should be carried out. The options are:

- (a) remand as an outpatient on bail [Section 121(2)(a)];

(b) remand as an inpatient in the forensic hospital service [Section 121(2)(b)(ii)];

(c) remand in prison [Section 121(2)(b)(i)].

We comment briefly on each option.

(a) Section 121(2)(a) (on bail).

The forensic service will provide a psychiatric report based on an outpatient assessment.

(b) Section 121(2)(b)(ii) (in hospital).

The remandee will be placed in the hospital facility appropriate to his clinical condition and after consideration of his known criminal behaviour. In some cases, that may mean placement in an acute open psychiatric hospital ward.

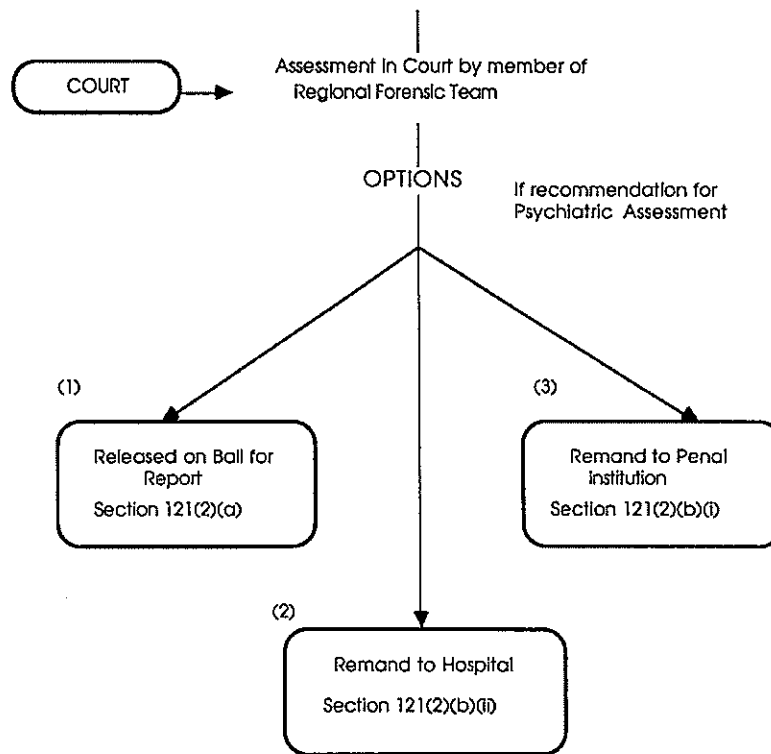
Nonetheless, the assessment remains the responsibility of the forensic service, and management of the remandee while in hospital is similarly the responsibility of the forensic service.

(c) Section 121(2)(b)(i) (in prison).

Information regarding the remandee's circumstances will be provided to the forensic service either by the team member seconded to work in the courts or by the prison service. Examination and assessment of the remandee will be carried out by arrangement with the prison superintendent. Wherever possible, a psychiatric report should be expedited without delay.

FIGURE 3

REMAND FOR PSYCHIATRIC REPORT



COURT HAS DISCRETION WHETHER TO ACCEPT RECOMMENDATION

OPTION 1 MOST PREFERRED;
OPTION 2 NEXT PREFERRED
OPTION 3 LEAST PREFERRED

(ii) In the Prisons

The range of facilities to be developed in the prisons by the forensic service have been described elsewhere in this report. When a prisoner is referred to the forensic service for assessment, he or she may remain as an outpatient within the prison psychiatric service or, if the condition requires hospitalization, may be transferred under Sections 42 or 43 Mental Health Act 1969. In the latter case, the prisoner will be placed in either the medium secure unit or application may be made to the Director of Mental Health for a transfer to the maximum secure unit. Whether the patient is managed within the prison service or the hospital facilities of the forensic service, responsibility still remains with the forensic service.

When a prisoner is due for release, the forensic service may recommend, as a condition of parole, that a referral be made to the community general psychiatric service or the forensic community service. We envisage that the forensic community service would continue its involvement with the patient in those cases where ongoing close scrutiny is required. There may also be circumstances where the forensic team recommends that a prisoner be transferred to the minimum secure unit.

It needs to be clearly understood that the regional forensic service will not operate a "catch-all" psychiatric service for ex-prisoners who may become psychiatrically disabled following release from prison.

Only those patients who have been treated by the forensic service while in prison will be entitled to follow-up services on discharge.

MANAGEMENT OF PATIENTS WITHIN THE COMMUNITY

The forensic community service will liaise closely with community psychiatric services, psychiatric hospitals and general hospitals. This service will take the form of specialist opinion, advice and support for the management of patients who are not in the care of the forensic service.

In some cases a community psychiatric team may ask the forensic team to provide specialist care for a patient. The forensic team may: (a) provide advice but leave the management of the patient to the general psychiatric service or (b) accept a transfer of the patient into the forensic community service.

In some cases the forensic team may ask the community psychiatric services to manage forensic patients who have been discharged either from prison or hospital. If that is agreed to, then in such cases the eight week trial period, and the consultation and negotiation process already described, will apply.

Geographical limitations and the small centres of population in New Zealand may mean that some forensic patients in the more remote areas of the country cannot be adequately cared for by the forensic team. The arrangements outlined above will make it possible for the normal community psychiatric services to maintain a forensic patient but in liaison with, and possibly support from, the regional forensic psychiatric team.

SPECIALIST TRAINING IN FORENSIC PSYCHIATRY

A specialist training programme for forensic psychiatrists will need to be set up in New Zealand. The criteria for entry into the training programme will be general adult psychiatric qualifications or part 1 RANZCP. Consideration should be given to similar training programmes overseas. We recommend that there be further consultation between the Director of Mental Health, the Royal Australian and New Zealand College of Psychiatrists and psychiat-

ric academic units throughout New Zealand to determine the content and duration of this training programme.

At the end of training in forensic psychiatry, the trainee should have competence in the seven basic skills of that discipline:

1. the assessment of behavioural abnormalities;
2. the writing of reports for Courts and Lawyers;

3. the giving of evidence in Court;
4. understanding and using security as a means of control and treatment;
5. the treatment of chronic disorders, especially those which exhibit behavioural problems, such as severe psychosis and personality disorders;
6. a knowledge of mental health law;
7. skill in the psychological treatment (particularly psychotherapy) of behaviour disorders.

The trained forensic psychiatrist should be able to take full clinical charge of forensic clinical services in several settings, including outpatients, inpatients, security and juvenile services. In addition, the forensic psychiatrist should

have expert knowledge of all the relevant literature, be able to teach the skills of forensic psychiatry to junior medical and para medical staff and be able to conduct research.

There should be experience of all treatment methods, (physical, behavioural and psychotherapeutical) which are employed in these settings, with a special emphasis on the management of behaviour disorder. Special emphasis should also be given to the importance of psychotherapy, especially long-term support psychotherapy, and to the management of chronic patients. Experience should be obtained in adult prisons, and services managing juvenile offenders. Liaison with the probation service is important.

COMMENT AND RECOMMENDATIONS

Several of the recommendations below have already been referred to in the text of this report.

Our objective is to recommend the ground rules for the establishment of a high quality comprehensive regional forensic psychiatric service. If our recommendations are adopted, then inevitably variations in the service will arise from region to region. For example it may not be possible to provide a comprehensive service to prisons in remote areas. We believe however that the service we propose will be flexible enough to allow for local variations whilst preserving the essential features of the forensic service.

We are particularly mindful of the cost involved in establishing and running a regional forensic service. It will not be cheap.

Nonetheless the provision of facilities and services for psychiatric patients is a problem which must be faced not only in human terms but also in financial terms.

1. THE REGIONAL FORENSIC PSYCHIATRIC SERVICE

We recommend the establishment of a Regional Forensic Psychiatric Service to provide:

A A SERVICE TO THE HOSPITALS

- (i) In the medium secure unit;
- (ii) In the minimum secure unit;

B A SERVICE TO THE JUSTICE DEPARTMENT

- (i) In the courts;
- (ii) In the prisons;

C A FORENSIC COMMUNITY SERVICE

- (i) For outpatients;
- (ii) Aftercare;

D A LIAISON SERVICE TO THE GENERAL PSYCHIATRIC SERVICES

- (i) Psychiatric hospitals;
- (ii) Community psychiatric service.

We recommend the establishment of five forensic regions centred on Auckland, Hamilton, Wellington, Christchurch and Dunedin. The Hospital Board / Area Health Board based in each of those cities will be responsible for establishing and administering the service in its region.

The boundaries of each of the five regions will be determined by the Hospital Boards / Area Health Boards in consultation with the Director of Mental Health.

We recommend that the regional forensic psychiatric service be fully established and in operation not later than 31 December 1991.

We envisage that planning, funding, staff recruitment and training and the provision of facilities will proceed at a rate which will ensure the development of a comprehensive service by that date.

(i) Administration and Staff

We recommend that each regional forensic service be headed by a Director of Forensic Services who will be accountable to the Director of Psychiatric Services. He/she will be responsible for the establishment of a multidisciplinary team in adequate numbers so as to provide a high quality forensic service. He/she will also be responsible for ongoing in-service education of staff.

We recommend that the Director of each regional forensic service be granted an adequate annual budget to ensure the development and maintenance of a high quality forensic service.

That budget will be negotiated with the Director of Psychiatric Services.

We recommend that male and female staff be employed in the regional forensic service and that they work on a rotation roster so that time is spent in all sectors of the service, i.e. the medium secure unit, the minimum secure unit, courts, the prisons and the community and liaison services.

We recommend that multidisciplinary teams include people with professional qualifications in psychiatry, psychology, nursing, social work, occupational therapy and physiotherapy and people who are skilled in taha Maori or other cultural perspectives appropriate to the population being served.

We recommend that staff in the regional forensic service be encouraged to participate in control and restraint technique courses.

(ii) Patients

We recommend that patients be referred to the regional forensic service from the following sources:

1. community psychiatric services;
2. general psychiatric services;
3. the prisons on the recommendation of the prison medical officer;
4. the courts;
5. the National Maximum Security unit at Lake Alice.

We recommend that entry into all sectors of the forensic psychiatric service be determined by the multidisciplinary team on the basis of clinical assessment.

We recommend that a register be kept of all patients in the care of the forensic service. The register will record information regarding:

- (a) location of the patient within the service;
- (b) mental state of the patient;
- (c) current management of the patient.

Registration of a patient will occur when he/she is first admitted in to the forensic service and will be

updated at six monthly intervals and on those occasions when the patient moves to another locality or facility.

We recommend that access to the register be restricted to forensic service staff, the Director of Mental Health and to those persons who are entitled to access through formal legal processes.

We recommend that all patients who enter the regional forensic service be cared for and treated in the least restrictive circumstances possible.

We recommend that, wherever possible, the same clinical team should care for the patient through the various stages of residential and community treatment.

We recommend that a key worker be allocated to each patient admitted to the regional forensic service.

The principle function of the key worker will be to provide support for the patient, to plan a treatment programme in consultation with the patient and other members of the multidisciplinary team and to liaise with the patient and the multidisciplinary team.

We recommend that an agreed patient transfer to or from a sector of the regional forensic service be undertaken on a trial basis for a period of eight weeks.

If during that period the patient's condition deteriorates, the patient may be returned to the facility or service from whence he/she came.

We envisage that the decision whether to return a patient will be a collective decision following consultation, assessment, negotiation and review between each clinical team involved in the care of the patient.

2. MEDIUM SECURE UNITS

We recommend that two medium secure units be established in Auckland, one in Hamilton, one in Wellington and one in Christchurch.

Each unit will consist of 15 beds with provision for two additional "emergency beds".

We recommend that the need for a medium secure unit in Dunedin be kept under review.

We recommend that each medium secure unit be stand alone, and purpose built and designed so as to achieve physical security for the patients but in a way which is neither all-pervading nor counterproductive to effective treatment.

We recommend that professional consultants be employed to advise on the design of the unit and the furniture, furnishings and interior decor of each unit.

We recommend that during the planning phase of medium secure units there be wide consultation with design personnel, nurses, psychiatrists and other para-medical staff.

We recommend that medium secure units offer specialized assessment, treatment and rehabilitation to carefully selected patients. These patients will:

1. require treatment in varied and adjustable levels of security as identified by each patient's individual needs;
2. will benefit from an intensive and carefully planned programme of care ranging from several weeks to approximately two years;

3. will not be considered an immediate danger to themselves or to the general public should they absent themselves without permission.

We recommend that medium secure units admit male and female offender and non-offender patients who do not require maximum security but who nonetheless are not suitable for treatment under the open conditions obtaining in psychiatric hospitals.

Such patients will be those who are severely disruptive, who exhibit dangerous behaviour, who may be mentally ill or mentally handicapped or who suffer from psychopathic or severe personality disorder.

We recommend that the staff to patient ratio in medium secure units be negotiated in the range of 2 to 2.8 nurses for each patient.

We envisage that appropriate architecture and electronic security will complement the staff levels to ensure a high level of security.

We recommend the development of non-repressive and non-punitive programmes by staff working in medium secure units.

Such programmes will take into account the age, intelligence, previous education and psychosocial background of the patient as well as the extent to which his/her potential has been impaired by mental disorder. Attention will need to be given to the ethnic and cultural background of the patient.

All caring and treatment programmes in the units will be the outcome of study and conference between patient and ward staff.

3. MINIMUM SECURE UNITS

We recommend that an audit be undertaken by the regional forensic service to determine the number of minimum secure units required in New Zealand.

Pending that audit, we recommend that units be established in Auckland, Hamilton, Wellington, Christchurch and Dunedin.

The units must not be isolated either from the general population or hospital services and will cater for not more than 30 patients each.

We recommend that minimum secure units cater for that group of mentally disordered persons who may not be willing to accept care voluntarily but whose conditions may not be treatable except on a long term basis and who could not cope adequately if discharged from hospital.

This group will contain the socially inadequate for whom the concept of "asylum" is still valid. It will also include some people who are too disruptive to manage in the community or in the general psychiatric hospital.

We recommend that long term active rehabilitation programmes be undertaken in minimum secure units.

4. PRISON SERVICE

We recommend that the forensic service in prisons be conducted on an outpatient basis. Inmates will return to the prison wing following treatment.

We recommend that the forensic facilities in prisons include some or all of the following:

1. an administration office;
2. individual interview rooms;
3. large all-purpose rooms;
4. occupational therapy centre; a large room for leisure skills programmes; flat including kitchen,

bathroom, toilet and bedroom for living skills;

5. school room and library.

The numbers and size of each facility will be determined in the main by the prison capacity.

We recommend that respite beds be made available to the forensic service in the prison hospital wing. If a prisoner requires continuing treatment beyond three days he/she will be transferred to a psychiatric hospital.

We recommend that forensic service staff in the prisons be additional to other health care staff. The forensic staff will comprise members of the multidisciplinary team and invited kaumatua and cultural advisers.

We recommend that prison superintendents be given an unfettered discretion in deciding whether a prisoner may participate in programmes conducted by the forensic service in the prison.

We envisage that this discretion will be exercised after consultation with forensic service personnel.

We recommend that prison officers be rostered to work in prison forensic units to gain experience in the general aspects of forensic psychiatry including nursing techniques.

We recommend that the regional forensic team be authorized to make recommendations to the Prisons Parole Board regarding the post release care of any prisoner in the care of the forensic service.

We recommend that only those prisoners in the care of the regional forensic service will be entitled to after care following release from prison.

5. COMMUNITY AND LIAISON SERVICE

We recommend that a comprehensive community service be developed as part of the regional forensic service.

There will be a need for cooperation and integration between the community and forensic psychiatric services.

We envisage that patients discharged from the forensic service will use the general facilities available in the community and that the forensic service will care for and treat those patients who need intensive follow-up.

We recommend that the regional forensic service develop hostel places for the rehabilitation of mentally ill offenders in to the community.

We envisage that these hostels will be used to rehabilitate the more disturbed, socially inappropriate patients on a step by step basis with a view to eventual discharge in to the community.

6. FUNDING

We see no real or immediate prospect of Hospital Boards/ Area Health Boards being able to fund the forensic service we have proposed.

We recommend that there be a direct allocation of Government funds over a three year period to meet the capital costs of planning and establishing the medium secure units, the minimum secure units the facilities in the prison service and the facilities in the community forensic service.

We recommend that the cost of running each regional forensic service be funded by a direct Government allocation to the appropriate Area Health Board/ Hospital Board for a 3 year period ending 31 December 1991.

7. TRAINING

We recommend that there be consultation between the Director of Mental Health, the Royal Australian and New Zealand College of Psychiatrists and psychiatric academic units to determine the content duration and implementation of a specialist training programme for forensic psychiatrists.

We recommend that overseas personnel experienced in forensic psychiatry and in the planning, establishment and management of forensic psychiatric services be invited to New Zealand to advise on suitable training programmes and the implementation of the forensic service in this country. Ideally some personnel would have skills in teaching control and restraint techniques.

We recommend that New Zealand personnel visit established overseas forensic services to develop clinical expertise in all aspects of forensic psychiatry.

We envisage that those persons would be bonded to work in the New Zealand forensic service for an agreed period on their return.

The bond would include an obligation to train New Zealand staff.

The selected personnel will include psychiatrists, senior psychiatric registrars and clinical nursing staff.

8. FOLLOW UP

We recommend the appointment of a Commissioner to liaise with the Hospital Boards/Area Health Boards in planning and establishing the regional forensic psychiatric service. That appointment will be for a three year period ending 31 December 1991. The qualifications of the Commissioner have been referred to in Part 1 of this report.

We envisage that the Commissioner will carry out his/her duties in an unobstructive and supportive manner and will make sure:

1. that action is taken to ensure that a high quality, comprehensive forensic psychiatric service is operating not later than 31 December 1991;
2. that inappropriate action is not taken by Hospital Boards/Area Health Boards;
3. that tagged Government funding for the capital and running costs of the forensic service is spent for the purposes for which it is allocated.

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PART 4: COMMUNITY CARE

BACKGROUND

In his paper entitled, The New Zealand Lunatic Asylum; Conception and Misconception, Warwick Brunton of the Department of Health describes the history of the development of the lunatic asylum from the mid nineteenth century in New Zealand. He identifies the 1876 change in funding and administration of the eight asylums as being significant in leading to a rapid increase in admissions, as the result of what Max Abbott (1987) describes as, "a strong tendency to throw every case that could be brought within the general definition of insanity off the local wages and into the general taxation of the colony."

Asylums were initially viewed to be humane and effective alternatives for the mentally ill to the workhouses, poverty, and other consequences of the industrial revolution. They were small, and fostered a home-like environment where patients were cared for with paternalistic affection, which nonetheless allowed for a quality of life some people had not been able to achieve in the wider community. They developed an optimism in the care for the insane, and examination of the papers from the asylums relating to this period of time shows that this optimism was well placed. (Brunton 1987)

Because of the prolonged economic depression, and reorganization of social services in the mid 1870's, the eight asylums were taken over by the Government. At the same time, there was a dislocation of the asylums from other hospitals and charitable trusts. All asylum patients were committed by court order, and the asylums had no alternative but to accept patients who were refused by other facilities. The psychogeriatric, the mentally handicapped, and patients with other conditions which were difficult to control and manage, were admitted.

Many of these patients were unsupported by family or community networks. As the burden of home care for the poor became intolerable in a time of economic depression, many people were committed to the asylums by their relatives. The asylums, which had been humane and effective alternatives for the care of the mentally ill, became large, physically isolated institutions which were little more than great crowded warehouses of despair.

In the early 1900's, over 90% of the patients were deemed incurable, and, at the peak of institutionalization, 499 per 100,000 of the general population were inpatients (Abbott 1987). The community attitude was one of suspicion and fear, and as a response to demands from the community, new institutions were placed in isolated areas, and had higher walls.

Periodic public outcry about deplorable conditions set the stage for deinstitutionalization. Other significant factors that helped the process were:

- the recognition that hospitalization labelled a group as separate; produced stigma, fostered chronicity and promoted symptoms and interactions based on the sick role;
- the introduction of antipsychotic drugs, which alleviated many distressing psychotic symptoms;
- the civil rights movement questioned whether it is ethically permissible to lock people away for the rest of their lives (Diamond 1987);
- better pay, training, and working conditions for hospital workers, which forced improved standards and expectations of better care, and elevated the cost of running the asylums; and
- the international development of a trend towards deinstitutionalization, the movement of the care of the mentally ill into the commu-

nity, and closure of the large hospitals.

The Joint Commission on Mental Illness and Health was formed in 1955, and its recommendations for community alternatives to state hospitals were published in 1961. As a result of these recommendations, patients who formerly would have been hospitalized for prolonged periods were able to return to the community following a relatively short stay in hospital. Parliament ensured that the mentally ill should be treated in the least restrictive setting, and the criteria for involuntary hospitalization was tightened. (Mental Health Act, 1969)

Although the emphasis on community care did not come into prominence in New Zealand until the 1970's, patient numbers have decreased since 1945. For the first 20 years from 1945 to 1965, inpatient numbers reduced from approximately 500 to 400 per 100,000. During the past 20 years however, they have dropped more dra-

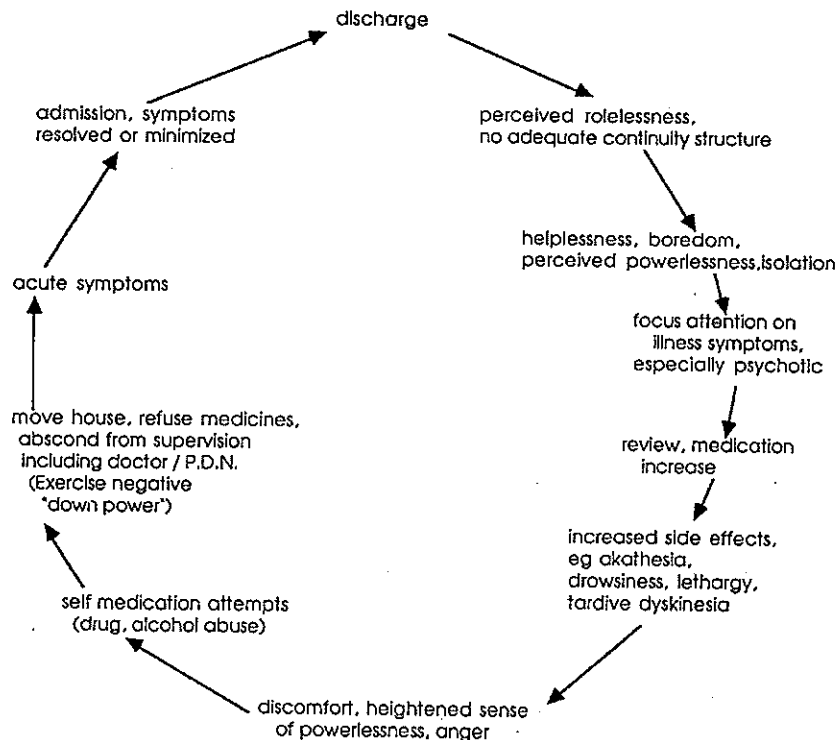
matically, to approximately 200 per 100,000 in 1984. This reduction of inpatient numbers is comparable with changes in many other western countries but less than that of the United States. (Abbott 1987).

A new pattern of management of psychiatric patients has emerged. We now have a significant number of discharges back into the community and a high readmission rate to the psychiatric hospitals (See Appendix 1). In 1979, in New South Wales, more than two thirds of all admissions were readmissions. The experience at Carrington Hospital, especially those wards which serve the central city, has been similar.

Therefore, although bed numbers have dramatically reduced, this has not been because of fewer patient admissions but rather because of dramatically shortened hospital stays. The average stay is now less than one month.

FIGURE 4

THE REVOLVING DOOR CYCLE



THE REVOLVING DOOR

The phrase, 'the revolving door', has been developed to describe the group of patients who repeatedly return to hospital. Often, hospital staff become dispirited by this pattern of simply placing band-aids on those who need more intensive care, but for whom they can provide little more than a brief respite. Dr Chris Wareing, of Auckland, describes the consequences of this as,

"(a) a feeling of futility with subsequent decline in morale;

(b) an awareness of the need to provide more community supports, as learning experiences in the hospital do not generalize to the community;

(c) concern at the ethics of acute symptom suppression when symptoms are a signal of the need for further supports and insignificant life styles;

(d) a lowering of expectations on the part of both the staff and the patients in spite of everybody's best efforts with adverse consequences for treatments and coping skill effectiveness."

The consequences of deinstitutionalization are that:

- large numbers of persons have been successfully treated with appropriate short stays in hospitals, or without hospitalization at all;
- significant numbers of persons who have been in hospital for prolonged periods have been successfully discharged from hospitals;
- many patients and former patients have been less than successfully discharged into the community, resulting in unsatisfactory standards of living and readmission; or in offending against the law leading, not infrequently, to imprisonment.

Often families and friends are concerned as to what will happen when a patient returns home. They are sensitized at the disruption caused by acute episodes, and the unspoken thought, "when will he/she do it again", prevails. (Hoult 1983)

As the needs of the patient exceed the coping capacity of their friends, relatives and social networks, the patients drift into supervised boarding homes or rest homes. These may be in suburbs away from their own support networks, and often in the absence of any support programmes or treatment programmes attached to

the boarding houses.

Patients may therefore be alienated from friends and familiar surroundings, and have the daunting task of establishing new relationships in a new environment at a time when their disability makes them poorly equipped to do so. Treatment provided by the outpatient service is often restricted to medication and nursing follow up, and any other activities are left to the patient's own initiative. This lack of support, and dislocation from the networks that had helped them in the past soon results in deterioration and relapse of illness, often leading to readmission.

This in turn undermines the patient's confidence in the health services, and in him/herself. So he/she becomes trapped into the revolving door cycle, and the psychiatric disability then becomes well established and permanent.

SPECIAL PATIENTS OR ALL PATIENTS?

In relation to psychiatric care after discharge we were faced immediately with the question as to whether it was appropriate, or even possible, to single out special patients as a class.

The Mental Health Foundation enunciated the problems involved in attempting to isolate the special patient. They pointed out, first, that, "special patients are a homogeneous group only in that they share a legal status. In terms of psychiatric diagnosis or behavioural patterns, they do not necessarily have much in common. They have all, at least once, committed a crime, but so have many other psychiatric patients (and citizens in general). When a psychiatric disorder is thought to be relevant to a crime, consequences can include no action, informal admission, committal under various legal sections or imprisonment. On the other hand, there are many prisoners who would be regarded as suffering from psychiatric disorders who never come into contact with psychiatric hospitals for one reason or another."

Second, there is what they referred to as an element of arbitrariness in the selection of special patients. A patient with a previous history of offending is more likely to appear before the

court irrespective of the presence or absence of symptoms of psychiatric disorder. A patient with a previous history of psychiatric disorder would be more likely to be placed in a psychiatric institution despite the criminal offence which had brought him/her to attention.

The Mental Health Foundation included institutionalized racism in the list of factors they considered influenced this arbitrary allocation of patients to the process which would label them either special patient or civilly committed patient. Maori were more likely than non Maori to appear before the courts and become special patients

Our terms of reference require us to look at the adequacy of psychiatric care and the provision of community facilities for special patients following discharge. We are aware of no community mental health facilities specifically for patients of one legal status. We therefore decided to examine the psychiatric care and community facilities available to all psychiatric patients.

SHOULD WE DISCHARGE SPECIAL PATIENTS?

The second question that needs to be addressed, because it is posed by sections of the public, is whether special patients should be discharged at all? Behind this question lies the prevailing fear of dangerousness and violence. (See Appendix 2) Having a history of violence is not a feature of all special patients, nor is it exclusive to special patients. Only a small number of psychiatric patients present in a dangerous way. Psychiatric patients without a history of offending are no more likely to offend than the average citizen. Furthermore, the ability of psychiatrists and mental health professionals to predict dangerousness is very inaccurate. If a clinician over-predicts, too much emphasis may be placed on detention for the safety of the public, and in the process the civil liberties of the patient may be severely infringed.

Research indicates that quality follow up in the community after discharge can lower the rate of reoffending. (Bowden 1981 and Acres 1975) We have no doubts that special patients should be eligible for discharge as is the case for all other patients.

COMMUNITY VIEWS

Mary O'Hagan, of Psychiatric Survivors, gave us a compelling description of what it is like being a psychiatric survivor within the community. She described the frustrations of attempting to set up self help initiatives in the absence of cooperation and support from either the health professionals or the community.

"I went to a meeting in South Auckland in the middle of the year. The residents were objecting to the Kingseat House being in their street and they were an ordinary, upwardly mobile sort of middle class street. I went anonymously, I did not say who I was until the end. There were a couple of Kingseat people there too.

The people were saying things like, 'will you make sure they are locked up at night', and, 'are they going to be allowed to walk in

the street unescorted'. 'They have caused a lot of trouble sitting on the footpath, standing by the gate.....' and these sorts of things. One person said, 'why not put the patients in the country where they cannot hurt people and where they have room to wander'; and one said, 'our kids will be unsafe. Why should we have to go outside every minute to check on them?'. Then another thing that was said, was, 'why do these people have to come here. We are all middle class people and we have worked hard for what we have got. Our houses will go down in value and we will be lucky to sell them'."

The general population appears to have a very distorted image of psychiatric patients. This image is influenced by a lack of education and knowledge of the major psychiatric disorders, and a misconception that psychiat-

ric illness is inextricably linked with dangerousness.

The lack of education is compounded by a source of unintentional education. As Professor Paul Mullen of the University of Otago comments, crimes and events involving psychiatric patients that are reported in newspapers are those which are frightening, and which develop some degree of notoriety. These may well achieve the purpose of selling newspapers but do not give a fair representation of the numbers of psychiatric patients who are supported in the community without catastrophe. Therefore the public develops the perception that psychiatric patients are too dangerous to be maintained in the community.

Psychiatric Survivors also believed that the media, in emphasizing the spectacular and notorious, were instrumental in perpetuating the public paranoia that they perceived existed. The consequence of this paranoia is the sense that psychiatric survivors are being shut out;

"...we are shut out of jobs, accommodation, money, all sorts of opportunities."

Coupled with this distorted view of people with psychiatric illness, the public has a well developed faith in the ability of health professionals to provide the necessary care. Psychiatric workers are perceived as committed, concerned people, who have both the skills and the responsibility to provide care for the mentally ill.

In their paper, Green, McCormick, Walkey and Taylor (1987) re-examined the findings of an earlier study looking at the attitudes of the community towards the mentally ill, the care given to the mentally ill, and the role of the community in this. Their paper examines attitudes over the 22 year period from 1962 to 1984, and draws the conclusion that mental patients are perceived in strongly and persistently negative ways, and the health professionals are perceived in the ways outlined above.

"The present authors consider it a rather sad commentary that community attitudes

towards the mentally ill have not changed over this substantial period of time. Until those attitudes do improve, the prevailing political and professional trends towards deinstitutionalization and community care are unlikely to succeed. At best, the large institutions might be abandoned and the patients placed in more conveniently located new and smaller institutions. Schemes

for integrating patients into the community will only succeed if the community has the desire, the confidence and the skill to show care and concern for them."

"Professionals... can no longer rely on the comforting assumption that the modern community is more enlightened and more tolerant about mental health matters than in the past. Instead they will have to accept the fact that fears, ignorance and inadequacies of various kinds still prevail. The one bright spot from the research is that the attitude of the community towards the 'ex-mental patient' remains steady. The implications are that once the mentally ill have recovered, the community can still be prevailed upon to play a bigger role in their rehabilitation than before."

Mental Health workers, both in New Zealand and in the United Kingdom, have addressed this particularly troublesome issue of community attitudes. On occasions community initiatives have been stopped, or blocked for lengthy periods of time, by community groups using the planning processes of local government to prevent the development of initiatives in the vicinity of their community. Health workers have therefore developed strategies for anticipating and coping with this expected opposition.

In Dunedin, in a process that has been successfully adopted, a community facility is set up and established before consultation with the local community, in much the same way as the establishment of any other home proceeds without notification to the community at large. Once group homes have been established, the

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key worker for those homes then visits the immediate neighbours. They are informed about the reasons for establishing the group homes and generally they are "put in the picture". They are given the opportunity to ask questions and are invited to meet the new residents. The key worker gives a contact telephone number to the neighbours who may, at any time, ask for support and information should they have any concerns. Calls will be taken at either office or home. The consequence of this approach is that no inappropriate complaints to the key worker have been received over a period of more than 12 months, and in fact the neighbourhood communities have regularly visited and supported the residents of the group homes.

When community facilities for psychiatric patients were being planned in the Exeter region of the United Kingdom, the planners made a decision not to approach the community en masse, but rather to deal with the community in the immediate vicinity of the planned facili-

ties.

Their experience showed that when small localized groups of people are given information and then approached for support, the results are better than those achieved from the collective, impersonal structure of large community meetings. The development of community services in both Southampton and Exeter has proceeded very successfully, without developing the negative consequences so feared by the community at large in New Zealand.

The various techniques outlined above attempt to cope with the reluctance of the community at large to accept a degree of responsibility for the support of mentally ill people in any setting other than hospitalization. The discharge of patients into the community is well established, and continues to increase in New Zealand. The ambivalence of the general community must be acknowledged and incorporated into any planning for community based psychiatric services.

RESULTS OF INQUIRY

A. COMMUNITY CARE AND THE PROVISION OF FACILITIES IN NEW ZEALAND

In conducting our Inquiry, we attempted to examine the range of community facilities in each region. As described, we have elected to expand our examination to include adequacy of care and provision of facilities in the community for all patients, not only for special patients. In each area, we attempted to inform people of this change.

The public notices we published contained the Terms of Reference only. We realize that some people may not have given evidence to us as they may have been unaware of the expanded nature of our Inquiry.

Time constraints were such that we were able to examine representations only of the service. We did not see all facilities. The following account is a representation of the range of facilities described to us in each area.

IN THE REGION ADMINISTERED BY THE AUCKLAND HOSPITAL BOARD

The region administered by the Auckland Hospital Board is divided into several catchment areas.

Community Mental Health Centre

In the Northern catchment, the Community Mental Health Centre operates from a house in Auburn Street, Takapuna; and a volunteer based mental health network operates out of a Board owned house adjacent to the North Shore Hospital. In the Eastern catchment, the Community Mental Health Centre functions from Cornwall House in Greenlane, and the Ponsonby Care Centre. The Ponsonby Care Centre also functions as a community support unit for former patients at Carrington. Maranga House in Mt Eden is being developed as a Community Mental Health Centre; Taniwha Street in Glen Innes offers limited community support facilities. In the Western catchment, the Community Mental Health Centre operates from houses in Henderson, Point Chevalier and Mt Albert.

In South Auckland, the Cottage in Otago provides a day unit, rapid assessment service and liaison psychiatry. The Papakura Day Clinic operates as a Community Mental Health Centre, and a limited day hospital has recently opened.

The Community Mental Health Centres were set up to provide outpatient psychotherapy and follow up services, mainly prevention and brief psychotherapy. Most units provide more than one service, incorporating these functions with day treatment centres and community support centres.

Accommodation

Hostel accommodation for 44 inpatients is provided close to Carrington by the Baptist City Mission. Two half way houses exist on the Carrington site. Rangimarie, in Ponsonby, is a 19 bed hostel owned by the Board but leased and operated by the Baptist City Mission. Two three-quarter-way houses are operated in Papakura from Kingseat Hospital.

The Social Work Department at Carrington Hospital also support several patients in group homes, where they are placed on a longterm basis in small groups and are supported by staff working out of the hospital. We were able to

visit several boarding houses run by the private sector for psychiatric patients. These were generally run down and dirty, with a paucity of programmes for patients to rehabilitate and develop their living skills. It appeared that the owners of the boarding houses had a vested interest in not developing these programmes, and in maintaining a level of dependence that required the patients to continue living within the facilities provided.

Occupation and Leisure

Some programmes in the community are run by the Framework Trust. There are sheltered workshops, often run by voluntary and private agencies; and a market garden scheme. These programmes are not sufficiently individualized to maximize patients' skills or gains, and some have a finite time of attendance which does not take into account the need for lifelong support for some patients.

The range of facilities available in the Auckland area for occupation and the development of leisure activities was described to us both by providers and consumers as being woefully inadequate. An added handicap to the development of these services is the limited number of professional staff working within the community. So long as limited staffing persists it will not be possible to develop new services or facilities.

In its submission, the Mental Health Services, an Auckland group, state that no catchment as yet contains a complete range of services, and they identify the lack of beds, particularly in the South and East catchments, as being a problem. Outpatient services are described as being inadequate and congested, and many crises are not dealt with promptly. This is an opinion shared by Mary O'Hagan of the Psychiatric Survivors, the Mental Health Foundation, the Manager at Kingseat Hospital, and Judith McKenzie, Chief Social Worker for the Auckland Hospital Board. Both providers and consumers of the service felt that community programmes are few and poorly supported, and as a result, deinstitutionalized patients living in the community do so without treatment, thereby ending up in urban ghettos or finding their way into the criminal justice system.

Despite the skill and the commitment of the providers of health care in the community, an

inadequate service exists in the Auckland region.

Proposed Developments

We were presented with a variety of submissions outlining proposed developments and the provision of aftercare facilities in the Auckland region. The Mental Health Services in Auckland and the Auckland Hospital Board gave us copies of strategic plans which aim at developing community mental health centres, day hospitals, and residential care in hostels within the community over a defined period of time. The closure of acute beds in Carrington Hospital was incorporated into these plans.

Similarly, in South Auckland, we were told that plans for the development of treatment facilities within the community are proceeding, with the resultant closure of acute inpatient beds in Kingseat Hospital. The care of the acutely disturbed and the dependent revolving door clientele was identified as a priority for the development of community care in South Auckland.

It is proposed that the large Auckland region be split into four smaller localities and that services be developed within each of these localities. These services would incorporate 24 hour 7 days crisis intervention, a community mental health centre, a day treatment centre, a community support unit, hospital beds as required, and some residential accommodation in the community. These changes are aimed at efficient care delivery, interaction between the services and continuity of care for patients.

Initiatives towards the Maori Community

He Putea Atawhai in Swanson, the Whare Paia at Carrington, and a very active whanau of Maori workers attached to Kingseat Hospital, are three identifiable Maori mental health groups in Auckland. We discuss these more fully in Part 5 of this report.

IN THE REGION ADMINISTERED BY THE WAIKATO HOSPITAL BOARD

The Waikato Hospital Board provides no aftercare facilities and, at the time of our visit, had no commitment to do so. The Board supports the large psychiatric hospital at Tokanui, and also has psychiatric units based in general

hospitals in the region. Tokanui Hospital is administered independently of the community services. This is reflected in a dislocation of inpatient services and aftercare services. There are no accommodation facilities for discharged patients in the region.

The District Psychiatric Nursing Staff has little contact with Tokanui Hospital, and patient follow-up in the community is therefore dislocated from the providers of inpatient services. The District Psychiatric Service is poorly staffed, and spread across a wide geographical area.

We were not informed of, nor shown, any day programmes which were available for patients in the community.

There was little evidence of any attempt to develop a bi-cultural perspective in the community. In Tokanui Hospital, a bicultural ward (Whai Ora) has been developed, and enjoys the support of the medical superintendent. This does not have outreach into the community, although the staff at Whai Ora ward were looking at that possibility. They believe they can be of real value in the community. However, they were reluctant to make this move as they were fearful that the resources available to them as an inpatient service would be cut off in the move into the community.

IN THE REGION ADMINISTERED BY THE WANGANUI AREA HEALTH BOARD

Psychiatric services administered by the Wanganui Area Health Board are unique in that they incorporate the National Maximum Security Unit at Lake Alice. This unit receives patients from all over New Zealand and therefore discharge from the unit is back to the hospital from whence the patient came. Aftercare in the community is therefore the responsibility of the psychiatric service of that region.

The Wanganui Area Health Board is developing a community based service. It has provided a 14 bed house, a community house and two halfway houses. It has also facilitated the development of community support drop-in centres, and runs a comprehensive outpatient clinic service. The Board also operates a rehabilitation programme, although this is not community based.

Despite this, it is clear from the evidence

given to us by patients, and the evidence of Dr T L Avery at Palmerston North Hospital, that the development of psychiatric services in the community in the Wanganui region still has a long way to go.

IN THE REGION ADMINISTERED BY THE WELLINGTON HOSPITAL BOARD

Psychiatric services in the Wellington region are sectorized into three communities; the Porirua basin, Wellington city and the Hutt valley. Inpatient services are provided by Porirua Hospital, by the psychiatric unit attached to Wellington Hospital, and the psychiatric unit attached to the Hutt Hospital.

Accommodation.

The accommodation provided by the hospital service includes a hospital/hostel in the community staffed from the hospital. Residential hostels and motel-type accommodation for those patients who wish to live independently is also available. The Richmond Fellowship also has facilities in the Wellington region. These are run independently of the health services.

Despite the range described above, there are limited accommodation facilities for ex psychiatric patients in the Wellington region. Patients and patients' representatives who appeared before us reiterated the pressing need for more accommodation. Attempts to establish group homes and facilities through the Housing Corporation and the Wellington City Council have been largely unsuccessful.

The Rehabilitation Service

The Rehabilitation Service is provided at Porirua Hospital for the regional psychiatric service. It offers a wide range of rehabilitation services, including programmes to develop social skills, and occupational skills aimed at equipping the recovering patient to re-enter the workforce. Patients who have been discharged from the hospital ward return to the Rehabilitation Services as day patients where appropriate.

Psychiatric District Nursing Service

A District Psychiatric Nursing Service operates in the Wellington region on a daily basis. It is poorly staffed, and nursing staff within the

service have large case loads. The quality of aftercare provided by the services is therefore severely compromised.

Outpatient Services

These services are provided at Porirua Hospital, Wellington Hospital psychiatric unit and Hutt Hospital psychiatric unit. In the Hutt Valley, outpatient services are conducted in medical centres in Upper Hutt and Wainuiomata. Hillview Community Service in the Hutt Valley provides an outpatient service and other community facilities, aimed at education and support of patients within the community.

There were no day hospital programmes in the Wellington region at the time of our visit. Patients may return to an inpatient programme on a daily basis if this is clinically appropriate.

Leisure Facilities

Facilities for leisure activities are largely provided by volunteers in the Wellington region. Although they are used mostly during office hours between Monday and Friday, some of the facilities are also open during the evenings.

Prison Service

A service is provided from Porirua Hospital to Arohata Women's Prison on a contract basis. A medical officer has been appointed to liaise with the staff in Arohata, and prisoners are readily transferred to the hospital when that is considered to be appropriate. The psychiatric service in the Wellington Prison at Mt Crawford is provided by a psychiatrist employed by the Justice Department. He is also employed on a part time basis at Porirua Hospital, and because of this dual role, transfers between the two institutions are readily facilitated.

Alcohol Services

A comprehensive treatment and rehabilitation programme has been developed in the Wellington region, under the umbrella of the community health services. The Bridge programme has a large and well developed alcohol and drug treatment programme. It also provides 100 residential beds, which form part of the psychiatric service.

Planning for the Future

The Wellington Hospital Board has recently appointed a committee to plan community mental health services for the region.

Maori Patients

No facilities have been developed in the Wellington region which specifically address the needs of the Maori community. The Inner City Mission, in conjunction with Te Ropu Taha Maori o Porirua is trying to establish a community based facility for Maori people. It is anticipated that this facility will have a dual purpose: the collection of data on the specific needs of the Maori people in the Wellington region, and the establishment and maintenance of health initiatives for the mentally ill Maori patient in the community.

IN THE REGION ADMINISTERED BY THE NELSON AREA HEALTH BOARD

The Nelson Area Health Board administers Ngawhatu Hospital. There is no prison in the region. Ngawhatu has had few special patients, and enjoys a close and supportive liaison with Porirua Hospital in Wellington in the provision of accommodation for such patients.

During the past decade at Ngawhatu there has been a systematic movement of patients into the community. Hospital staff have established and maintained many patients within the community and conduct a comprehensive rehabilitation programme which begins in half-way houses situated in the hospital grounds. In these houses, the patients are responsible for much of their self care, including cooking meals at the weekends and at breakfast time. Hospital staff work both in the hospital and in the community, and are therefore able to provide assistance and continuing care for discharged patients.

Social workers at Ngawhatu run a group home, where an active rehabilitation programme for younger patients is conducted.

During the day, residents from the group homes travel to the hospital for various activities and sheltered workshop opportunities. Younger patients participate in educational programmes.

There is no crisis intervention in the Nelson region, and out of hours services are provided

by an on-call medical roster at Ngawhatu.

Staff at Ngawhatu are aware of the need to develop bi-biculturalism in psychiatry, and are moving steadily in that direction. The medical superintendent, who is committed to this development, and his staff, have close supportive links with the local marae.

The Nelson Area Health Board has initiated encouraging moves in the provision of psychiatric services in the community, and has developed accommodation and other resources to support patients. While it is impossible to place a dollar value on resources which have been moved from the hospital into the community, it is clear that this system of patient care has had worthwhile benefits for patients and staff alike.

IN THE REGION ADMINISTERED BY THE CANTERBURY HOSPITAL BOARD

The Canterbury Hospital Board has been very active in developing a community psychiatric service. At Board level, there is a strong commitment to the development of this service, and funds have been made available for this purpose.

Accommodation

There is a well supervised group home system for patients run by the psychiatric district nurses. Many of these patients live in boarding houses and are visited by psychiatric district nurses.

"There is a clear commitment on the part of the Hospital Board, and the Medical Superintendent that provision of accommodation is the responsibility of the Health Services."
(Dr L Ding, Sunnyside Hospital)

Day Care Centres

Day care centres are generally based in local churches. Many are run by volunteers. It is intended that staff from the hospital will gradually be released to develop services within the community. Community volunteers whom we met told us that the pace of development was too slow and that financial resources were not readily available to them. A charitable trust, the Comcare Trust, has recently been formed. This Trust includes community members and Hos-

pital Board members on its Board. The aim of Comcare is to develop accommodation, and leisure and work related needs for the mentally disabled.

Other facilities in Christchurch include St Lukes Centre, a day centre run by volunteers; Step Ahead, a social network with group activities for younger people with chronic disorders; a drop in centre run by the Schizophrenia Fellowship; a craft centre run by the Methodist Central Mission; and Lincoln Road Community Help Centre which is supported by the Baptist Church.

The Christchurch Medical School runs a one year, part time course in community psychiatric care which is open to professionals and non professionals. One objective of the course is to share the skills and expertise of the medical school staff with those people who look after psychiatric patients in the community.

Psychiatric District Service

There are currently 18 psychiatric district nurses maintaining 720 patients in the community.

Occupational Therapy

An occupational assessment and intervention service is available which focuses primarily on the development of skills for independent living. Basic living skills, time management, work, leisure and recreation skills, supportive counselling, and symptom management, are included in the programme

Despite the comprehensive range of services and facilities described above, workers in the voluntary sector, patients and patients' representatives told us that the facilities in the Christchurch region were still inadequate. Some volunteers said that they felt unsupported by the hospital both in terms of financial support and staff support; and that workers within the voluntary sector were seldom consulted for an opinion about a patient who was attending their service.

Prison Service

A well developed liaison exists between the Sunnyside Hospital Psychiatric Service and the local prisons. The forensic psychiatrist at Sunnyside Hospital conducts regular clinics at the

prisons. Another psychiatrist employed by the Justice Department part time also works at Sunnyside Hospital on a part time basis. The psychiatric services in the prisons are viewed as needing extensive development.

Bicultural Community Service

The Christchurch Hospital Board employs a Maori Health Coordinator who is based at Sunnyside Hospital. One of her roles is to liaise with the Maori community. The Board is fortunate in having the support and experience of the only Maori Official Visitor in New Zealand, Mr Hohua Tutengaehe. Notwithstanding the influence of these two people, we saw no evidence of a bicultural dimension in the provision of services in the Christchurch region. Maori people whom we met at Rehua Marae told us that mental health services had little to offer Maori people and that they had little impact on the planners and decision makers in that area.

The provision of community services in the Christchurch region is therefore comprehensive and plans for development are well under way. The medical superintendent and his team based at Sunnyside Hospital are enthusiastic, and their commitment and impetus were supported at the time of our visit by the provision of bridging finance to assist in furthering community development.

IN THE REGION ADMINISTERED BY THE WEST COAST HOSPITAL BOARD

Seaview Hospital, in Hokitika, services the entire West Coast of the South Island, and community services have to cope with this large catchment area. There are no special patients or civilly committed patients at Seaview.

Domiciliary nursing support is available to patients following discharge. Medical supervision is provided at outpatient clinics. The region has two halfway houses. The hospital has several informal networks in the community, but some people in Hokitika have expressed concern that the town may have insufficient accommodation if the transfer of patients from the hospital to the community is too rapid.

IN THE REGION ADMINISTERED BY THE OTAGO HOSPITAL BOARD

In Dunedin, the Psychiatric Community Services Working Group was set up by the Cherry Farm Management Committee. This is a multidisciplinary group. Its objective is to promote and develop a coordinated community service, providing accommodation, special employment arrangements and improved liaison within the services; and to review the lines of communication between general practitioners and psychiatric services. It sees reliable case management for patients as essential to ensure that the patients' needs for continuing care are met in a consistent, coordinated way.

Outpatients, Daypatients and Occupations

The outpatient services in the Dunedin region are based at Dunedin hospital. These are comprehensive and well established. In the same facility, a day hospital has been developed for patients living in the community but who require intensive treatment. A 24 hour crisis intervention service is being developed. This is based in the hospital but has the flexibility to move into the community for management of crises.

A centre has been established and funded by the Otago Hospital Board which provides day care for psychiatric patients in the community. This is staffed by a multidisciplinary team, and the services provided by the unit range from a drop-in centre for patients through to organized and structured group programmes. Individual programmes are also available. Patients in this centre have now developed a work cooperative, which is successfully competing for work on a contract basis. The administration and day to day management of this cooperative has now been left entirely to an ex-patient group.

There is also a range of church-run voluntary agencies in the Otago Hospital Board region.

Psychiatric District Nursing Service

The Psychiatric District Nursing Service is based in the community, and employs 15 people. This service is available seven days per week from 8.00a.m. to 5.00p.m., although evening visits are possible. Patients are seen in their own homes. Nurses will also make visits during

crises, and function in both an assessment and management capacity.

Accommodation

The Otago Hospital Board maintains several types of accommodation in the community. These range from hostels supervised by the District Psychiatric Nurses, to group homes which are supported by the multidisciplinary team.

The Otago Hospital Board also operates a joint venture with the Otago and Southland Baptist Association. This venture is administered by a Trust Board. The Trust maintains 12 homes in Dunedin, and one in Mosgiel. Thirty patients, who were formerly patients at Cherry Farm Hospital, are now living in these homes, and by pooling their financial resources for rent, food and other expenses, they are able to maintain self-sufficient households. They are supported by paid staff of the Corstorphine Baptist Trust Board, some volunteers, mainly from church groups, together with back up services of Board staff from a variety of psychiatric services. The Corstorphine Baptist Trust, in our opinion, is an excellent example of what can be achieved when a Hospital Board cooperates with the private sector to establish and maintain accommodation for psychiatric patients and to provide occupational options in the form of leisure centres and rehabilitative workshops. The Trust maintains a staff independent of the Hospital Board. Staff wages are met in part by disability allowances from the Department of Social Welfare, rent from the homes, and staff salary subsidies.

Prison Service

Dunedin psychiatric services also offer a service to the Dunedin Prison, which is situated in the centre of the city. The service is provided by a consultant psychiatrist, who is on call. The medical superintendent or one of her staff will, on request, examine a prisoner in prison, and expedite transfer to the hospital if necessary.

Bicultural Community Service

We saw no evidence of community psychiatric services which were specifically aimed at the Maori community.

The Otago Hospital Board has its commu-

nity programme well established and is engaged in ongoing research and redevelopment to meet the changing needs of the community. The Board was the only one in New Zealand which was able to tell us what proportion of its annual budget is invested in community services. As Cherry Farm Hospital sends more of its patients into the community, funds from that

source are also redirected in to community care. Nonetheless, some workers and patients told us that, despite the widespread provision of services, these are not as well coordinated as they might be. It was suggested that an important priority for the development of services in the future would be coordinated management of services for patients.

B. MENTAL HEALTH FOUNDATION SURVEY

The Mental Health Foundation's national report on Community Mental Health Services for Psychiatric Patients, conducted in 1985 but not yet published, paralleled our examination of community services and facilities. Its results also paralleled our findings. Nowhere in New Zealand has the development of community services kept pace with the growing need that has resulted from deinstitutionalization. This was particularly so in Auckland, including South Auckland; Waikato and Wellington. The survey looked at each service.

(a) Day Hospital Services

Most Hospital Boards in the main centres had plans for day hospital services but these are still more a vision than a reality.

(b) Outpatient Services

Psychiatric outpatients is the oldest form of non inpatient service delivery, and dates back to the 1930's. Not surprisingly, such services are established right across the country. In most Board areas, there are insufficient services, the major problems being understaffing, long waiting lists, and short consultations.

(c) Psychiatric District Nurses

A Psychiatric District Nursing Service is available in all Board areas with a population of over 300,000, with the exception of Taranaki and Southland. This service was seen as insufficient. Consumers rated the psychiatric district nurses most highly in the survey. Some of the problems encountered by the district psychiatric nurses were heavy case loads, poor coordination with community agencies, including General Practitioners, and a restriction on the outreach hours for services, which further diminished their effectiveness.

(d) Crisis Services

At the time of the survey, there were no 24

hour outreach crisis services in New Zealand. Some areas were beginning to develop multidisciplinary crisis teams but these were usually hospital based and functioned for limited periods. In most Board areas, crises came to the hospital door, at times delivered by the police. Even in those areas where staff maintained that a crisis service was available, relatives and patients were poorly informed as to its availability. In rural areas, crises pose great problems, with the absence of responsive services compounded by the distances involved. A good liaison between General Practitioners and the psychiatric district nurses was seen as essential to handle crises.

(e) Sheltered Work Programmes

Sheltered work programmes of one kind or another were available in all Board areas with a population of over 100,000. There was a strong feeling that these were insufficient in number, and that at times programmes were used inappropriately. The current social reality of rising unemployment makes it particularly difficult for ex-patients to obtain work, and the closure of PEP and similar work schemes makes the situation even worse. The principal difficulty encountered with the programmes is that they are not specifically designed for people with psychiatric disorders, and staff involved in the

schemes often lack the required skills in this area. Many of these schemes are temporary, and respondents complained at the lack of collaboration between Hospital Boards, the Labour Department, and the Department of Social Welfare. The schemes are often poorly funded, and boring in the quality of work provided.

(f) Daytime Activities (Excluding sheltered work)

These are mostly available in centres with populations over 50,000. Often they are drop-in centres run by voluntary agencies, open for short hours and catering for a wide range of different needs. In the regions surveyed, they were seen as insufficient. The main problems were the lack of availability, insufficient staffing, role confusion with the local community psychiatric service, insufficiently trained staff, and a confusion as to who should be responsible for running this type of service. Many were situated in unsuitable buildings, often catering for a particular age range, which discouraged other population groups from attending.

(g) Housing

Specialized housing schemes catering for ex patients were often run by voluntary organizations. The need for more housing is seen as urgent, particularly in Auckland, Wellington and the Waikato; but also in many of the smaller regions. The most common reason for not developing services was lack of finance. There were many complaints about the lack of effective cooperation between agencies involved in housing. Many of the houses provided by voluntary organizations had too many occupants and did not necessarily provide a good service.

Foster schemes for ex patients, which, according to overseas studies have a demonstrated potential, are rare.

(h) Support Schemes

Support groups for patients are available in

nearly all regions but are often very tenuous. They were poorly coordinated and supported by psychiatric staff. Most were run by voluntary organizations, and by the patients themselves. Support groups for relatives were available in all regions, the Schizophrenia Fellowship being the major agency. Befriending schemes specifically for ex patients were rare.

(i) Barriers to Services

The study examined the barriers to provision of community services, and concluded that the most important barrier was inadequate

funding. Other important factors included shortage of mental health personnel, inadequate provision for continuity of care, and the lack of precise planning goals. Negative public attitudes to psychiatric illness and deinstitutionalization were also important factors. Poor coordination of resources, lack of research into effectiveness of community services, and inadequate dissemination of existing knowledge were contributing factors; as were the lack of both consumer input and community input

into decision making. There is a breakdown in cooperation from the Hospital Board level to community level, and a lack of cooperation with government departments and local bodies in the provision of care. A less important factor was the geography of the region, but lack of understanding of different needs, inadequate training of mental health personnel, and lack of inter disciplinary cooperation were also cited as major problems. Concern was expressed that if adequate funding was not available to support patients in the community this would result in a heavier burden being placed on relatives. This was seen as undesirable.

In summary, research shows that community mental health services for psychiatric patients are severely under resourced, despite the fact that deinstitutionalization is well under way. The point needs to be made that all areas are seriously under resourced, although

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Auckland, Wellington and Waikato are worse off than other areas. The lack of sheltered housing, daytime activities, and employment schemes is significant. The barriers to good care are not merely financial. Poor planning and lack of coordination of resources, some-

times stemming from the lack of cooperation between various groups concerned, present major problems. Sometimes it was not clear who had the responsibility to provide a particular service which then meant that no resources were channelled into that area.

ISSUES IN COMMUNITY PSYCHIATRIC CARE

The Mental Health Foundation states,

"Our view can be clearly summarized; we think that deinstitutionalization has not gone far enough, and neither has provision of community alternatives and after care. In a nutshell, the problem is not so much early discharge as discharge with inadequate follow up and inadequate provision for a suitable living environment and suitable activities."

Despite criticisms levelled at community mental health care, the evidence presented to us is consistent with evidence from other studies. Patients prefer community living; and even prefer substandard boarding house accommodation to inpatient care. It has been said that, in New Zealand, relatives and professional unions are opposed to deinstitutionalization. It is clear however, both from the evidence we heard and after examining the literature, that this is not the case. There is a marked unity in the belief that mental health services need to move more into the community. Houl's Australian study showed that relatives preferred good community alternatives. Campbell L (1987), cited by the Mental Health Foundation, showed that many relatives say they resorted to hospitalization only because there were no alternatives available. Moore (1987), cited by the Mental Health Foundation, described a similar positive attitude to community care.

(i) The Need for National Policy

The need for a national direction for development of community psychiatric services was emphasized by health workers throughout New Zealand. The Mental Health Foundation identifies national policies and guidelines in mental health as being fundamental to good community care.

Accordingly, it is our opinion that, unless development of these services is supported by both the Minister of Health and the Department of Health, and a clear description given of the nationwide components of a comprehensive mental health service, the uncoordinated services that currently exist in New Zealand will continue to persist. These services are the key

components of an effective psychiatric service for the mentally ill offender.

(ii) Need for Coordination of Government Departments

We received submissions from many people identifying the lack of coordination between government departments in the provision of services. In the absence of a stated policy, it appears each department is reluctant to commit itself to provide services beyond those which it is required by statute to provide. Consequently, many people fall through the gaps between poorly coordinated services, and remain unsupported.

Coordination of the services provided by

government departments is important if the needs of ex patients are to be met. Cooperation is required from all government sectors involved in the provision of services.

This intersector cooperation has been achieved in Napier, and has resulted in the development of a very good service incorporating the Department of Social Welfare, the Housing Corporation, and the Local Health Authority. We saw a community service which includes residential facilities, and daytime and outpatient facilities linked to the local psychiatric unit. Officials in both the Housing Corporation and the Department of Social Welfare were committed to this service. As a result of that commitment, a flexibility has emerged which allows this service to develop in a very creative way. We commend this as an example of good intersector cooperation.

(iii) Funding

We were repeatedly told that the amount of money being currently spent on community services is woefully inadequate. It is clear that there needs to be an increase in expenditure, and that this is urgent. This needs to be on two levels:

(a) bridging finance to enable the development of facilities before patients move into the community;

(b) an increase in the day to day budgets for maintenance of community psychiatric services.

Many people were fearful that funds would not follow patients into the community after closure of hospital beds. Many people who appeared before us believed that deinstitutionalization was a cost cutting device. Their fears were reinforced by the slow rate at which community facilities have developed. Unless resources accompanied patients into the community, they feared it would be impossible to develop and maintain a community psychiatric service.

Voluntary agencies asked for support from health resources, both in terms of funding, and support from health workers in maintaining their service. We were told that often volunteers felt obliged to provide services in the community as a consequence of inadequate funding for recognized social agencies.

(iv) Consultation with the Community

We were informed that community groups wish to be incorporated into the planning of services. In the past, consultation has generally been a one way process, with little incorporation of community groups into planning and monitoring bodies. Consultation with community groups needs to occur at the stage services are being planned.

Patient groups have asked that they be consulted and their views incorporated into the development and management process.

Groups which support patients and patients' relatives, (e.g. Schizophrenia Fellowship) also wish to have an input into the planning and maintenance of community services. These groups often find they are supporting patients and patients' families in the community without assistance from health services.

Members of the Maori community also spoke of their lack of impact in the development of psychiatric services, and criticized the monocultural quality of services being developed at the moment. While asking for bicultural services in all areas, the Maori communities are not asking for separate services. They wish to find a balance between the benefits of Western psychiatry, and the equally important benefits of incorporating Maori perspectives into services.

(v) Facilities

In all regions, community psychiatric facilities were found to be variably established, and experienced by patients, their families and community groups to be inadequate.

The lack of appropriate housing for the seriously mentally ill in the community was commented on by many people who appeared before us. There was debate as to who should be responsible for accommodation. The Mental Health Foundation claims that the Housing Corporation should be given statutory responsibility for the homeless. The Housing Corporation in its submission said,

"no patient who is under any psychiatric disability should be discharged from hospital inpatient care if he/she requires fulltime supervision on account of compliance with medical instructions and/or dangerousness."

The Housing Corporation does not see psychiatric disability as a priority factor when

deciding whether to allocate accommodation to a discharged patient. Its submission refers to a new policy which would allow more houses to be allocated for ex psychiatric patients, especially in areas of high demand such as Auckland and Wellington.

(vi) Patients' Incomes

At present, psychiatrically ill patients in the community are eligible for sickness/invalid benefits, but the level of these benefits appears to be too low to maintain even a subsistence standard of living. Patients with family commitments, or long-established financial commitments, find it difficult to make ends meet. Many fall into a poverty cycle.

Sometimes the control of finances in some areas is taken from the patient, and benefits are paid directly to the manager of the facility in which the patient lives. In such circumstances, the rights of the patient are compromised. Along with many others, we question the need for such practices, which often result in the continuation of disability.

(vii) Clinical Management

(a) Discharge Planning

Many submissions identified the lack of discharge planning as a key factor in the inadequate care of patients following discharge. The Richmond Fellowship, of Auckland, submitted:

"It is the lack of discharge planning, coupled with refusal of medical responsibility for crisis intervention in some areas, which has occasioned most of the post-hospital difficulties suffered by patients."

They suggested that a planned procedure for discharge be adopted, incorporating a trial period of frequent daytime and night time assessments over a wide range of normally expected social behaviour, and that this be the criteria for discharge from inpatient status. They also suggested that the health worker who will

provide ongoing care in the community should take part in pre discharge assessment, and that a written, signed agreement between the parties concerned form a contract for a trial period of discharge, the period to be clearly stated. The responsibility for immediate readmission to inpatient care is to be acknowledged by the discharging clinical team if, in the opinion of one of the three parties, that was considered to be appropriate.

"It is the lack of discharge planning, coupled with refusal of medical responsibility for crisis intervention in some areas, which has occasioned most of the post-hospital difficulties suffered by patients."

Dr Wilson Young, Deputy Medical Officer of Health at Takapuna, expressed his concern at the premature release of special patients into the community. He believed they were inadequately prepared, often had great difficulty adjusting back into society, and were inadequately supervised on release. He was concerned about the burden of work falling on the public health nurses and medical officers of the Department of Health as a result of poorly planned discharges of psychiatric patients.

Dr P R Lamb of Carrington Hospital identified the need to plan for discharge, and to incorporate into those plans all members of the patients network in the community as well as the treating team. His views were echoed by Judith McKenzie, Chief Social Worker in the Auckland Hospital Board. Miss McKenzie comments further that the hospital and community links must include the friends and family of the patient.

"For those individuals who have no significant family, hospital staff must take responsibility for initiating and developing those resources, both people and places, that will provide essential social support."

The Schizophrenia Fellowship described the difficulties encountered by patients and families because of the lack of support for the patient in the community. It was suggested that the family of a patient should be given adequate notice of his/her intended discharge. This would enable plans to be made well in advance for the return and management of the patient in the community. Written notification of the exact

conditions of discharge should also be given. The need for education, and for patients and families to get a clear understanding of the nature of the illness, were also identified.

(b) Key Worker

The Hutt Regional Community Services commented,

"The need for good follow up is paramount. The designation of one person to be the principle contact responsible for linking the discharged patient into appropriate accommodation, appropriate activities, and to ensure the person is in receipt of an income is essential. This manager needs to be a part of a team, some of whom are available on a 24 hour basis to provide both support to the worker and a back up service to the patient. The manager can only work effectively if the case load is not so high as to make him/herself unavailable, or that adequate time be unavailable to the patients. In addition, there needs to be accommodation, employment, leisure, and income facilities within the community for the manager to link the patient into."

They discuss the difficulties of transition from institution to community, and say that this transition must be gradual. They also identify the need for follow up on discharge as crucial. This view was widely expressed.

The New Zealand Police in their submission to us identified the need for a system which would provide control mechanisms in respect of patients who are reclassified from special

patient status and eventually discharged. They suggested a similar system to the parole provisions which apply to people released from a sentence of life imprisonment. That would require their reporting to qualified staff at regular intervals to facilitate up to date assessments of mental status.

The quality of rehabilitation programmes which prepare patients for discharge into the community was the subject of many submissions. The need for after care follow up was seen as being of paramount importance, as was the need to include networks and families in both rehabilitation programmes and after care.

(c) Readmission to Hospital

We received several submissions which pointed out the difficulty in obtaining readmission of a patient to hospital when his/her condition deteriorated. This pattern was variable from area to area, but was particularly noticeable in Auckland.

It appears to us that this difficulty is a direct consequence of the breakdown between hospital services and community services. If the services were integrated, a better service would be available to the community and :

(a) the factors leading to deterioration which then lead to the need for readmission will be minimized;

(b) as a consequence of (a), pressure on acute beds will be lessened as readmissions are prevented. Close coordination of staff in inpatient services and in community services will further facilitate this process.

SUMMARY

In our opinion, the barriers to good community care may be summarized as follows:

1. the absence of a national direction for the development of community psychiatric services, and a national policy which is clearly articulated by the Minister of Health and the Health Department;
2. the lack of coordination of government departments which provide various facets of care, and the apparent reluctance of government agencies to take responsibility for any service other than that which they are required by statute to provide;
3. lack of adequate funding; there needs to be,
 - (i) bridging finance which enables the development of community facilities before patients are discharged into the community; and,

- (ii) an adequate budget for the ongoing provision of community psychiatric services;
- 4. lack of consultation with patient groups; with community groups and with the Maori community in planning and implementation of services;
- 5. lack of management structures which would enable the development of initiatives and the incorporation of all participants within the community into these planning structures;
- 6. poorly developed facilities within the community as a result of factors (1) - (5) above; and,
- 7. lack of liaison and cooperation between hospital services and community services with regard to, (a) discharge, (b) continuity of care and, (c) readmission.

COMMUNITY PSYCHIATRIC SERVICES: VARIOUS MODELS

THE RICHMOND FELLOWSHIP

The Richmond Fellowship Inquiry, 1983, conducted in the United Kingdom and cited by the Mental Health Foundation, sets out the components of a community mental health service:

- "(i). The early identification of people in need;
- (ii) prompt assessment of the problem requiring help, repeated as necessary;
- (iii) prescription and long term supervision of medication;
- (iv) advice to patients and relatives about physical health and the management of positive and negative symptoms;
- (v) the provision of residential units providing for various degrees of shelter, support, and challenge, ranging from hospital wards through to staffed hostels and unstaffed group homes; from supervised lodgings to housing and bed sitters;
- (vi) a similar spectrum of day units, from day hospitals through occupational therapy and industrial therapy centres, to sheltered workshops or specifically created conditions in open industry;
- (vii) help with welfare rights and benefits, obtaining education, vocational training and decent housing;
- (viii) social clubs, dinner clubs and other forms of support during the leisure hours and weekends."

THE ROSIN MODEL

An Australian framework for comprehensive community mental health services was developed by Dr Alan Rosin, a Sydney psychiatrist. His essential ingredients are:

- (a) **Service Organization:**
 - 1. as local catchment area responsibility;
 - 2. integrating community and hospital mental health services in each area;
 - 3. provided in the less restrictive smaller scale;
 - 4. giving highest priority to serious psychiatric disorder; and,
 - 5. actively involving local consumers, families and self help groups in service planning and organization:
- (b) **Service Provision:**
 - 1. having 24 hour availability, rapidly crisis responsive, mobile;
 - 2. based on intensive home-based interventions;
 - 3. actively involving individual family or caretakers in informed decision making and care;
 - 4. giving consistent care by one multidisciplinary team with a personal case coordinator;
 - 5. providing ongoing rather than time-limited services; assertive rather than passive response services;

6. restoring personal, social and occupational skills and roles; community skills, vocational and leisure programmes;

7. providing a range of residential facilities, programmes and levels of supervision;

8. having local inpatient facilities under the same team where possible; and,

9. linking with local support services, e.g. housekeeping, welfare benefits, etc.:

(c) Cultural Provisions:

1. encouraging age appropriate life transitions;

2. encouraging extended networks, care and selfhelp groups; and,

3. ensuring access to services for ethnic minorities:

(d) Staff Provisions:

1. with assured stability of staffing levels;

2. providing a network between functional sub teams across regions;

3. giving career structures in advancement while still providing direct services and working in the community;

4. having continued retraining,

5. peer supervision, support and enrichment by multidisciplinary sub teams,

6. adequate secretarial and administrative support for each sub team,

7. adequate reorganization, recoil and recuperation time for staff and some variety of type of work, and,

8. close liaison with local community and voluntary agencies and engaging in cooperative projects with them:

(e) In Every Aspect of the Service:

1. making continuous non alienating participatory monitoring and evaluation of programmes;

2. negotiating, setting and recording clear goals, objectives and strategies, regularly reviewing their progress;

3. drawing on a coherent body of knowledge (i.e. theory and current research evidence) which inform our practice;

4. providing well documented, repeatable therapeutic programmes which have been adequately field tested, with clearly set out "how to do it one step at a time" manuals and audio visual aids.

MORRIS - EIGHT PRINCIPLES

Morris (1986), in a review of studies of programmes in community services for schizophrenics, demonstrated the gains resulting from well designed rehabilitation programmes, and commented on the need to combine new eclectic treatment with psychosocial interventions. She identifies Bachrich's eight general principles, common to successful modelled programmes:

1. assigning top priorities for the care of the most severely impaired;

2. making realistic linkages with other resources in the community;

3. providing out-of-hospital alternatives for all functions performed in hospital;

4. tailoring individual treatment to the needs of each patient;

5. tailoring programmes to the local realities, the community;

6. providing trained staff who are attuned to the survival problem of the chronically mentally ill in the community;

7. guaranteeing access to hospital beds when necessary; and,

8. generating continuous self monitoring.

MENTAL HEALTH COMMITTEE FRAMEWORK

In New Zealand, the report of the Mental Health Committee of the Board of Health, outlines the elements of a comprehensive range of mental health services, covering both the less severe mental health problems and the more severe. Their framework is:

- health education;

- health promotion;

- the early identification of people in need;

- prompt and comprehensive assessment;

- access to appropriate treatment;

- 24 hour crisis intervention services;

- the provision of residential units providing various degrees of shelter, support and challenge ranging from hospital wards through to staffed hostels and unstaffed group homes; supervised lodgings and supportive housing;

- a similar spectrum of day units from day hospitals through occupational therapy and industrial therapy centres, to sheltered workshops for specifically created conditions and open industry;

- help with social welfare rights and bene-

fits, obtaining education, vocational training, and suitable housing;

- advice to patients and relatives about management of the disorder concerned;
- provision of live-in temporary nursing and/ or home help, social clubs, and other forms of support during the leisure hours and weekends;
- for the intellectually handicapped, the availability of early training;
- for the elderly, mentally impaired, the integration of physical and mental health services.

With the seriously mentally ill, revolving door population, there seems to be an unmet need for simple, target oriented programmes designed to suit the individual. Suggested aspects of these programmes may involve:

- (a) personal care - presentation skills;
- (b) social and communication skills;
- (c) money management, shopping, budgeting;
- (d) transport, knowledge of community resources;
- (e) patients rights, civil liberties, and complaints procedures;
- (f) creative use of leisure time;
- (g) work skills and work co-operatives with the depressed employment market;
- (h) medication information.

PUBLIC SERVICE ASSOCIATION - FACTORS IN GOOD COMMUNITY CARE

The Public Service Association, Northern Region, Auckland Branch, identifies the following factors as being important in the provision of good community care:

1. respect for all aspects of the situation of identified patients, particularly as this applies to cultural issues;
2. one integrated service, with both hospital and community components for a defined population;
3. consistent care by one case manager;
4. a preparedness to go out to patients and relatives in a persistent and assertive but not

intrusive manner;

5. provision of intensive care in an acute crisis phase, and an extensive ongoing service where the acute phase is in remission;
6. help given in the person's living situation with as little disruption as possible to the person's social network;
7. 24 hour availability of service, easily accessible with fast response;
8. a range of residential facilities supported by a variety of rehabilitation programmes designed for the patient.

The aim of this service is to enable the patients to reach the highest possible level of good health and independence. Essential features are a place of safety to live, adequate nutrition, social contacts, adequate finance, rapid access to support services, purpose of activity, and medical services both physical and psychiatric.

TWO PSYCHIATRISTS

Dr D Antcliff, psychiatrist at Carrington Hospital states, "After assessment and treatment, high quality after care is vital to the maintenance of wellbeing. This needs to be very active, mobile and domiciliary based. It cannot depend on patients being motivated to come to the staff because motivation and initiative are often lacking in a post psychotic state. Staff must therefore be sufficient in number, flexible and mobile to seek out patients and provide support for them and their families over a long term."

Dr Robyn Hewland, psychiatrist of Christchurch, recommends that community based services be flexible, diverse and sensitive to cultural needs. There needs to be a paid statutory case manager, responsible for the individual's case care and programmed within local networks: a paid coordinator for neighbourhood and tribal group services and programmes: skilled assessment of the individual's needs and changing needs.

Essential features are a place of safety to live, adequate nutrition, social contacts, adequate finance, rapid access to support services, purpose of activity, and medical services both physical and psychiatric.

THE SCHIZOPHRENIA FELLOWSHIP

The Schizophrenia Fellowship identifies basic requirements for community services as being:

- a place to live;
- an opportunity to socialize;

- meaningful activity;
- medical services;
- money;
- 24 hour crisis intervention;
- support in the community in which the patient will live.

OUR MODEL FOR COMMUNITY PSYCHIATRIC CARE

We see community psychiatric care as the lynch pin of all psychiatric services, and as such it must be closely linked with those services, whether they are provided in hospitals or any other institution. At all stages in the development of a community care psychiatric system, including planning, implementation, and review of services, it will be essential for wide consultation to take place with union representatives, health professionals, patient groups, the Maori community, and other interested individuals and organizations. Our proposed service is aimed at early identification and recognition of patients' needs, and the provision of facilities and personnel to ensure a rapid response to meet those needs.

1. MANAGEMENT

(a) Within the Psychiatric Services

The Mental Health Bill currently before Parliament provides for the appointment of a Director of Psychiatric Services as management head of all psychiatric services. We agree with that proposal.

We have already recommended the establishment of a forensic service. We now propose that a community care service be established with its own independent management structure. This service will be directly accountable to the Director of Psychiatric Services, who will be accountable to the Chief Executive of the Hospital Board/Area Health Board.

(b) Within the Community Psychiatric Services

The Director of Psychiatric Services will appoint a Director of Community Psychiatric Services. This person will be head manager of a community psychiatric service. He/she will be responsible for the development, management and ongoing review of community psychiatric services in total and

the appointment of a multidisciplinary team which will be of adequate size to provide the range of services he/she wishes to develop within the community.

The multidisciplinary team will comprise medical staff, psychologists, physiotherapists, social workers, occupational therapists, nursing staff, a Maori health team and any other discipline the Director of Community Services considers necessary to develop an efficient service. The head of each occupational group will be appointed as an identified head of service. The heads of service, together with the Director of Community Services, will make up the management team. The Director of Community Psychiatric Services is overall head of the management team, and the heads of the various services will be directly accountable to him/

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her. Although the Director of Community Psychiatric Services is overall head of the team, it is envisaged that this team will function as an egalitarian multidisciplinary team, and that decisions will be made following debate and

consensus.

It is the responsibility of the heads of service to organize the service delivery for that particular discipline and the range of interventions appropriate to that discipline, after decisions have been made by the management team. In larger regions, this may involve the development of more and smaller multidisciplinary teams.

(c) Lines of Accountability

Staff will be directly accountable to the head of service, who is accountable to the management team and the Director of Community Psychiatric Services. The Director of Community Psychiatric Services is accountable to the Director of Psychiatric Services.

We envisage that multidisciplinary teams will function on a consensus basis, with supervision being provided by an identified leader of the team. Each team will be accountable to the management team.

(d) Funding

(1) Management within the Psychiatric Service

Development of a community psychiatric service will be dependent on adequate funding. This needs to be available in two ways:

(i) bridging finance to be made available to facilitate the development of services before patients are discharged from hospital; and,

(ii) an adequate budget being made available to the Director of Community Psychiatric Services.

We envisage that the Director of Community Psychiatric Services and the Management Team will be allocated a budget by the Director of Psychiatric Services as a part of the total psychiatric budget. That budget will be negotiated. The budget will be subject to regular audit by the Director of Psychiatric Services.

The budget must be sufficient to ensure the development and maintenance of an excellent service. In short, the quality of a community psychiatric service will depend on how much the taxpayer is prepared to pay.

(2) Management within the Community Psychiatric Service

Allocation of the budget will be the responsibility of the Director of Community Psychiatric Services and the Management Team. We envisage that the budget will be devolved as much as possible to support initiatives within the community and to develop new facilities and services as is considered appropriate.

(e) Reviews

There must be a clearly understood process of regular review. There will be internal and external reviews.

(i) There will be self review by the multidisciplinary teams of its own services, facilities, management and finances so as to ensure the maintenance of a high standard of service.

(ii) There will be an external review of the community psychiatric service conducted by the Director of Psychiatric Services. This review will be similar to that referred to in (i) above and will have a similar objective, i.e. the maintenance of a high quality of service.

The internal and external reviews will be carried out at intervals of not more than one year.

The external review panel, appointed by the Director of Psychiatric Services, should include a manager, a clinician, a representative of the community and/or consumer, a Maori member, and any other person the Director of Psychiatric Service considers appropriate to review the service.

2. PATIENT MANAGEMENT

All patients accepted into the community psychiatric service will be allocated a key worker, i.e. a team member. This key worker will be responsible for the primary care and planning of treatment programmes incorporating members of the multidisciplinary team, the patient and family, and any other community members it is seen fit to include. It will be a requirement that the key worker consult with the family and community members where appropriate. The

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key worker will be supported by members of the multidisciplinary team, who will be identified to the patient. Thus, in the absence of a key worker, the patient will know which staff members he can approach for knowledgeable help. The key worker will be responsible for ongoing support, assisting in arrangements for the individual needs of the patient, and liaison with government agencies. Where the patient is referred from an inpatient service, the key worker should ideally meet the patient prior to discharge to establish a therapeutic relationship, and in the event of readmission, the key worker should be incorporated into management while in the ward, albeit on a limited basis. The key worker will be incorporated into discharge planning, and will provide liaison after discharge with the inpatient service.

It is of the utmost importance that key workers do not carry a heavy case load. The quality of care they can give to individual patients will be determined by the amount of time they can give to that patient.

Key workers will be responsible for an identifiable case load. They may work in the community with voluntary agencies, and this work must be seen as a part of their case load and their patient case load amended accordingly. Similar lines of support and accountability described for the patient case load should develop for the agency case load. We see this movement of key workers into the community as being of great importance in linking the community psychiatric service into the voluntary initiatives in the community thereby providing support in the form of workers who bring knowledge, expertise, some training opportunities and perhaps some financial assistance.

3. FACILITIES TO BE PROVIDED

(i) Accommodation

A range of accommodation must be provided in the community for patients being discharged. It is the responsibility of the Area Health Board/ Hospital Board to develop and maintain these facilities. The range should include,

(a) a hospital/ hostel which, although based in the community, is staffed by medical and nursing staff in the same way as a ward within the hospital. This facility will be for the severely

impaired patient recovering from an acute episode and needing total care; and,

(b) facilities ranging from hostels with varying hours of supervision to visiting support in unsupervised homes. These facilities will also range from hostels serving between 8 and 12 patients through to group homes for 3 or 4 patients.

We realize that Hospital Boards and Area Health Boards do not have bottomless financial baskets and that the provision of quality housing is one of the more expensive components in any community mental health scheme. In some of the more high priced areas this may be almost prohibitively so.

Nonetheless, the problem must be faced, otherwise the plight of psychiatric patients will continue to deteriorate.

We have been impressed at what can be achieved by cooperation between Hospital Boards and charitable trusts or other independent groups.

In Southampton we saw a range of facilities, from supervised hostels to bedsits, which were provided and maintained by the Stonham Housing Association. This Association employs approximately 80 people in the Southampton area, and has as its principle objective the provision and maintenance of housing for the disabled (including the psychiatrically disabled), and, where necessary, the provision of staff to undertake housekeeping and management duties in the various facilities.

The Stonham Housing Association is a charitable trust, obtaining its funds from government and community donations. Each resident in its homes pays a rent, which is calculated after taking into account the need to meet mortgage instalments, ongoing maintenance, redecoration, wages and the other costs involved in maintaining a home.

The residents pay their rent from the welfare benefits they receive from the Department of Health and Social Security and care is taken to ensure that each resident is left with a sufficient income so as to enjoy a reasonable standard of living.

The Association employs its own maintenance staff and redecorates its facilities annually.

The Association is run by a Board of Trustees which is chaired by a psychiatrist. The

Board includes representatives from the health service, the social services, MIND (the equivalent of the New Zealand Mental Health Foundation) and representatives of the community.

Because it has representation on the Board, the local community psychiatric service is able to participate in the ongoing monitoring and review of the accommodation facilities and the appointment of staff, and generally to become actively involved in the planning processes.

One of many advantages in this cooperative system is that the psychiatric service is able to become actively involved in planning accommodation facilities, but thereafter the development and maintenance of those facilities becomes the responsibility of the Stonham Housing Association. That means, of course, that the health professionals are able to get on with the job they know best, which is caring for psychiatrically disabled people. Another advantage is that the cost of providing and maintaining accommodation (and some staffing) is not a direct charge on the health vote, which in turn means that already scarce funds can be diverted into other community resources.

We are satisfied that charitable trusts function well in this particular area, not least because donations are tax deductible. We would be concerned at any alteration to the law in this regard. If that were to occur, we believe that the effectiveness of charitable trusts would be seriously undermined.

The Corstorphine Baptist Centre Trust in Dunedin, the Comcare Trust in Christchurch and the Stonham Housing Association in Southampton, United Kingdom, are examples of organizations providing accommodation for the psychiatrically disabled. The nature of each organization is such that the provision of quality facilities and care for patients outweighs the pursuit of profit. Hospital Boards and Area Health Boards could well learn from their experiences.

ii) Rehabilitation

Rehabilitation programmes for re-establishment of personal skills, inter personal skills, living skills and occupational skills are often situated in hospitals. We are of the view that these would be better situated in the community, to maximize the value of the skills acquired from those programmes.

(iii) Leisure Activities

Drop in centres and leisure activities within the community have developed as various voluntary agencies, especially the church groups, have perceived the need and done something about it. These agencies need to be supported by the community psychiatric services. Such activities and facilities should be available in the evenings and during weekends to provide leisure activities which are appropriate to various ages, stages and needs within the community.

(iv) Occupations

The employment needs of psychiatric patients are often neglected. The key worker will be required to smooth the path through to whatever sheltered workshop, or other occupational opportunities are available to patients. The coordinator of the multidisciplinary team will encourage government departments and private sector and other organizations to develop appropriate schemes and employment for patients. It is also necessary for that coordinator to work with established employment agencies to encourage the employment of people with psychiatric disabilities. This should not be the responsibility solely of health workers. There must be an increased commitment on the part of the Housing Corporation, Department of Social Welfare, Department of Labour and other organizations to provide services targeted at the disabled, and specifically the psychiatrically disabled.

(v) Outpatient Service

Outpatient services, which include assessment and management of individuals and groups by all disciplines, should range from extremely active response and treatments on a day patient basis through to regular appointments at less frequent intervals. This service must be responsive to the needs of the community, and must be adequately staffed so that waiting lists are not excessive.

(vi) Crisis Intervention Services : Acute Assessment

There needs to be an acute assessment service run by a multidisciplinary assessment team

which is able to respond immediately to psychiatric crises within the community. The team must maintain close links with all psychiatric services in the region and should have respite beds available to it. The team should operate in a flexible way and in the event of a severe crisis it may be required to attend a patient in his or her own home. The team must have a defined base of operations, the location of which is known to the general public.

4. TRANSITION FROM INPATIENT TO OUTPATIENT

The period of transition from inpatient to outpatient services is a difficult one for patients. It is important to incorporate key workers from the community psychiatric service in the management process as part of the discharge planning. Advice from members of the patient's family and community should be sought where appropriate. The discharge must be carefully monitored by all participants, and there should be a system of review after a stated period. During this period, in the event of the patient deteriorating, members of the inpatient management team, the key worker, the patient, or the patient's family may initiate assessment for readmission.

5. DISCHARGE FROM COMMUNITY PSYCHIATRIC SERVICE

Discharge from the Community Psychiatric Service is a clinical decision to be made by the multidisciplinary team treating the patient.

6. STAFF SUPPORT

The management structures outlined above will provide clear lines of responsibility and support. The multidisciplinary team must have

access to regular peer support and be subject to peer review. There should be a comprehensive, ongoing process of in-service education.

7. CULTURAL APPROPRIATENESS OF SERVICES

It is important that community psychiatric services be culturally sensitive. The multidisciplinary team will include a Maori Health Coordinator and a Maori team.

The allocation of funds as previously described will enable members of the Maori team to participate in the development of community based health initiatives for Maori people. The same lines of accountability will also apply, and they will be subject to the same audit and review as all others within the community psychiatric service.

8. RESEARCH

Ongoing research is important. Research programmes should be integrated into all planning processes. Links should be established to universities, polytechnic institutes and other institutions of learning.

9. ADVOCACY

Advocacy for patients will be a responsibility of the key worker.

It is important that independent advocacy be available to patients in the community psychiatric services. Currently, advocacy is provided by the District Inspector and Official Visitor, but only within the hospital system. We believe that Official Visitors and District Inspectors should be entitled to see patients who are being cared for in the community psychiatric service. They should also be entitled to entry to any facility provided within the community for psychiatric patients.

FIGURE 5
COMMUNITY PSYCHIATRIC SERVICES

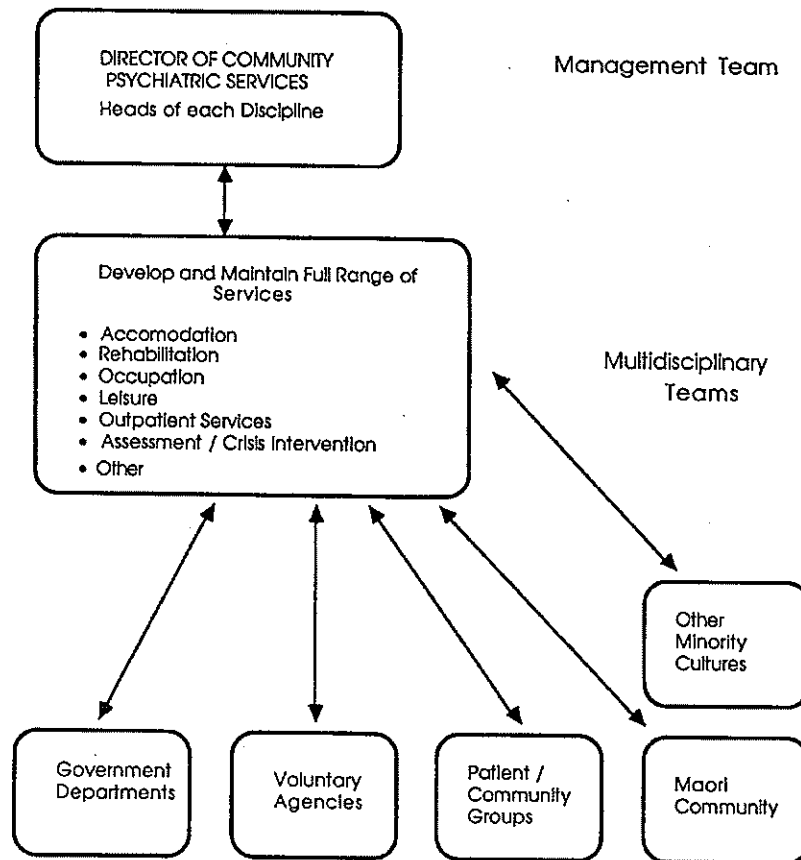
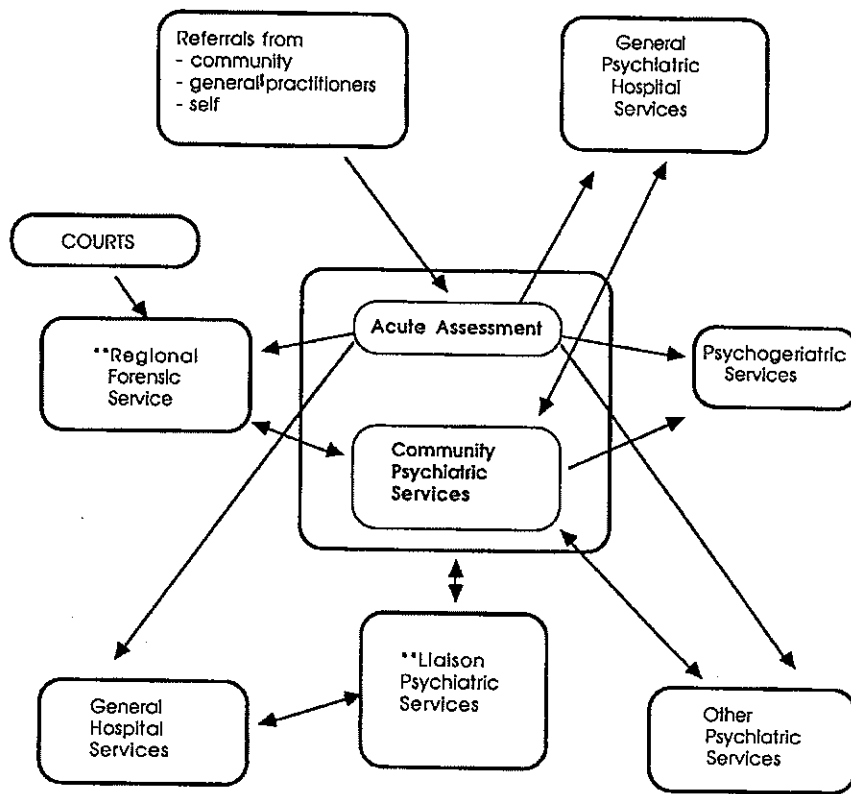


FIGURE 6

INTEGRATED PSYCHIATRIC SERVICES
Managed by Director of Psychiatric Services
Transfer possible in direction of arrows
**Liaison between all services



RECOMMENDATIONS

1. POLICY

We recommend that Government give a clear, unequivocal commitment to develop a comprehensive range of community psychiatric services for those who are psychiatrically disabled.

2. THE COMMUNITY PSYCHIATRIC TEAM

We recommend the appointment of a Director of Community Psychiatric Services. He/she will develop and maintain a comprehensive community psychiatric service in terms of our proposed model described in this part of our report.

We recommend the establishment of multidisciplinary teams to provide aftercare in the community for the psychiatrically disabled.

3. FUNDING

We recommend that the Director of Community Psychiatric Services be provided with an adequate annual budget to ensure the development and maintenance of high quality community services and facilities.

We recommend that the running costs of community psychiatric services be met by a direct allocation of Government funds for the 3 year period ending 31 December 1991.

We recommend the promotion of active policies enabling funds to be transferred from hospital based services to community based services.

We recommend that the management structures in the community psychiatric team be flexible enough to allow for the devolution of funds to individuals and community groups who are actively working in the community to promote the interests and welfare of the psychiatrically disabled.

4. REVIEW AND AUDIT

We recommend that the multidisciplinary team review its own services, facilities and finances at intervals of not more than one year. The Director of Community Psychiatric Services will be responsible for this review.

We recommend that the Director of Psychiatric Services undertake a review of the community psychiatric services at intervals of not more than one year. This review will be undertaken by a review panel appointed by the Director of Psychiatric Services.

5. DEVELOPMENT OF SERVICES

We recommend community consultation in the planning and development of community psychiatric services.

We recommend that representatives from patient groups be consulted, and wherever possible incorporated into, the policy making and management structures of community mental health services.

We recommend the appointment of a Maori Health Coordinator as head of a group of Maori workers who will form part of the multidisciplinary team.

We recommend wide consultation with those unions and other organizations representing psychiatrists, nurses and para-medical staff in planning the development, establishment or review of community facilities and services for the psychiatrically disabled.

(a) Accommodation

We recommend that Area Health Boards and Hospital Boards be responsible for providing a range of accommodation for psychiatric patients in the community and that such accommodation be allocated according to the clinical needs of the patients.

We recommend that staffing levels and the range and maintenance of all community accommodation be reviewed by the Area Health Board/Hospital Board at intervals of not more than one year. All accommodation must be of a high standard.

(b) Rehabilitation

We recommend the establishment of community based rehabilitation programmes for the psychiatrically disabled.

(c) Leisure Activities

We recommend that the multidisciplinary community psychiatric team be responsible for developing a range of leisure programmes in the community for the psychiatrically disabled.

We envisage that these programmes will be developed in conjunction with voluntary agencies to whom, where necessary, appropriate funding should be devolved.

(d) Occupations

We recommend that the multidisciplinary community psychiatric team liaise with government departments, employment agencies, employer organizations and other organizations and individuals to maximize employment opportunities for the psychiatrically disabled.

(e) Outpatient Services

We recommend the establishment of outpatient facilities sufficient in number to meet the needs of the community.

(f) Crisis Intervention/Acute Assessment

We recommend the development of acute assessment/crisis intervention services in sufficient numbers to adequately meet the needs of the psychiatrically disabled.

6. PATIENT MANAGEMENT

We recommend that a key worker be allocated to each patient accepted by the community psychiatric team.

7. PATIENTS INCOME

We recommend that sickness and invalid benefits be reviewed and set at a level which enables psychiatric patients to enjoy a reasonable standard of living.

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PART 5: PSYCHIATRY AND MAORI PATIENTS

INTRODUCTION

Mental health in traditional Maori society was part of a composite whole, and the established traditions of the time were flexible enough to deal with distress in both individuals and communities. We discuss Maori Mental Health more fully in Appendix 5.

Because of the disproportionate representation of Maori people in prisons and in psychiatric hospitals, and particularly in the special patient population, we have chosen to investigate the quality of psychiatric services for Maori people. We have met with Maori people in each area we visited and have discussed their views about the local psychiatric services. We were treated with courtesy at each hui and were supported with aroha from our people. Kaumatua and kuia attended our hearings, and we acknowledge their wisdom and assistance.

FINDINGS ON A REGIONAL BASIS

OTAGO

We spent many hours in the company of clinical staff in Dunedin. We noted that they were aware of the need to be culturally sensitive when dealing with Maori patients and members of other ethnic groups. We met with members of the local Maori community at Arai Te Uru Marae which has been visited by staff from Cherry Farm hospital on several occasions. Dr Julia Faed, the Medical Superintendent at that hospital, has established a close liaison with the local Maori community and, as a result, Maori patients are now being visited by local Maori.

The people at Arai Te Uru expressed some concern about the slow pace at which programmes and interventions had developed not only at Cherry Farm but also within the wider psychiatric community.

CANTERBURY

The Canterbury Hospital Board has appointed a Maori Health Coordinator, who is responsible for liaison between the local community and Sunnyside Hospital. Clinicians who spoke to us were aware of the need to develop a culturally sensitive psychiatric service for Maori people within the hospital. Hospital Board members and hospital staff had attended a hui at Rehua Marae. Sunnyside Hospital has the only Maori Official Visitor in New Zealand, Hohua Tutengaehe, who brings a wealth of experience of taha Maori to the position.

We met with local Maori at Rehua Marae, where concern was expressed about the lack of bicultural facilities in the city and region. We heard of the difficulty experienced by Maori people in negotiating with various government bureaucracies to obtain assistance in developing services within the papakaianga of the region. The readiness of government departments

to rely on Matua Whangai and other Maori organizations without giving any real support to these groups was deplored. The lack of trained Maori professionals was of concern, as was the absence of any significant Maori input into training programmes or other issues which clearly warranted a Maori perspective.

The Rehua whanau affirmed the need to incorporate people who are skilled in taha Maori into treatment teams: a subject raised frequently by Maori groups around the country.

"There needs to be a change in the prerequisite for working with people. There is no way you can convince me that a 19 year old registered nurse has any more clues than these two [refers to kuia] who have raised their families and grandchildren and worked on a limited budget. There must be ways we should be looking at in facilitating their access and working there. These kingdoms, they are hierarchically structured, and they are made to block other people out. Our people for years have been working with our people and doing a great job, but of course they come under stress because they are under resourced, and they are doing it for nothing. I am sure with people like this there must be ways we can make them feel more welcome in Sunnyside."

Speaker at Hui, Rehua Marae

NELSON

The setting for our hui in Nelson was important, in that we met in a building which had been donated by the Nelson Area Health Board to the local marae. That act was significant and a measure of the degree of support given by the Area Health Board, and particularly Ngawhatu Hospital, to the local Maori people. We met with people in Ngawhatu Hospital who were trying to establish long lost contacts with the families of their patients, despite the fact that many of these families were scattered throughout New Zealand. Maori patients in Ngawhatu were being encouraged to re-establish whanau links, and were frequently taken to the marae for hui and daily activities. We met with patients from Ngawhatu who had accompanied staff to our hui.

Themes which were familiar from other areas were repeated in Nelson: lack of a bicultural

perspective in the education of doctors and other workers in the health system; groups being set up in the community without adequate resources and information, and without the support of those who have expert skills and knowledge; lack of family involvement in assessment and management decisions.

WEST COAST

There are no formal bicultural health services on the West Coast. The population is a close-knit one, and the psychiatric hospital enjoys close informal contacts with the local Maori community. Although small, the Maori community in Hokitika is active and its links with Seaview are well established and supportive.

WELLINGTON

In the Wellington region, we met with a small group, Te Ropu Taha Maori, which is based in Porirua Hospital. It comprises employees of the Hospital Board who are working to establish a bicultural component in psychiatric services. We also met at Takapuwhia Marae with a wider representation of the Maori community of Wellington.

We were told that there was no tangible evidence of a commitment to biculturalism and the Treaty of Waitangi in the Wellington region, despite assurances of support to that effect. The Medical Superintendent of Porirua Hospital and some of her staff accompanied us to Takapuwhia Marae.

The grief expressed at Takapuwhia was profound. People there spoke of a history of neglect in many of the services which were discussed. In addressing the psychiatric services specifically, various themes emerged. Several speakers referred to the absence of a Maori perspective or assessment when an initial decision was made to admit or treat a psychiatric patient. The "gatekeepers" to the services were said to be monocultural. Workers and patients in the hospitals said that lip service was paid to taha Maori and the incorporation of the principles of the Treaty of Waitangi into health services. Others told us that illnesses and signs of distress which could be interpreted in the context of a patient's Maoriness were misidentified and treated in terms of Western psychia-

try. For example, if a person under stress was seen to be speaking to his or her tipuna, this was thought to be hallucination. Because this was interpreted as evidence of psychosis, the diagnosis may be made accordingly and treatment carried out with anti psychotic medication.

The absence of family involvement in management, planning and care of the patients in the hospital was criticized. Likewise, the absence of family involvement in deciding when to discharge a patient into the community was also criticized.

The group whom we met at Takapuwhāia said that, in their experience, the psychiatric service did not acknowledge the needs of Maori people. Psychiatric hospitals were seen by them as hostile places: psychiatric services as monocultural and resistant to change.

The Wellington Hospital Board has appointed a Maori Health Coordinator. One of her duties is to develop bicultural services in the region administered by the Board. This is an enormous task which, without further support, appears impossible.

Te Ropu Taha Maori, in Porirua Hospital, is a small group which functions under the burden of each of its members being required to carry out his/her normal clinical duties. There is no acknowledgement by the hospital administration, nor the Hospital Board, that the development of psychiatric services for Maori people by this group is valid work which should be an integral part of their clinical responsibilities.

WANGANUI

The appointment of a Maori liaison officer at Lake Alice Hospital has been a significant step forward in the development of a bicultural service. This officer, with other staff members, has fostered the development of Te Ropu Arahi, which comprises both staff and patients. It is well supported by the local Maori community. Although small in numbers, Te Ropu Arahi is an important group which meets on a weekly basis so that patients and staff can foster their taha Maori and, in the context of a Maori envi-

ronment, attend to their spiritual needs.

Te Ropu Arahi enjoyed considerable support from the Medical Superintendent of the time, Dr Stephanie du Fresne, who was an active member of the group, and from Mr John Boyack, the Chief Executive of the Board. This was one of several worthwhile initiatives taken by the Wanganui Area Health Board in trying to develop a bicultural service.

WAIKATO

We visited the Whai Ora unit in Tokanui Hospital. This was the first hospital-established bicultural unit in New Zealand. The objectives of the unit are to provide patients with an environment in which to foster their sense of pride in their cultural heritage, and to incorporate Maori cultural values and beliefs into treatment programmes. The Whai Ora unit is available to both Maori and pakeha patients, and both Maori and pakeha staff work in the unit. We discuss Whai Ora more fully in Appendix 5.

All staff in the unit, including domestic staff, are an integral part of the therapeutic team, and each person has a strong commitment to the ward, patients, their taha Maori and to the Waikato Hospital Board. Families of patients are involved in the management process and, if they are able, they may stay with the patients. Whai Ora has close contact with the Matua Whangai group in Hamilton.

We were impressed by the peace and aroha of the unit. The care and nurture provided by staff was impressive in every respect.

Whai Ora is a bicultural unit with a distinctly Maori kawa. It has kaumatua support and well established links with the community. It is well supported by both the Maori community and staff at the psychiatric hospital. It has incorporated Western psychiatric practices, including recording techniques, and it is open to external scrutiny. It provides a service which is appropriate to the Waikato community, and is a tribute to the commitment and skills of the people who work in the unit and support it.

Psychiatric hospitals were seen by them as hostile places: psychiatric services as monocultural and resistant to change.

In Hamilton, we met with the local Matua Whangai group. This group receives little financial support from government departments. It is an active group which provides a service to the local courts, and also runs a community house for those in need of help. We admire the support Matua Whangai was able to give to the people with whom they were involved.

The group also told us of plans to develop a hostel for offenders in the community. They hoped that their programmes would incorporate a bicultural perspective and provide for cultural and spiritual rehabilitation as well as social and personal needs.

AUCKLAND

We visited He Putea Atawhai which is a community based facility in Swanson providing care for people with moderate to severe psychiatric disability. Many of the patients had been in hospital for lengthy periods, and have now been established in the community under the care of a predominantly Maori group. Care is provided according to a bicultural philosophy, incorporating Western psychiatry as well as taha Maori. Maori and pakeha patients are admitted to He Putea Atawhai. Close links have been developed and maintained with the outpatient service from Carrington Hospital and the Hoani Waititi Marae. Kaumatua from Hoani Waititi Marae are trustees on the He Putea Atawhai Trust.

At Kingseat Hospital, in South Auckland, a whanau group comprising both Maori and pakeha staff has been established and is supported by senior management. It has close links with the Papakura community and is working towards the development of biculturalism in the hospital and community psychiatric services.

We are very supportive of the whanau group at Kingseat, and other such groups in psychiatric hospitals in New Zealand. We see these groups as initiators of change directed at developing a sensitivity towards the Maori dimension in psychiatric services. We encourage hospital administrators to recognize the

difficulties facing such groups, and to minimize these difficulties whenever possible.

The Whare Hui operates as a bicultural unit at Carrington Hospital. In June 1987, His Honour Mr Justice Wallace was asked to conduct an Inquiry into events at Papillon House involving John Papalii, which we have described earlier in this report. He sought opinion from Whare Hui staff as to the manner in which the Inquiry should be conducted. Mrs Titewhai Harawira, speaking for the staff at Whare Hui, expressed concern that the Inquiry focussed only on the Auckland area. She said that many of the problems of the Auckland region were also common to other parts of New Zealand.

The membership of the Inquiry was also questioned. Dr Erihana Ryan and Robert Ludbrook, an Auckland lawyer, had been invited to assist Mr Justice Wallace in conducting the Inquiry. Mrs Harawira said that the composition of the Inquiry was contrary to the principles of the Treaty of Waitangi, that there should be at least 50% Maori representation on the Inquiry, and that people from the Auckland region should be appointed. Mrs Harawira made it clear that Whare Hui staff would not appear before the Inquiry under the circumstances then existing.

The (then) Minister of Health agreed to:

(a) enlarge the Terms of Reference to include all areas in New Zealand which provided a service to special patients; and,

(b) change the membership of the Inquiry to include a stronger

Maori representation.

We hasten to add that Mr Justice Wallace was unable to participate in a protracted Inquiry because of his judicial duties and his responsibilities as Chief Human Rights Commissioner. It was under these circumstances that this present Committee of Inquiry came into being.

**We are very
supportive of
the whanau
group at
Kingseat, and
other such
groups**

THE WHARE PAIA

Our Inquiry in the Auckland region commenced on 2nd November 1987. On that day, we asked Dr Peter McGeorge, Acting Medical Superintendent at Carrington Hospital to arrange meetings for us in the hospital. We specifically asked to meet with staff at the Whare Hui and Whare Paia.

The staff at Whare Hui initially agreed to a meeting. Later, Dr McGeorge informed us that the staff at Whare Hui had requested a change of venue and asked that we attend Whare Paia, a new unit which had been set up in Carrington Hospital. We were happy to accept this new arrangement.

On 12 November 1987, we attended Carrington Hospital to meet with the Medical Superintendent and staff who wished to make representations to us. We were accompanied by kaumatua. We welcomed the opportunity to learn from the experiences of staff at the Whare Paia and Whare Hui.

Two minutes before the time agreed upon for the meeting, Dr McGeorge told us that Mrs Harawira had informed him that neither she nor her staff would be present at Whare Paia. There was no explanation for this refusal to meet with us, nor was there any apology. We were reluctant to embarrass our host, Dr McGeorge, or our kaumatua. We asked that our disappointment be expressed, and suggested a further meeting on a date suitable to Whare Paia staff. We heard nothing further.

The bicultural unit at Carrington Hospital has been both praised and criticized. The praise is enthusiastic, particularly from Miss Murphy, Chief Nurse of the Auckland Hospital Board. She said the unit has,

"developed in a very very healthy way. I believe it is one of the few, one of the only therapeutic communities which has gone on operating. What is really stimulating about it is that patients actually run their lives. They sit down in the mornings, one of them chairs the meeting of the day, and they

decide what is going to happen to them and the people who work in that environment. I have never seen in such a short time so many good things happen to people. There has been a lot of heartache, and a lot of trauma for the people who are good enough to come and work with us and for us, but the improvement in the individuals who one day could not actually eat with a knife and fork, or dress themselves or keep themselves clean, now walk around as tall men. I think

that is tremendous, and it is only three months. Most of these patients are special patients, who were judged as too dangerous to handle in an open ward "

Mrs Janet Quinlan, Principal Nurse at Carrington Hospital also supported the quality of care given at Whare Paia without resort to locked doors or seclusion.

Dr McGeorge stated:

"the Whare Paia has managed extremely well over the past couple of months with what we have previously seen as very dangerous special patients. It is an open ward where they rely on intense supervision and the use of volunteers, but those people seem to have a knack of dealing with some of the disruptions that people in that ward cause in a quite remarkable fashion. There is no doubt that the efforts of the Whare Hui, and more recently the Whare Paia, have had positive benefits to many patients. They deserve continued support. Nevertheless the establishment of minimal medical and nursing standards is essential if the true partnership is to be attained. This will require attention to history taking, case reviews, and the prescribing and giving of medication by trained staff. It will also require respect for Maori custom. There are challenges for Maori and European alike, and both parties should take care not to be over zealous in having the right perspective, and as a consequence, over-exerting their authority or calling into

**"I have never
seen in such a
short time so
many good
things happen to
people"**

disrespect the views of the other."

Dr Mc George also commented that he was aware of variable support in the Maori community for Whare Hui and Whare Paia, and of a reluctance among some Maori people to become involved with the units. He said that he was free to come and go into Whare Paia and Whare Hui at will, but that many members of the staff were not made welcome and were prevented from participating in the activities of the bicultural units.

Dr McGeorge expressed a guarded enthusiasm for the bicultural units.

Edgar Rout, a senior social worker, expressed concern at the lack of access for staff from Carrington Hospital to Whare Paia or Whare Hui. He was also concerned that special patients, whose movements were restricted by law, seemed able to leave the hospital at will.

He suggested that the Whare Hui and Whare Paia acted independently of the management of Carrington Hospital. It was not possible for him to comment on the standard of nursing, or other standard practices, including administration of drugs, in the Whare Hui and Whare Paia. He indicated that perhaps these basic services were not being provided according to acknowledged and well established patterns in the hospital and in Western psychiatry. He was also concerned that the (then) Official Visitor had been refused admission to the Whare Paia, thus depriving the patients of their statutory rights of representation and advocacy.

Mr Rout referred to two patients who had left the Whare Paia and were later the subject of a high speed car crash. One of the patients was later returned to the Whare Paia but admission was refused. Mr Rout acknowledged that patients in Whare Paia initially saw their needs

being met by the unit, in that they were given many outings and privileges to which they were unaccustomed. He also believed that a number of patients had since changed their views and saw the administration as quite restrictive.

Mr Rout was not the only member of staff who expressed concern at the management policies practised in the Whare Paia. A Staff Nurse stated,

"we were told it is a multicultural unit. It

is otherwise defined as a bicultural unit. That is not true. It is a single cultural unit. It has no criteria of admission; it has no stated function; it has no stated role; it has no stated methods of practice; it has no stated purpose. This is a unit which is being run, I believe with hospital funds, by a staff who are employed by the Hospital Board. The whole hospital working staff are ignorant of happenings in the Whare Paia. It is excluded from Carrington Hospital systems, and it does not give any information. Discharge from the unit has been followed by reappearance of the patient within 24 hours, either to the psychiatric service or the police, and refusal of admission back into that unit. Many of those patients, at readmission, have at that stage been becoming ill. It is my opinion that when pa-

tients are becoming a management problem, they are discharged from what used to be M7, is now the Whare Paia, and in many cases, have been readmitted into other areas in the hospital within 24 hours."

"we were told it is a multicultural unit. It is otherwise defined as a bicultural unit. That is not true. It is a single cultural unit. It has no criteria of admission; it has no stated function; it has no stated role; it has no stated methods of practice; it has no stated purpose.

We wanted to find out, with some certainty, what was going on at the Whare Paia. We asked our Assessment Team to intervene.

Our brief to the Assessment Team was:

"The Committee emphasizes that it expresses no decided view as to the effectiveness of the care and treatment being received by patients in the Whare Paia.

The Committee now asks that those patients who are in the Whare Paia (and those who have been transferred from that Unit since 17 August 1987) be seen by the Assessment Team and that you advise the Committee as to whether the standard of security, care and management and the granting of leave is adequate, bearing in mind the degree of mental illness of each patient.

The Committee would welcome any further recommendations which the Assessment Team may wish to make."

When the Assessment Team arrived at Carrington Hospital on 9 February 1988, they encountered difficulty in gaining access to the Whare Paia, and to the clinical notes about the special patients in the unit. On arrival in the hospital, they were met by the Medical Superintendent, Dr McGeorge, and the Principal Nurse, Mrs Quinlan. The hospital management questioned the advisability of the assessment, and expressed fears that the arrival of the Assessment Team at Whare Paia would precipitate a crisis with its staff. The Assessment Team was also led to believe that it was doubtful whether they would be admitted to Whare Paia.

In spite of these doubts, the Team, accompanied by Dr McGeorge, went to the Whare Paia where they were greeted by the staff. No patients were present on the ward. After powhiri, they were told that their visit was not welcomed and that in effect the Whare Paia staff did not regard the visit as being of any importance. The team was then shown round the unit, and after lunch they tried to alleviate the fears which were being expressed. The Assessment Team requested that patients be made available the following day. They left.

When the Assessment Team arrived at the Hospital the next day, 10 February 1988, they were informed that all the patients from Whare Paia had gone on a picnic with the staff. When they asked to see the psychiatrist who provided the medical cover for the Whare Paia, they were

informed that he too had gone on the picnic. The Assessment Team were given a tour of the hospital, during which time they were able to meet with staff in other wards. The Assessment Team accepted the Medical Superintendent's invitation to examine all special patients in Carrington Hospital. They stated, however, that their first priority was to carry out the brief given to them by us. They were then given the files of some special patients in the hospital. None of these files concerned patients in Whare

Paia. After spending some time perusing the files, the Assessment Team realized that they would be unable to see patients that day, and left the hospital. They informed the Medical Superintendent that they expected to see patients on Thursday, 11 February, in the morning.

On 11 February 1988, they were told that they could only examine the patients in Whare Paia in the company of the consultant psy-

chiatrist attached to the Whare Paia, Dr Felgate. This was not acceptable to the Assessment Team, although they wished to meet with Dr Felgate so they could discuss the Whare Paia patients with him. They were told they could not see patients; that Whare Paia would not allow this to happen.

A debate then ensued between the Medical Superintendent and members of the hospital, and representatives of the Hospital Board, as to who was actually in charge of the Whare Paia. When the Medical Superintendent attempted to instruct staff in the Whare Paia, he was informed that he had no authority to do so. After a discussion with the Chief Executive of the Hospital Board, Dr McGeorge was given permission to direct the staff as he considered appropriate. A short time later this permission was rescinded following a discussion between Mr Campbell, the Chief Executive, and Miss Murphy, the Chief Nurse, as to who had authority over the Whare Paia. The ensuing confusion was testament to the lack of clear lines of responsibility and accountability in Carrington Hospital and the Auckland Hospital Board in respect of the Whare Paia. At this stage, our chairman was contacted. He instructed the Assessment Team to leave the hospital.

A debate then ensued... as to who was actually in charge of the Whare Paia.

That night, Mrs Harawira of the Whare Paia informed a member of the Assessment Team that her patients should not be examined. She asked for a meeting with our Inquiry and the two Maori members of the Assessment Team. She asked that the two non-Maori members of the Team be excluded. The invitation was refused.

The next day, 12 February 1988, the last day of the week allocated for examination of patients, the Assessment Team again returned to Carrington Hospital. They were again asked to see special patients other than the Whare Paia patients, and elected not to do this as their time was now extremely limited.

At 11 a.m. on 12 February 1988, the files of the special patients, including those in the Whare Paia, were finally released to them. Dr Felgate declined an invitation to meet with the team, saying that he did not think it wise to see them unless a staff member from the Whare Paia was also present. Dr Felgate was then instructed by Dr McGeorge to meet with the Assessment Team. He refused, and said that the Medical Superintendent had no authority to direct him. Dr Felgate agreed to explain the files to the Assessment Team, and indicated he would collect more files and return. He left and did not return.

The Assessment Team were then told that the Whare Paia staff would not allow the patients to be examined, and that they (the staff) would leave the unit if the team insisted on seeing them. They said they would place the patients in the care of Dr McGeorge. The Assessment Team said they were instructed by us to meet with the patients. The staff at Whare Paia then agreed to the patients being seen by the Assessment Team, and said that the Principal Nurse and Dr McGeorge would present each patient individually.

There was further debate between the managers of the hospital and the staff at Whare Paia. By mid afternoon the Assessment Team had not been given access to any patients. Staff in the Whare Paia then decided that all the patients would be presented en masse at the Administration Block, where the Assessment Team intended to see them. Whare Paia staff then demanded that the Assessment Team see the patients as a group. The Assessment Team did not agree to do this, judging that the only

valid assessment would be one conducted on an individual basis. Dr McGeorge then requested that each assessment be observed by a member of Psychiatric Survivors. This was not acceptable to the Assessment Team. This was the first and only occasion on which Psychiatric Survivors had been introduced into the sequence of events.

The Assessment Team once again appeared to have encountered a stalemate. However, late on Friday afternoon, 12 February 1988, the first patient was presented and the Assessment Team was able to commence the assessment process. The gathered patients were first spoken to collectively.

Mr Tutengaeha opened with karakia. The purpose of this meeting was to start the procedures in Carrington Hospital in a way which observed the Maori spiritual perspective. The patients were told what would be happening and of the need for assessment. They were given the opportunity to ask questions, and at the end of this formal part of the process, the Assessment Team greeted each member of the assembled group, patients and staff alike, and then proceeded with individual assessments.

After two patients had been examined, the Assessment Team left, to return the following Tuesday, 16 February 1988. On their return to the hospital, Dr McGeorge indicated that permission to assess the patients had again been withdrawn by the Whare Paia staff, and would need to be renegotiated. Eventually the patients were released for assessment. However, Dr McGeorge was instructed by Whare Paia staff to ferry the patients between the administration block and the Whare Paia.

The individual assessments of the patients in the Whare Paia then proceeded without significant difficulties. The method of examination followed the pattern established at Paremoremo. A psychiatrist and a Maori member of the Assessment Team formed a smaller team to examine each patient. Before the assessment, the patient was greeted by the Maori member of the team and asked if he would like to commence with karakia. In every case, the patient agreed to this and participated fully. The Maori member of the team then led in to the interview and the psychiatrist later explored matters he considered to be clinically relevant.

The Assessment Team informed Dr

McGeorge that, as part of their assessment, they would like to meet with the multidisciplinary clinical team in the Whare Paia. This was refused by the staff in Whare Paia, and, despite repeated invitations, no meeting took place. As a result of the unwarranted delays caused by the obstructive tactics outlined above, the Assessment Team did not have sufficient time to examine other special patients in Carrington as requested by Dr McGeorge.

Despite the many difficulties outlined in gaining access to Whare Paia, and in complying with the instructions given by us, the members of the Assessment Team had some positive comments to make about the Whare Paia. They were all taken by the peace and pleasantness of the environment. The sincerity and commitment of staff to provide both a treatment alternative and a protective environment for their patients was commented on and applauded by members of the Team, particularly the psychiatrists.

In their view there appeared to be some contradictions in the stated philosophies of the Whare Paia. We were told that some in the Whare Paia completely rejected the practices and values of Western psychiatry, while others sought a partnership to reap the benefits of both Maori and non Maori practices. When this contradiction was identified, it was not adequately or satisfactorily explained. The Maori members of the Assessment Team expressed some reservations as to the quality of taha Maori being practised within Whare Paia. They were concerned that there were no kaumatua present. They were also concerned that there was no depth of taha Maori, taha wairua, tikanga Maori or te Reo.

The clinical notes on the patients were incomplete, and did not contain current nursing notes or medication charts. These were not provided when requested. As a consequence, it was difficult for the Assessment Team to find out how the patients had been managed.

They were also unable to comment on medical management, or on the administration of drugs.

The Whare Paia is a beautiful old villa which is newly renovated and very pleasant. There is an air of calm and healing in the place, which connotes a positive therapeutic environment. Security in the unit is provided by staff: there were no locked facilities. The relationships between staff members and patients were observed as being caring and supportive, and the staff were described as being nurturing/motherly in behaviour. One of our psychiatrists commented,

"I had a number of quite favourable impressions. I thought there was a great deal of warmth and very genuine attempts at caring for these people who presented a very mixed bag from a diagnostic point of view. They included two or three people who were grossly retarded. They also had some physical disabilities and there were people with paranoid psychosis, some with personality disorders. As I say, I had some very good impressions."

The Assessment Team reported that the staff of Carrington Hospital regarded the Whare Paia unit as being too independent, as being careless

of hospital etiquette, and acting in disregard of the ordinary lines of communication. There were claims of carelessness regarding the reporting of leave for special patients. They said that the staff in the Whare Paia were resentful of attention and criticism.

Some of the patients seen by the Assessment Team were judged to be unpredictable and possibly quite dangerous. One patient was so unpredictable that the Medical Superintendent was reluctant to transport him in his car without assistance. A member of the Assessment Team accompanied the Medical Superintendent and patient back to Whare Paia after examination.

Most of the patients seen by the Assessment Team had been absent-without-leave at some time during the previous three months.

Contact with the patients families has been minimal since the establishment of Whare Paia;

Most of the patients... had been absent-without-leave at some time during the previous three months.

this in spite of the professed emphasis on family involvement in both treatment and management programmes, and the importance of taha whanau to Maori people.

In summary, the Assessment Team reported that despite the warmth and pleasantness of Whare Paia, there was little evidence of a Maori perspective being incorporated into the treatment programmes. Specifically, there was little evidence of taha wairua, taha whanau, tikanga Maori and te Reo, and there was clear evidence of ambivalence as to the benefits of Western psychiatry. The absence of links with kaumatua of the area, and the various iwi groups, was commented on. The Assessment Team also expressed real concern at the absence of adequate supervision and security in Whare Paia. The patients have been moved from a locked environment to a much more open environment in one step and without preparation for the altered degree of freedom. The large number of absences-without-leave demonstrated that they have found difficulty in this transition. Some of the patients seen by our psychiatrists were assessed as being unpredictable and dangerous at the time they were assessed. The comment was made that,

"if I were the consultant of this ward, I would be very worried if I did not know where that young man was."

The Assessment Team was grateful for the ready cooperation of all the patients who welcomed the bicultural nature of the examination. There was no apparent distress at the method of examination, nor any indication of unresolved distress on completion of the examination.

On 14 February, 1988, the staff at Whare Paia informed the Sunday Times that,

"they would not allow their patients, who had already been psychologically raped, to go through the same experience again."

The media invited our chairman to comment. Out of concern for the interests of the patients, he declined to embark on a public debate.

On Wednesday, 17 February 1988, the Anti-Racist Action Group at Carrington Hospital issued a press release which said:

"we consider the whole process by

which the Assessment Team was formed and is carrying out its tasks to be racist."

There are several methods of monitoring behaviour in a psychiatric hospital. Scrutiny both from within and outside the hospital system, is important in the maintenance of standards. If that scrutiny does not occur, deterioration of standards, and aberrant behaviour, may develop.

An examination of the day to day happenings at Whare Paia has been difficult. Much of the evidence we heard was hearsay, and even the impressions given by the Assessment Team are based on interviews with some patients who may have been severely impaired in terms of their mental status at the time they gave the information.

Nonetheless, when one looks at the system which has evolved within the Whare Paia, and how that fits into the general hospital system, it is obvious that there is a self imposed isolation from scrutiny by, and support from, others in the hospital. The Whare Paia discourages entry to its premises unless those persons are chosen and approved by its staff: it does not encourage external scrutiny.

There is a lack of clearly identified lines of management and authority both in Carrington Hospital, and in the Auckland Hospital Board. This was apparent when Dr McGeorge tried to obtain access to the Whare Paia for our Assessment Team. He was told by the Chief Executive on one occasion that he had authority: within an hour he was told by another member of the hospital executive, the Chief Nurse, that he had no such authority. We wish to point out that no criticism for the events involving our Assessment Team can be directed at Dr McGeorge. He was as helpful as he could be within the constraints and demands imposed on him by others.

The introduction of the State Sector Act 1988 on April 1 1988 has no doubt clarified the lines of management and resolved, to some extent, the matter of accountability within the Board system. But we refer again to the comment made in Part 1 of this report.

It is difficult to reach conclusions from the mass of submissions we have heard about the bicultural unit at Carrington Hospital because

of the refusal of staff to meet with us.

Therefore we ask:

1. What is the basis of the claimed Maori treatment programme in the absence of *kau-matua, taha wairua, tikanga Maori* and *taha whanau*?

2. Who administers the bicultural unit at Carrington? Does the Hospital Board have any control over the management practices and staff in the unit? If so, in what way does it exercise that control? To whom is the Whare Paia accountable?

3. Does the Whare Paia come under the umbrella of Carrington Hospital and therefore under the authority of the Hospital Management team, or is it an independent organization?

4. What is the history of the Whare Hui Trust, and from whom does it receive its funds? Is it funded by the Hospital Board, and if so, to what extent?

5. What are the criteria for admission to Whare Paia, and how are these criteria set?

6. What are the management options for patients in Whare Paia, and on what basis are these management options provided?

7. Who are the staff of Whare Paia? What are the criteria for selection of staff there? What training programmes, at both the initial stages of appointment and at in-service level, are pursued there?

8. What process exists for monitoring the multidisciplinary team at the Whare Paia, and what support is provided for people who do not have experience in dealing with psychiatric patients with poor impulse control who are unpredictable and who are known to be potentially damaging to themselves or to others?

9. What is the method of reviewing management structures? What happens to staff who develop interventions which are contrary to the stated philosophy of the unit, or to the hospital philosophy regarding the quality of care to which patients are entitled?

10. What advocacy is available to patients? How are patients informed of their rights, and who provides independent advice and representation? Is the Official Visitor allowed unrestricted access to patients?

11. Does the philosophy of Whare Paia incorporate Western psychiatry, and do staff intend to work in partnership with trained health professionals, or do the staff there believe that Western psychiatry has no benefits to offer their patients? If a partnership is envisaged, how will it operate?

12. Is the view expressed by the Principal Nurse and Chief Nurse, that the unlocked facility provides adequate security for potentially dangerous patients, a valid one?

We believe that the answers to these questions are important both for the present and the future in determining the quality of care for patients in the bicultural unit in Carrington

Hospital. It is to be remembered that the 17 patients who were transferred from Oakley M3 to Whare Paia were considered by the hospital team as being too dangerous to manage in an open ward.

We speculate that one or more of these patients may leave the security of the Whare Paia and Carrington Hospital, and, while in the community, respond to a stressful situation in a dangerous and potentially catastrophic way. The consequences of such an event

would be outrage in the community, and a demand for retribution. This would have a profound impact on Carrington Hospital, the Whare Paia and on other bicultural units in the country. This impact could set back by many years the further development of bicultural units in psychiatric hospitals and in the community.

What is happening in Whare Paia is anomalous. It bears little resemblance to the other bicultural services we saw. We applaud the development of bicultural units for the psychiatrically disabled. There is much that Maori and non Maori people can learn from one another. Despite the uncertain nature of some of the evidence we heard, we are convinced that the Whare Paia is not an adequate facility for the care and containment of people with poor impulse control who are unpredictable and whose behaviour is known to be potentially damaging either to themselves or to others..

For the past 150 years, many people have worked towards providing a bicultural social

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service in New Zealand. That work has accelerated during the past 10 years. There are few, if any, checks and balances on staff and management at Whare Paia. There appears to be no accountability.

We are fearful that the work and commit-

ment by many people, both Maori and non Maori, will be undermined by an event which has nothing to do with the philosophy of the Whare Paia but which has a great deal to do with the absence of an effective monitoring system.

HE KORERO MO TE WHAREPAIA ME ONA TIKANGA

Ko enei kupu e whai ake nei
Ka taraia hai whakaro ma nga tohunga,
Nga kaiarahi me nga kaimahi
Tiaki inga turoro wairangirua
Ote wharepaia.
Inumia kia moakona rawa koutou.

Ite timatanga te kupu
Na io-matuakore te kupu
Ko io-matuakore ano taua kupu
Ite timatanga.

KAORE HE PAHEKETANGA
E KORE E TAEA E TE AROHA TE WHAKAMAMA.
KAORE HE MATE URUTA
E KORE E TAEA E TE AROHA TE WHAKAORA.
KAORE HE KUWAHA WHAKAKEKE
E KORE E TAEA E TE AROHA TE HUAKI.
KAORE HE WEHEWEHENGANGA
E KORE E TAEA E TE AROHA TE HONO.
KAORE HE PAKITARA PARAE
E KORE E TAEA E TE AROHA TE WHAKATANUKU.
KAORE HE HARA
E KORE E TAEA E TE AROHA TE HOROI KIA MA.
AHAKOA PEWHEA TE NOHO HOHONU OTE RARURARUTANGA,
TE NGOIKORE KI NGA AHUATANGA,
TE POWHIWHI OTE POKAPOKAI,
TE NUI RANEI OTE, MAMAE,
MA TE MAHARANUI KI TE TIKANGA OTE AROHA,
E MEMEHA AI ENEI MEA KATOA.
NO REIRA MEHEMEA KI TE MAU I A KOE TE AROHA PONO,
OTI RA KO KOE TE TANGATA TINO HARINUI,
TINO MAIA KAHARAWA OTE AO KATOA.

Ko te tumanako:
Kia mau ki te pono
Kia mau ki te tika
Kia mau ki te aroha
Kia mau ki te rangimarie
Kia mau ki te whakaiti

Aroha tino nui-na matou katoa.

SUMMARY OF MAORI CONCERNS

The concerns expressed to us fall into the following categories:-

1. Planning

The Health Department has a policy which commits it to incorporating the principles of the Treaty of Waitangi into all management decisions. We were told that Maori people saw little evidence of this commitment.

Incorporation was regarded as fundamental to the development of a bicultural service.

All planning should involve consultation with the community being served. Maori groups representing all iwi groups in the area should be consulted.

2. Education and Training

Health professionals are rarely educated in taha Maori or the application of taha Maori to the service they provide. Many current training programmes create a barrier to Maori people entering the health professions. Most of the programmes are monocultural.

The qualifications that result from these training programmes then become the criteria for admission into the multidisciplinary team. One person commented,

"That is proper in terms of Western psychiatry. There are however, many aspects of care in which the training is in Taha Maori, and it is for us to determine the validity of the quality of that training. This training is a lifelong process, which is performed in context of the individual's whanau, hapu, iwi, and with their Kaumatua and Kuia. This qualification is equally as valid as any university degree you may set as a criterion, and people with these qualifications must be incorporated into multidisciplinary psychiatric teams. Only people with this training can provide this quality of care - taha Maori".

3. Assessment of Patients

Patients are assessed largely in terms of Western psychiatry. There is little acknowledgment of the impact of culture, family and spiritual being on identity. Differences between Maori and pakeha were often neglected in a psychiatric assessment. This "gatekeeping" process was seen as the appropriate time to involve people with a knowledge of taha Maori.

4. Psychiatric Management

Hospital care, pre-discharge decisions and post-discharge care must involve the families of Maori patients and representatives of the iwi group from which that patient comes. The management team must also involve people skilled in taha Maori.

5. Review

All review panels at multidisciplinary team level, hospital level, and national level must include a group of people who have skills in taha Maori.

Members of review panels should have equal status, and each member should be paid at the same rate.

Maori people told us that they were often asked to assist in the assessment process and to help in other ways in the psychiatric service, but were given no status, no voting rights and therefore they had no

impact on the ultimate decision. They are asked to work on a voluntary basis. In some cases, they take time off from their paid employment, and are given little or no financial recompense.

6. Staff

Selection of staff for a multidisciplinary team was considered to be important. Maori people felt that, unless they were included in the selection process for staff, especially for positions of power and high status, the empowerment of Maori people would be diminished. They saw little chance of the principles of the Treaty of Waitangi being incorporated into management decisions.

7. Management

Management structures must be flexible and able to respond to innovation and culturally different ways of providing services. Service delivery must be carried out in a bicultural setting.

COMMENT AND RECOMMENDATIONS

We have outlined the marae and hui we attended during the course of our Inquiry. Although we did not meet with substantial numbers of Maori people, we believe that the concerns which were expressed to us are representative of the views held by many Maori.

We do not believe that a regional forensic service or a community psychiatric service should be developed on racially segregated lines. Our recommendations are directed at developing an integrated bicultural psychiatric service in which resources, knowledge and funds can be applied for the benefit of all patients. That service will operate with clear lines of accountability.

We recommend that the job description for the positions of Director of Psychiatric Services and Director of Forensic Services includes a requirement that he/she develops a bicultural service embracing taha wairua, tikanga Maori and te reo.

We recommend that representatives of the Maori community (who must be of the multiple iwi groups resident in that region) be included on interview panels to decide all major appointments to Area Health Boards/Hospital Boards. In the context of this report such appointments would include the Chief Executive, the Director of Psychiatric Services, the Director of Forensic Services and the Director of Community Psychiatric Services.

We recommend that all senior appointments to Area Health Boards/Hospital Boards will be conditional upon the appointee having a knowledge and appreciation of Maori culture, tikanga Maori and taha wairua or alternatively giving an undertaking to acquire that knowledge as soon as is reasonably practicable following appointment.

We envisage that under these circumstances senior appointees will seek advice from kaumatua and kuia as to how best this can be achieved. We have no doubt that the Maori community will respond in a supportive way.

We recommend obligatory consultation with the Maori community and other significant ethnic minority groups in planning and establishing a regional forensic service.

We recommend that a Maori Health Coordinator be appointed to the regional forensic team.

This person must be skilled in taha Maori and have a knowledge of te reo. He/she may not necessarily possess any formal medical qualification.

The appointment will be conditional upon the appointee having suitable qualifications or experience in management/administration skills or alternatively agreeing to acquire such skills as soon as is reasonably practicable following appointment.

This appointment is to be made by the Director of Forensic Services after consultation with Maori representing the multiple iwi groups in the region.

The Maori Health Coordinator will establish a whanau of Maori health workers in sufficient numbers to meet the needs of the Maori population in the region being served. The members of that whanau will be involved in:

1. the assessment and management of patients on an active basis as full team members;
2. the training and support of the multidisciplinary team in bicultural matters;
3. the development of services in Maori related ways;
4. establishing and maintaining close working contacts with the various iwi groups of the region.

The Maori Health Coordinator will have the same status as any other head of service within the regional forensic service and will be directly accountable to the Director of Forensic Services.

The Maori Health Coordinator and members of that department must be free to work in a manner consistent with tikanga Maori but in balance with their responsibilities to other members of the multidisciplinary team.

We recommend that the responsibilities of the Maori Health Coordinator and his/her staff embrace all sectors of the regional forensic psychiatric service.

We recommend that members of the multidisciplinary team of the regional forensic service be chosen by a panel of at least four persons. They are:

1. the Director of Forensic Services as a permanent member;
2. the Maori Health Coordinator as a permanent member;
3. the senior worker of the discipline for which the appointment is being considered;
4. any other member of the multidisciplinary team from some other discipline.

The Director of Forensic Services may appoint any other person whom he/she thinks appropriate on to the selection panel.

We recommend that biculturalism be incorporated in to all training programmes both in-service training and basic training.

We hope that ultimately multicultural training programmes will also be developed.

We recommend that the importance of taha wairua, taha whanau and tikanga Maori be recognized in all assessment and management decisions made in respect of psychiatric patients.

PART 6 : SUMMARY OF RECOMMENDATIONS

PART 1 : THE AUCKLAND AREA

We recommend the appointment of a Commissioner to oversee the establishment, efficient management and administration of all psychiatric services and facilities in the region for a period of at least 3 years. That Commissioner will report to and be directly accountable to you. The Commissioner should possess administrative, management and financial skills and ideally will have had some association with medical or psychiatric services. The Commissioner must be possessed of aroha and inter-personal skills. He/she would be expected to consult with all interested groups in the psychiatric service and to liaise closely with the Director of Mental Health. The Commissioner would be empowered to coopt such individuals or organizations as he/she thought appropriate. In simple terms, the Commissioner would be an interim General Manager for psychiatric services in the Auckland region.

PART 2 : THE REGIONS : INCLUDING AUCKLAND

We recommend that a National review panel be established by the Director of Mental Health to review each regional forensic service, and certain designated patients therein, at intervals of not more than one year. The personnel and functions of that review panel have been described earlier in this report.

We recommend that a review panel be established by the Director of Psychiatric Services in each forensic region. The personnel and functions of the regional review panel have been described earlier in this report.

We recommend that Section 121 (2) Criminal Justice Act 1985 (as amended by Section 3 of 1986 No. 83) be amended by deleting from SS (2A) the words "a psychiatrist or (where no such specialist is available) another medical practitioner" and substituting therefore the words "a person approved by the Regional Director of Forensic Services".

There will need to be a consequential amendment defining the office of Regional Director of Forensic Services.

We recommend that Section 44 (1) Mental Health Act 1969 be repealed and that the Director of Mental Health in his absolute discretion be authorised to direct the removal of any patient detained in hospital pursuant to an order made on an application under Section 42 Mental Health Act 1969 and further that the Director be authorised to delegate those powers to the National Review Panel.

We recommend that any patient detained in hospital pursuant to Section 43 Mental Health Act 1969 be authorised to request a transfer to a penal institution and that the Director of Forensic Services be empowered in his/her discretion to direct a transfer accordingly.

PART 3 : THE FORENSIC PSYCHIATRIC SERVICE

1. THE REGIONAL FORENSIC PSYCHIATRIC SERVICE

We recommend the establishment of a Regional Forensic Psychiatric Service to provide:

A A SERVICE TO THE HOSPITALS

- (i) In the medium secure unit.
- (ii) In the minimum secure unit.

B A SERVICE TO THE JUSTICE DEPARTMENT

- (i) In the courts.
- (ii) In the prisons.

C A FORENSIC COMMUNITY SERVICE

- (i) For outpatients.
- (ii) Aftercare.

D A LIAISON SERVICE TO THE GENERAL PSYCHIATRIC SERVICES

- (i) Psychiatric hospitals.
- (ii) Community psychiatric service.

We recommend the establishment of five forensic regions centred on Auckland, Hamilton, Wellington, Christchurch and Dunedin. The Hospital Board / Area Health Board based in each of those cities will be responsible for establishing and administering the service in its region.

The boundaries of each of the five regions will be determined by the Hospital Boards / Area Health Boards in consultation with the Director of Mental Health.

We recommend that the regional forensic psychiatric service be fully established and in operation not later than 31 December 1991.

We envisage that planning, funding, staff recruitment and training and the provision of facilities will proceed at a rate which will ensure the development of a comprehensive service by that date.

(i) Administration and Staff

We recommend that each regional forensic service be headed by a Director of Forensic Services who will be accountable to the Director of Psychiatric Services. He/she will be responsible for the establishment of a multidisciplinary team in adequate numbers so as to provide a high quality forensic service. He/she will also be responsible for ongoing in-service education of staff.

We recommend that the Director of each regional forensic service be granted an adequate annual budget to ensure the development and maintenance of a high quality forensic service.

That budget will be negotiated with the Director of Psychiatric Services.

We recommend that male and female staff be employed in the regional forensic service and that they work on a rotation roster so that time is spent in all sectors of the service, i.e. the medium secure unit, the minimum secure unit, courts, the prisons and the community and liaison services.

We recommend that multidisciplinary teams include people with professional qualifications in psychiatry, psychology, nursing, social work, occupational therapy and physiotherapy and people who are skilled in taha Maori or other cultural perspectives appropriate to the population being served.

We recommend that staff in the regional forensic service be encouraged to participate in control and restraint technique courses.

(ii) Patients

We recommend that patients be referred to the regional forensic service from the following sources:

1. community psychiatric services;
2. general psychiatric services;
3. the prisons on the recommendation of the prison medical officer;
4. the courts;
5. the National Maximum Security unit at Lake Alice.

We recommend that entry into all sectors of the forensic psychiatric service be determined by the multidisciplinary team on the basis of clinical assessment.

We recommend that a register be kept of all patients in the care of the forensic service. The register will record information regarding:

- (a) location of the patient within the service;
- (b) mental state of the patient;
- (c) current management of the patient.

Registration of a patient will occur when he/she is first admitted in to the forensic service and will be updated at six monthly intervals and on those occasions when the patient moves to another locality or facility.

We recommend that access to the register be restricted to forensic service staff, the Director of Mental Health and to those persons who are entitled to access through formal legal processes.

We recommend that all patients who enter the regional forensic service be cared for and treated in the least restrictive circumstances possible.

We recommend that, wherever possible, the same clinical team should care for the patient through the various stages of residential and community treatment.

We recommend that a key worker be allocated to each patient admitted to the regional forensic service.

The principle function of the key worker will be to provide support for the patient, to plan a treatment programme in consultation with the patient and other members of the multidisciplinary team and to liaise with the patient and the multidisciplinary team.

We recommend that an agreed patient transfer to or from a sector of the regional forensic service be undertaken on a trial basis for a period of eight weeks.

If during that period the patient's condition deteriorates, the patient may be returned to the facility or service from whence he/she came.

We envisage that the decision whether to return a patient will be a collective decision following consultation, assessment, negotiation and review between each clinical team involved in the care of the patient.

2. MEDIUM SECURE UNITS

We recommend that two medium secure units be established in Auckland, one in Hamilton, one in Wellington and one in Christchurch.

Each unit will consist of 15 beds with provision for two additional "emergency beds".

We recommend that the need for a medium secure unit in Dunedin be kept under review.

We recommend that each medium secure unit be stand alone, and purpose built and designed so as to achieve physical security for the patients but in a way which is neither all-pervading nor counterproductive to effective treatment.

We recommend that professional consultants be employed to advise on the design of the unit and the furniture, furnishings and interior decor of each unit.

We recommend that during the planning phase of medium secure units there be wide consultation with design personnel, nurses, psychiatrists and other para-medical staff.

We recommend that medium secure units offer specialised assessment, treatment and rehabilitation to carefully selected patients. These patients will:

1. require treatment in varied and adjustable levels of security as identified by each patient's individual needs;
2. will benefit from an intensive and carefully planned programme of care ranging from several weeks to approximately two years;
3. will not be considered an immediate danger to themselves or to the general public should they absent themselves without permission.

We recommend that medium secure units admit male and female offender and non-offender patients who do not require maximum security but who nonetheless are not suitable for treatment under the open conditions obtaining in psychiatric hospitals.

Such patients will be those who are severely disruptive, who exhibit dangerous behaviour, who may be mentally ill or mentally handicapped or who suffer from psychopathic or severe personality disorder.

We recommend that the staff to patient ratio in medium secure units be negotiated in the range of 2 to 2.8 nurses for each patient.

We envisage that appropriate architecture and electronic security will complement the staff levels to ensure a high level of security.

We recommend the development of non-repressive and non-punitive programmes by staff working in medium secure units.

Such programmes will take into account the age, intelligence, previous education and psychosocial background of the patient as well as the extent to which his/her potential has been impaired by mental disorder. Attention will need to be given to the ethnic and cultural background of the patient.

All caring and treatment programmes in the units will be the outcome of study and conference between patient and ward staff.

3. MINIMUM SECURE UNITS

We recommend that an audit be undertaken by the regional forensic service to determine the number of minimum secure units required in New Zealand.

Pending that audit, we recommend that units be established in Auckland, Hamilton, Wellington, Christchurch and Dunedin.

The units must not be isolated either from the general population or hospital services and will cater for not more than 30 patients each.

We recommend that minimum secure units cater for that group of mentally disordered persons who may not be willing to accept care voluntarily but whose conditions may not be treatable except on a long term basis and who could not cope adequately if discharged from hospital.

This group will contain the socially inadequate for whom the concept of "asylum" is still valid. It will also include some people who are too disruptive to manage in the community or in the general psychiatric hospital.

We recommend that long term active rehabilitation programmes be undertaken in minimum secure units.

4. PRISON SERVICE

We recommend that the forensic service in prisons be conducted on an outpatient basis. Inmates will return to the prison wing following treatment.

We recommend that the forensic facilities in prisons include some or all of the following:

1. An administration office.
2. Individual interview rooms.
3. Large all-purpose rooms.
4. Occupational therapy centre; a large room for leisure skills programmes; flat including kitchen, bathroom, toilet and bedroom for living skills.
5. School room and library.

The numbers and size of each facility will be determined in the main by the prison capacity.

We recommend that respite beds be made available to the forensic service in the prison hospital wing. If a prisoner requires continuing treatment beyond three days he/she will be transferred to a psychiatric hospital.

We recommend that forensic service staff in the prisons be additional to other health care staff. The forensic staff will comprise members of the multidisciplinary team and invited Kaumatua and cultural advisers.

We recommend that prison superintendents be given an unfettered discretion in deciding whether a prisoner may participate in programmes conducted by the forensic service in the prison.

We envisage that this discretion will be exercised after consultation with forensic service personnel.

We recommend that prison officers be rostered to work in prison forensic units to gain experience in the general aspects of forensic psychiatry including nursing techniques.

We recommend that the regional forensic team be authorised to make recommendations to the Prisons Parole Board regarding the post release care of any prisoner in the care of the forensic service.

We recommend that only those prisoners in the care of the regional forensic service will be entitled to after care following release from prison.

5. COMMUNITY AND LIAISON SERVICE

We recommend that a comprehensive community service be developed as part of the regional forensic service.

There will be a need for cooperation and integration between the community and forensic psychiatric services.

We envisage that patients discharged from the forensic service will use the general facilities available in the community and that the forensic service will care for and treat those patients who need intensive follow-up.

We recommend that the regional forensic service develop hostel places for the rehabilitation of mentally ill offenders in to the community.

We envisage that these hostels will be used to rehabilitate the more disturbed, socially inappropriate patients on a step by step basis with a view to eventual discharge in to the community.

6. FUNDING

We see no real or immediate prospect of Hospital Boards/ Area Health Boards being able to fund the forensic service we have proposed.

We recommend that there be a direct allocation of Government funds over a three year period to meet the capital costs of planning and establishing the medium secure units, the minimum secure units the facilities in the prison service and the facilities in the community forensic service.

We recommend that the cost of running each regional forensic service be funded by a direct Government allocation to the appropriate Area Health Board/ Hospital Board for a 3 year period ending 31 December 1991.

7. TRAINING

We recommend that there be consultation between the Director of Mental Health, the Royal Australian and New Zealand College of Psychiatrists and psychiatric academic units to determine the content duration and implementation of a specialist training programme for forensic psychiatrists.

We recommend that overseas personnel experienced in forensic psychiatry and in the planning, establishment and management of forensic psychiatric services be invited to New Zealand to advise on suitable training programmes and the implementation of the forensic service in this country. Ideally some personnel would have skills in teaching control and restraint techniques.

We recommend that New Zealand personnel visit established overseas forensic services to develop clinical expertise in all aspects of forensic psychiatry.

We envisage that those persons would be bonded to work in the New Zealand forensic service for an agreed period on their return.

The bond would include an obligation to train New Zealand staff.

The selected personnel will include psychiatrists, senior psychiatric registrars and clinical nursing staff.

8. FOLLOW UP

We recommend the appointment of a Commissioner to liaise with the Hospital Boards/ Area Health Boards in planning and establishing the regional forensic psychiatric service. That appointment will be for a three year period ending 31 December 1991. The qualifications of the Commissioner have been

referred to in Part 1 of this report.

We envisage that the Commissioner will carry out his/her duties in an unobstructive and supportive manner and will make sure:

1. that action is taken to ensure that a high quality, comprehensive forensic psychiatric service is operating not later than 31 December 1991;
2. that inappropriate action is not taken by Hospital Boards/Area Health Boards;
3. that tagged Government funding for the capital and running costs of the forensic service is spent for the purposes for which it is allocated.

PART 4 : COMMUNITY CARE

1. POLICY

We recommend that Government give a clear, unequivocal commitment to develop a comprehensive range of community psychiatric services for those who are psychiatrically disabled.

2. THE COMMUNITY PSYCHIATRIC TEAM

We recommend the appointment of a Director of Community Psychiatric Services. He/she will develop and maintain a comprehensive community psychiatric service in terms of our proposed model described in this part of our report.

We recommend the establishment of multidisciplinary teams to provide aftercare in the community for the psychiatrically disabled.

3. FUNDING

We recommend that the Director of Community Psychiatric Services be provided with an adequate annual budget to ensure the development and maintenance of high quality community services and facilities.

We recommend that the running costs of community psychiatric services be met by a direct allocation of Government funds for the 3 year period ending 31 December 1991.

We recommend the promotion of active policies enabling funds to be transferred from hospital based services to community based services.

We recommend that the management structures in the community psychiatric team be flexible enough to allow for the devolution of funds to individuals and community groups who are actively working in the community to promote the interests and welfare of the psychiatrically disabled.

4. REVIEW AND AUDIT

We recommend that the multidisciplinary team review its own services, facilities and finances at intervals of not more than one year. The Director of Community Psychiatric Services will be responsible for this review.

We recommend that the Director of Psychiatric Services undertake a review of the community psychiatric services at intervals of not more than one year. This review will be undertaken by a review panel appointed by the Director of Psychiatric Services.

5. DEVELOPMENT OF SERVICES

We recommend community consultation in the planning and development of community psychiatric services.

We recommend that representatives from patient groups be consulted, and wherever possible incorporated into, the policy making and management structures of community mental health services.

We recommend the appointment of a Maori Health Coordinator as head of a group of Maori workers who will form part of the multidisciplinary team.

We recommend wide consultation with those unions and other organisations representing psychiatrists, nurses and para-medical staff in planning the development, establishment or review of community facilities and services for the psychiatrically disabled.

(a) Accommodation

We recommend that Area Health Boards and Hospital Boards be responsible for providing a range of accommodation for psychiatric patients in the community and that such accommodation be allocated according to the clinical needs of the patients.

We recommend that staffing levels and the range and maintenance of all community accommodation be reviewed by the Area Health Board/Hospital Board at intervals of not more than one year. All accommodation must be of a high standard.

(b) Rehabilitation

We recommend the establishment of community based rehabilitation programmes for the psychiatrically disabled.

(c) Leisure Activities

We recommend that the multidisciplinary community psychiatric team be responsible for developing a range of leisure programmes in the community for the psychiatrically disabled.

We envisage that these programmes will be developed in conjunction with voluntary agencies to whom, where necessary, appropriate funding should be devolved.

(d) Occupations

We recommend that the multidisciplinary community psychiatric team liaise with government departments, employment agencies, employer organisations and other organisations and individuals to maximise employment opportunities for the psychiatrically disabled.

(e) Outpatient Services

We recommend the establishment of outpatient facilities sufficient in number to meet the needs of the community.

(f) Crisis Intervention/Acute Assessment

We recommend the development of acute assessment/crisis intervention services in sufficient numbers to adequately meet the needs of the psychiatrically disabled.

6. PATIENT MANAGEMENT

We recommend that a key worker be allocated to each patient accepted by the community psychiatric team.

7. PATIENTS INCOME

We recommend that sickness and invalid benefits be reviewed and set at a level which enables psychiatric patients to enjoy a reasonable standard of living.

PART 5 : PSYCHIATRY AND MAORI PATIENTS

We recommend that the job description for the positions of Director of Psychiatric Services and Director of Forensic Services includes a requirement that he/she develops a bicultural service embracing taha wairua, tikanga Maori and te reo.

We recommend that representatives of the Maori community (who must be of the multiple iwi groups resident in that region) be included on interview panels to decide all major appointments to Area Health Boards/Hospital Boards. In the context of this report such appointments would include the Chief Executive, the Director of Psychiatric Services, the Director of Forensic Services and the Director of Community Psychiatric Services.

We recommend that all senior appointments to Area Health Boards/Hospital Boards will be conditional upon the appointee having a knowledge and appreciation of Maori culture, tikanga Maori and taha wairua or alternatively giving an undertaking to acquire that knowledge as soon as is reasonably practicable following appointment.

We envisage that under these circumstances senior appointees will seek advice from Kaumatua and Kuia as to how best this can be achieved. We have no doubt that the Maori community will respond in a supportive way.

We recommend obligatory consultation with the Maori community and other significant ethnic minority groups in planning and establishing a regional forensic service.

We recommend that a Maori Health Coordinator be appointed to the regional forensic team.

This person must be skilled in taha Maori and have a knowledge of te reo. He/she may not necessarily possess any formal medical qualification.

The appointment will be conditional upon the appointee having suitable qualifications or experience in management/administration skills or alternatively agreeing to acquire such skills as soon as is reasonably practicable following appointment.

This appointment is to be made by the Director of Forensic Services after consultation with Maori representing the multiple iwi groups in the region.

The Maori Health Coordinator will establish a whanau of Maori health workers in sufficient numbers to meet the needs of the Maori population in the region being served. The members of that whanau will be involved in:

1. The assessment and management of patients on an active basis as full team members.
2. The training and support of the multidisciplinary team in bicultural matters.
3. The development of services in Maori related ways.
4. Establishing and maintaining close working contacts with the various iwi groups of the region.

The Maori Health Coordinator will have the same status as any other head of service within the regional forensic service and will be directly accountable to the Director of Forensic Services.

The Maori Health Coordinator and members of that department must be free to work in a manner consistent with tikanga Maori but in balance with their responsibilities to other members of the multidisciplinary team.

We recommend that the responsibilities of the Maori Health Coordinator and his/her staff embrace all sectors of the regional forensic psychiatric service.

We recommend that members of the multidisciplinary team of the regional forensic service be chosen by a panel of at least four persons. They are:

1. the Director of Forensic Services as a permanent member;
2. the Maori Health Coordinator as a permanent member;
3. the senior worker of the discipline for which the appointment is being considered;
4. any other member of the multidisciplinary team from some other discipline.

The Director of Forensic Services may appoint any other person whom he/she thinks appropriate on to the selection panel.

We recommend that biculturalism be incorporated in to all training programmes both in-service training and basic training.

We hope that ultimately multicultural training programmes will also be developed.

We recommend that the importance of taha wairua, taha whanau and tikanga Maori be recognised in all assessment and management decisions made in respect of psychiatric patients.

APPENDIX 1

RESEARCH : DATA ANALYSIS AND EVALUATION

The purpose of the following analysis was to assess the movement (i.e. admission and discharge) of special and remand patients throughout psychiatric hospitals in New Zealand, and to determine a description of these persons.

METHOD

Health Department data was provided by the National Statistics Department, Wellington, as to the number of admissions of remand and special patients for the years 1980 to 1986.

Comprehensive data for 1985 enabled an indepth analysis of admissions and discharges of remand and special patients, including age groups, sex, race, discharge type and length of hospital stay.

Data for 1986 is provisional and does not include sufficient information to allow as comprehensive an analysis as that of 1985.

Health Department data was not available for 1987. However, some information for the months January to June 1987 was provided by the Department of Justice, Wellington. This includes first admissions only of those remand and special patients admitted under the Criminal Justice Act, 1985.

RESULTS

Admissions 1980 - 1986

Table 1 shows the total number of remand and special patients admitted to psychiatric hospitals during the years 1980 to 1986, and the percentage of these admissions identified as Maori. The total admissions range from a high of 442 in 1981 to a low of 149 in 1986. The percentage of Maori admissions during these years ranges from a low of 26% of total admissions in 1981 to a high of 36% in 1986. Over the six years to 1985 Maori people comprised an average of

25.3% of total remand admissions and an average of 42% of total special patient admissions.

In 1986 however, Maori accounted for 31% and 67% of total remand and special patient admissions, respectively.

In Figure 7a total admissions of special and remand patients are presented graphically, showing the number of admissions for Maori, Pacific Islander and Other racial groups for the years 1980 to 1986.

Figures 7b and 7c show the same data divided into remand and special admissions for the three racial groups. The figures indicate a decreasing trend of total admissions from 1981 to 1986. This trend is more obvious for admissions of the Other racial groups than for Maori and Pacific Islanders. Whilst admission of special patients for the Other racial group has shown a steady yearly decrease from 1982 to 1986, Maori special patients admissions for 1986 have, for the first time, accounted for the greater proportion of total special patients admissions.

Age Groups of Admissions, 1980 - 1985

Figures 8a - f illustrate the age groups of special and remand admissions, separated into the three racial groups (Maori, Pacific Islander and Other) for the years 1980 to 1985. Whereas admissions for the Other racial group tends towards a bi-modal distribution, with a peak at the younger (20 - 24 years) and older (40+) age groups, the majority of Maori admissions is concentrated in the younger age group. There are no distinctive trends for the Pacific Islander admissions.

Admissions 1985

Table 2 shows total remand and special patients admissions for 1985, the admission type and racial group. Of the total of 255, 75 were first admissions and 180 (71%) were readmissions. Remands accounted for 82% of total admissions, and of remand admissions, 24% were Maori, 4% Pacific Islander and 72% of the Other racial groups.

A higher proportion of Maori patients (28%) were admitted as special patients compared with Pacific Islander (20%) and Other (13%) groups. Hospitals admitting the largest proportion of remand and special patients were Cherry Farm, Oakley and Sunnyside. Cherry Farm and Oakley each admitted 20% of the total admissions and Sunnyside 15%. Remands accounted for 88%, 84% and 100% of these total admissions at Cherry Farm, Oakley and Sunnyside, respectively.

Sex of Admissions 1985

A frequency count of the sex of remand and special patients admitted during 1985 is shown in Table 3. In that year, 21% of the total admissions were female. They comprised 22% of the total remand and 13% of the total special patient admissions. Maori females comprised the largest proportion of the total female admissions; they accounted for 24% of total Maori admissions, whilst female Other accounted for 20% of total Other admissions and female Pacific Islanders accounted for only 10% of total Pacific Islander admissions. All but 6(11%) of female admissions were remands, and all female special patients were of the Other racial group.

Admissions 1986

Table 4 shows total admissions of remand and special patients to each psychiatric hospital during 1986, the admission type and racial group. No division is made between first admission and readmissions.

Remands accounted for 86% of all admissions. The majority of admissions were to Oakley, Tokanui, Sunnyside and Lake Alice Hospitals. Oakley and Tokanui admitted 56% and 11% of total admissions respectively, whilst Sunnyside and Lake Alice each admitted 8%.

Race of Admissions 1986

Of the total admissions, 36% were Maori, 8%

Pacific Islanders and 56% Other racial groups. Special patients comprised 24% of Maori admissions compared to only 8% of Pacific Islander and Other admissions, (see Table 5).

Boards of Domicile of Admissions 1986

The majority of special and remand patients were admitted to psychiatric hospitals within their Board of Domicile. A total of 87 (58%) of admissions were from the Auckland Board of Domicile, and 85 (98%) of these were admitted to hospitals within the Auckland area (mainly Oakley). The Boards of Domicile for some of the remaining admissions (approximately 10-11%) were some great distance removed from the admitting hospital.

Comparison of 1985 and 1986 Admissions

Table 6 compares the number of special and remand admissions during 1985 and 1986.

Total admissions for 1986 were 58% of those for 1985, a reduction of 106. Eight out of ten hospitals admitted less patients in 1986, the greatest decrease being shown at Cherry Farm, which admitted 15% of the 1985 total, and Sunnyside, which accounted for 31% of the 1985 total. Oakley, however, increased its admission rate by 66% over its 1985 figure; Kingseat had no admissions in 1986, compared to 10 the previous year.

Discharges and Replacements 1985

Table 7 shows the number and type of discharges of special and remand patients during 1985, and the hospital from which discharge occurred.

Outright discharges account for 86 (92%) of total discharges while 6(6%) were discharged on leave. The remaining 2% were discharged from leave. During this year a total of five patients were recalled from leave.

The highest number of total discharges were from Tokanui and Cherry Farm, at 16 each which together accounted for 34% of the total discharges.

Maori patients comprised 26% of the total discharges, Pacific Islanders 4% and Other 70%.

Most patients discharged were remands (67%). Data was studied to determine the length of hospital stay. The great majority of patients (75%) were discharged within 30 days of admission while only 1% spent longer than 12 months in hospital.

Discharges 1986

Data for total discharge of remand and special patients during 1986 is shown in Table 8. A total of 207 patients were discharged. 87% of this total had not been committed.

Maori patients accounted for 69 or 33%, Pacific Islanders 5% and Other 62% of total discharges.

The great majority of discharges were remand patients comprising 81% of the Maori, 80% of Pacific Islanders and 91% of Other racial group discharges.

Oakley hospital with 66, accounted for 32% of total discharges, followed by Sunnyside with 32 (15%) and Tokanui and Lake Alice, with 27 (13%).

As in 1985, 75% of patients stayed less than 30 days in hospital. When determining length of hospital stay by racial groups, a greater proportion of Maori (84%) were discharged in less than 30 days, compared to 70% of Pacific Islanders and the Other group.

Comparison of Discharges 1985 and 1986

Table 9 compares discharges from psychiatric hospitals for 1985 and 1986. For 8 of 11 hospitals discharge rates were greater in 1986 than in 1985. The largest increase in the number of discharges was at Oakley, where the figure rose from 12 in 1985 to 66 in 1986, an increase of 54 or 550%. Discharges from other hospitals e.g.

Carrington, Tokanui, Sunnyside, Cherry Farm and Lake Alice also increased substantially.

Admissions under Criminal Justice Act 1985 January - June 1987

Table 10 shows the total number of persons remanded under Section 121 of the Criminal Justice Act 1985 during January to June 1987 as 189. Of this total, 61 (or 32%) were remanded to hospital.

The number of persons admitted to psychiatric hospitals under the Criminal Justice Act 1985 for the same period totals 80 (see Table 11), and 61 (or 76%) of these were Section 121 remands. Sections 115 and 118 admissions total 12 or 15% and 7 or 9% respectively.

Table 12 shows a further frequency count of the Section 121 remands by the variables of age, sex and race. Of those remanded under Section 121, 26.5% were Maori, 4.2% Pacific Islanders and 63% Caucasian. Other races and those whose race was unknown account for 6.3% of the total.

Approximately 25% of Maori and Pacific Islander remands were female, compared to less than 9% of Caucasian remands.

Of the total Section 121 remands January - June 1987 37.57% were for property offences, 28.04% were for violence and sexual offences and 13.23% were for offences against good order.

COMMENT

Admissions

The decreasing rate of remand and special patient admissions which has gained momentum over the past few years commenced and coincides with the 1982 Oakley (Gallen) Inquiry.

The "open-door" policy of psychiatric hospitals has probably also resulted in some hospitals refusing to admit patients who require security. It has been said that skills in nursing these often "difficult" patients have been gradually lost, whilst a dependency upon rapid positive response to psychotropic medication has increased. We cannot comment on this.

The 58% decrease in total admissions from 1985 to 1986 is the largest in any one year. It is significant that, whilst admission rates decreased for all three racial groups, this was not as great in the Maori group as in the Other group; whilst the Maori comprises 10-12% of the general population this group accounted for 67% of special patient admissions in 1986.

It is obvious from the statistics that Maori are more likely to be admitted as special patients than any other group. It is important to ask why this should be so because the over representation of Maori within the prisons does not entirely account for this discrepancy. The issue of the Maori offender and his reaction to incarceration is one which urgently needs to be addressed.

The age group distribution of admissions (Figures 8a - f) indicates that the greater proportion of Maori admissions within the younger age group may well reflect the age distribution of Maori within the

general population.

Analysis of the sex of special and remand patients was possible only for 1985 and for remands in the first half of 1987. The data indicates that Maori females are more likely to be admitted as remand and special patients than females of any other racial groups.

Discharges

While hospital admission rates for 1986 decreased by 58% compared to 1985, discharges for the same period increased by over 100% (Table 9). Because the total rate of discharge is actually greater than the total admission rate, it is assumed that these figures must include the discharge of patients admitted in the previous year. For both 1985 and 1986 the length of stay in hospital was less than 30 days for 75% of the patients, and of those whose stay exceeded 30 days, very few remained for longer than 12 months.

Another point of interest, and concern, is that the greater proportion of patients were discharged outright, compared to those discharged on leave (Tables 7 and 8). This indicates that for the large majority of patients there was a total lack of follow-up and supervision following discharge. Whilst readmission rates were not available for 1986, there is no reason to believe that the proportion of readmissions would be very different from that of 1985. The large readmission rate for that year may well reflect this lack of post discharge care and supervision.

We do not believe that the above data accurately reflects the number of people who were psychiatrically disordered to the extent that they required hospitalisation. Persons who should otherwise have been in hospital ended up staying in gaol. This occurred at least in the Auckland region, for reasons referred to in Part I of this report.

Figure.7a : TOTAL NUMBER of SPECIAL and REMAND ADMISSIONS for EACH RACIAL GROUP

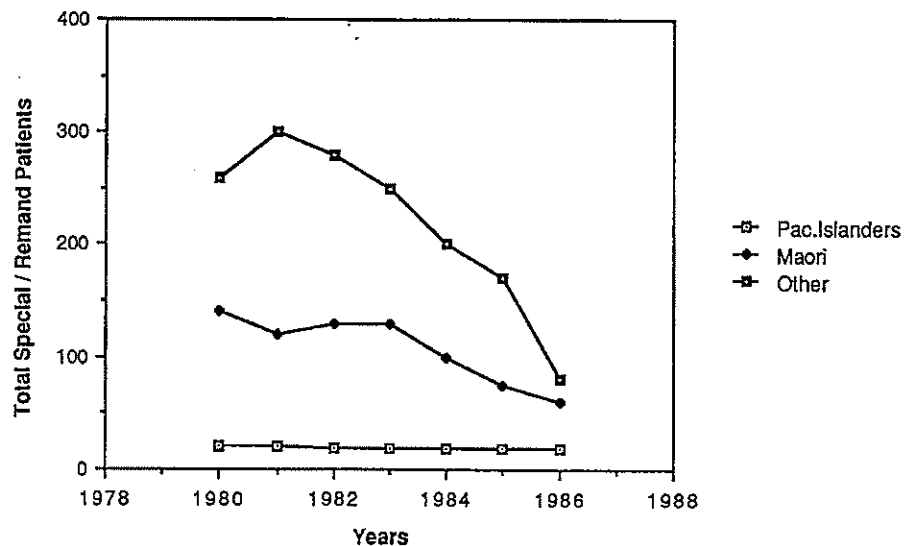


Figure.7b : TOTAL NUMBER of SPECIAL PATIENTS ADMITTED for EACH RACIAL GROUP

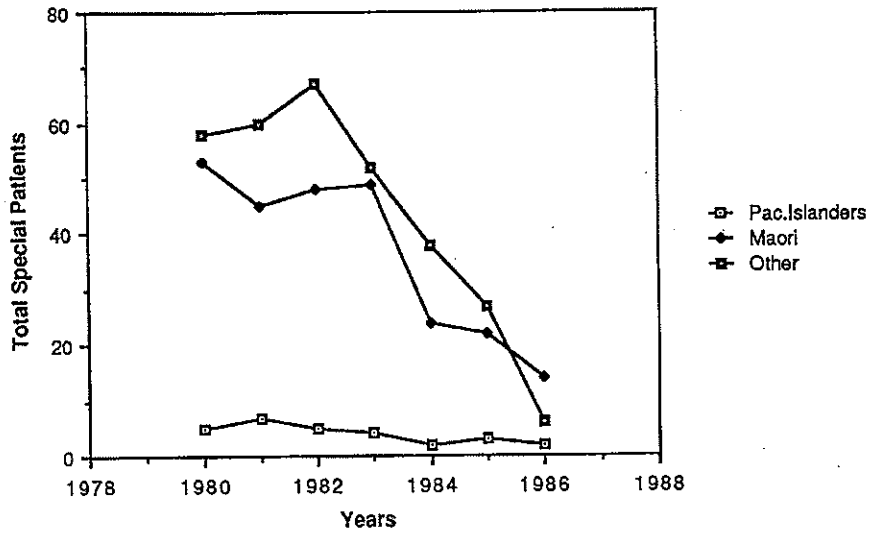
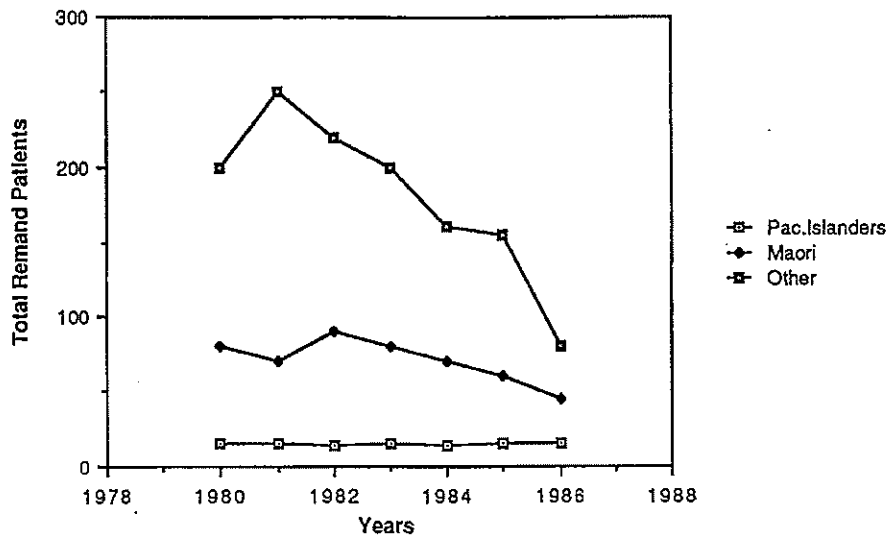
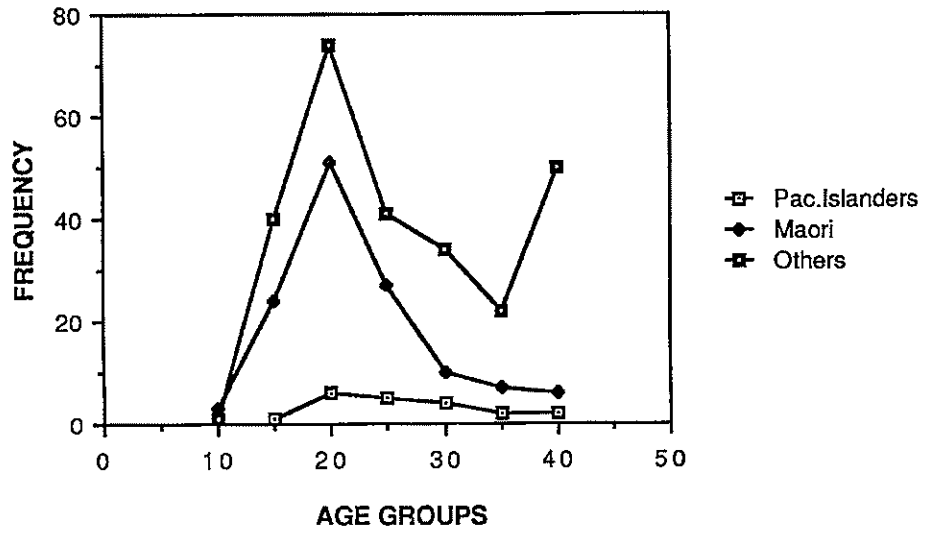


Figure.7c : TOTAL NUMBER of REMAND PATIENTS ADMITTED for EACH RACIAL GROUP

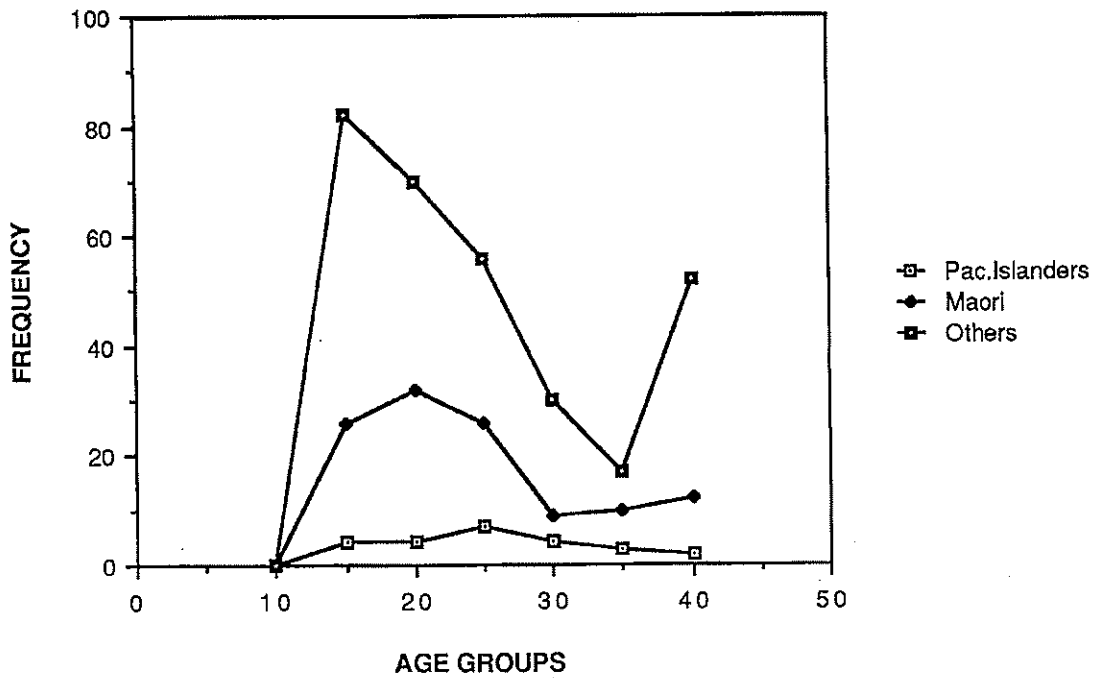


FIGURES 8a TO 8f ILLUSTRATE THE AGE GROUPS OF SPECIAL AND REMAND ADMISSIONS SEPARATED INTO THREE RACIAL GROUPS FOR THE YEARS 1980 TO 1985

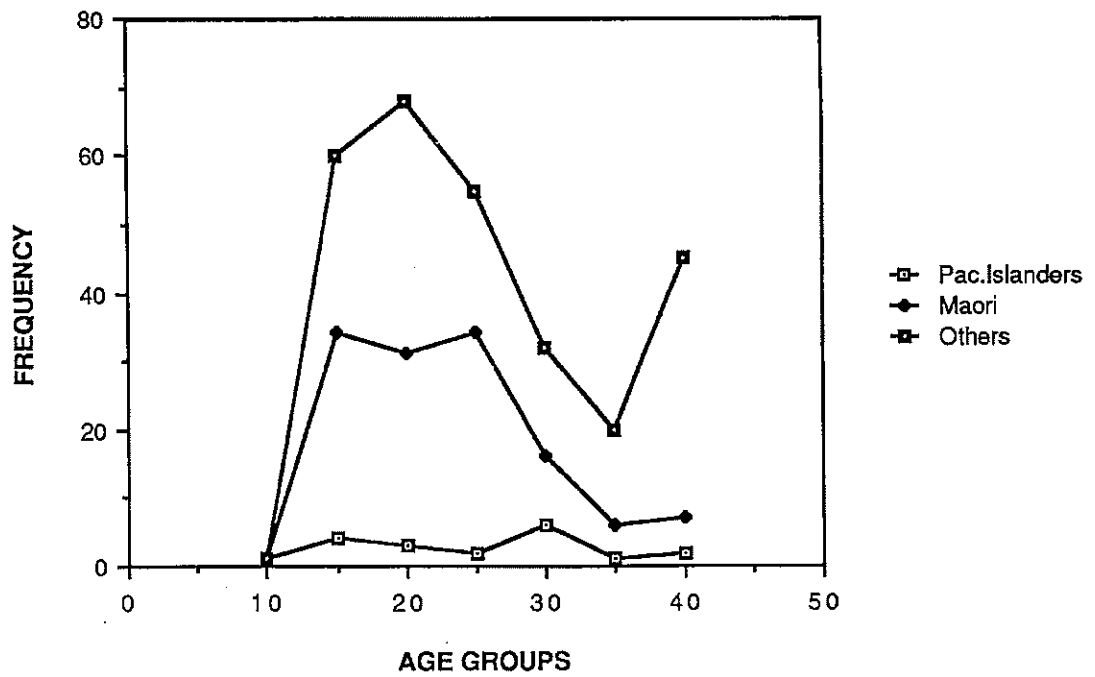
8a: 1980



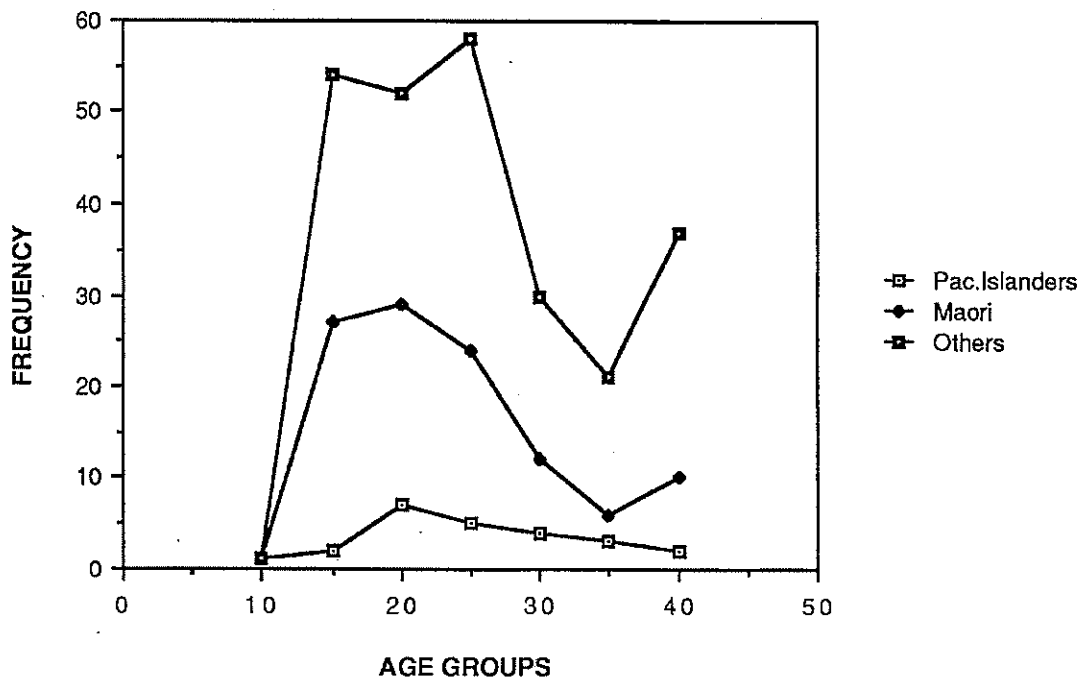
8b: 1981



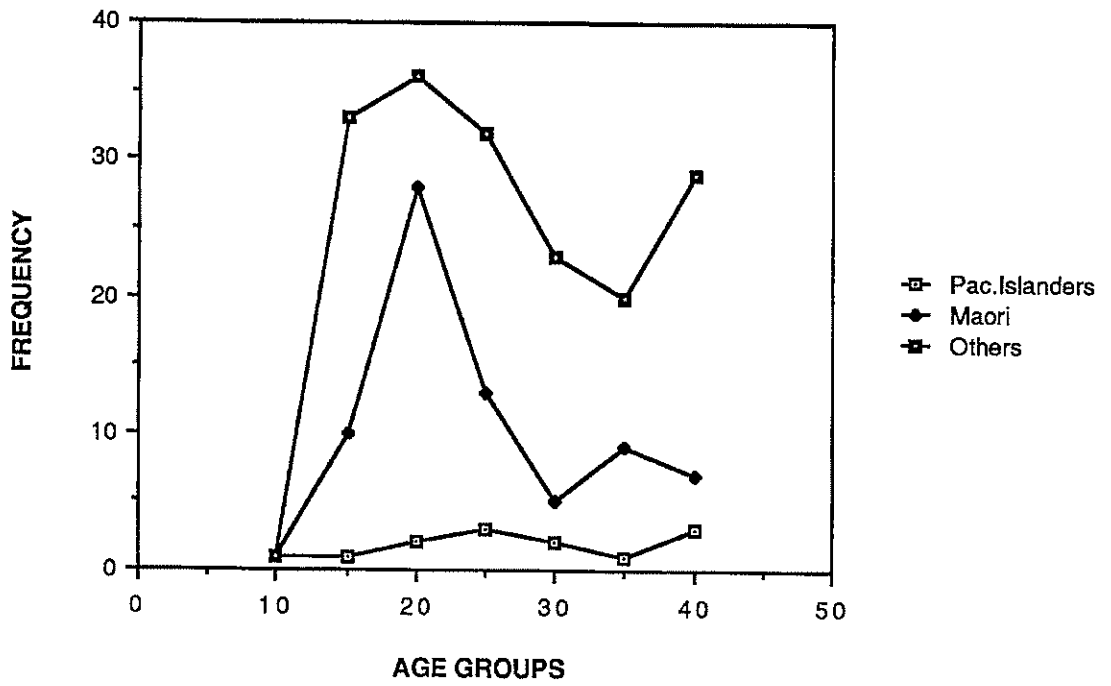
8c: 1982



8d: 1983



8e: 1984



8f: 1985

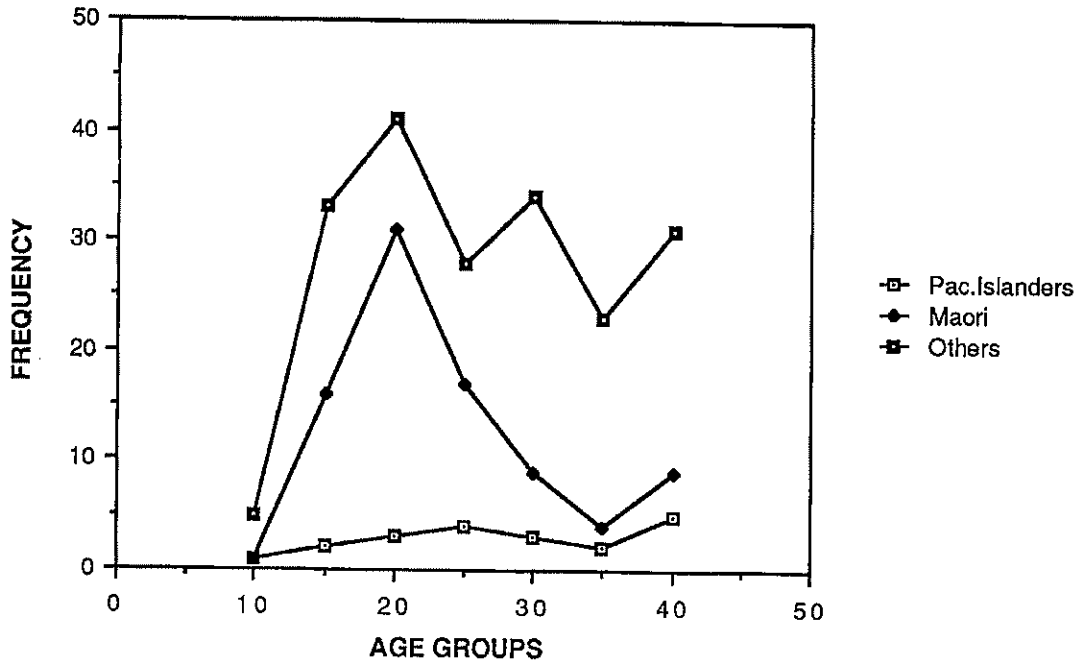


TABLE 1: Total special and remand patients admitted to psychiatric hospitals during the years 1980 - 1986, and the percentages of these admissions identified as Maori

Year	Total Admissions	MAORI		
		%Total Admissions	%Remands	%Special Patients
1980	414	32	27	45
1981	442	26	21	40.5
1982	425	30	26	40
1983	390	31.5	26	47
1984	298	29.5	27.5	37
1985	255	28	24.5	42
1986	149	36	31	67

TABLE 2: Total admissions to psychiatric hospitals of remandees and special patients during 1985

Admitting Hospital	Admission Type						Race		
	Total	S115	S42	S43	S42(4)	Remand	M	PIs	O
Carrington	18	-	-	-	-	18	5	1	12
Oakley	50	2	2	1	3	42	15	5	30
Kingseat	10	1	-	-	-	9	3	-	7
Tokanui	32	3	3	2	2	22	7	-	25
Porirua	27	-	3	1	-	23	9	3	15
Sunnyside	39	-	-	-	-	39	10	-	29
Cherry Farm	52	1	-	4	1	46	12	-	40
Lake Alice	20	-	4	12	-	4	10	1	9
Ngawhatu	7	-	-	-	-	7	-	-	7
TOTAL	255	7	12	20	6	210	71	10	174

First admissions = 75 (29%)
 Readmissions = 180 (71%)
 TOTAL = 255

Section by Race

	M.	PIs	O
Remand	51(24%)	8(4%)	151(72%)
S115	2	-	5
S42	8	2	2
S43	8	-	12
S42(4)	2	-	4
TOTAL	71	10	174

Remands = 82% of admissions
 Special Patients = 18% of admissions

TABLE 3: Number of female special and remand patients admitted to psychiatric hospitals during 1985, their race and patient type

Admitting Hospital	Sex of Patient		Race of Female Patient			Type of Female Patient	
	M	F	M	PIs	O	Special	Remand
Carrington	6	12	3	1	8	2	12
Oakley	50	0	-	-	-	-	-
Kingsseat	4	6	2	-	4	-	6
Tokanui	23	9	7	-	2	4	5
Porirua	22	5	2	-	3	2	3
Sunnyside	33	6	4	-	2	-	6
Cherry Farm	38	14	5	-	9	-	14
Lake Alice	19	1	1	-	-	-	1
Ngawhatu	7	0	-	-	-	-	-
Sub Totals	202	53	24	1	28	6	47
TOTALS	255		53			53	

TABLE 4: Total admissions to psychiatric hospitals of remands and special patients during 1986 (provisional)

Admitting Hospital	Total	Admission Type				Race		
		S115	S42	S43	Remand	M	PIs	O
Carrington	7	-	-	-	7	-	2	5
Oakley	83	3	2	2	76	31	9	43
Tokanui	16	2	1	1	12	9	-	7
Porirua	10	-	-	1	9	1	-	9
Sunnyside	12	-	1	-	11	1	-	11
Cherry Farm	8	-	-	-	8	5	-	3
Lake Alice	12	1	4	3	7	7	1	4
Seaview	1	-	-	-	1	-	-	1
TOTAL	149	6	8	7	128	54	12	83

TABLE 5: Admission type and race of special and remand patients admitted to psychiatric hospitals during 1986 (provisional)

Admission Type	RACE			Total
	Maori	Pac.Is.	Other	
Remand (S121)	41	11	76	128
S115	4	-	2	6
S42	5	-	3	8
S43	4	1	2	7
TOTAL	54	12	83	149

TABLE 6: Comparison of admissions of special and remand patients to psychiatric hospitals during 1985 and 1986

Admitting Hospital	Years		Difference
	1985	1986	
Carrington	18	7	-11
Oakley	50	83	+33
Kingseat	10	0	-10
Tokanui	32	16	-16
Porirua	27	10	-17
Sunnyside	39	12	-27
Cherry Farm	52	8	-44
Lake Alice	20	12	- 8
Ngawhatu	7	0	- 7
Seaview	0	1	+ 1
TOTAL	255	149	-106

TABLE 7: Special Patients and remands discharged from Psychiatric Hospitals during 1985

Hospital	Outright Discharge						Disch. on Leave			Disch. from Leave			Totals	%Total Disch.			
	R	M	Sp	Pis	R	Sp	R	O	Sp	M	Pis	O			M	Pis	O
											Special			Special			
Carrington	-	-	-	-	-	3	-	-	-	-	-	2	-	-	-	5	5
Oakley	-	4	1	-	-	5	-	1	1	-	-	-	-	-	-	12	13
Kingseat	2	-	-	-	-	3	-	-	-	-	-	-	-	-	-	5	5.3
Tokanui	4	1	-	-	-	7	3	-	-	-	1	-	-	-	-	16	17
Porirua	4	1	1	1	-	5	1	-	-	-	1	-	-	1	-	15	16
Sunnyside	1	-	-	-	-	12	-	-	-	-	-	-	-	-	1	14	15
Cherry Farm	2	1	-	-	-	8	5	-	-	-	-	-	-	-	-	16	17
Lake Alice	1	2	-	-	-	-	4	-	-	-	-	-	-	-	-	7	7.5
Ngawhatu	-	-	-	-	-	3	-	-	-	-	-	-	-	-	-	3	3.2
Ashburn Hall	-	-	-	-	-	1	-	-	-	-	-	-	-	-	-	1	1
TOTAL	14	9	2	1	-	47	13	1	1	1	4	0	0	2	94	100%	

TABLE 8: Special and remand patients discharged from Psychiatric Hospitals during 1986 (provisional)

Hospital	Discharge Not Committed			Outright Discharge						Discharged on Leave			Totals	% of Total
	M R	Pis R	O R	Maori R	Sp	Pisder R	Sp	Other R	Sp	M Sp	Pis Sp	O Sp		
Carrington	2	1	6	-	-	-	-	-	-	-	-	1	10	5
Oakley	25	6	32	-	2	-	-	1	-	-	-	-	66	32
Kingseat	2	-	1	-	-	-	-	-	-	-	-	1	4	2
Tokanui	10	-	11	-	2	-	-	-	2	1	-	1	27	13
Porirua	2	1	12	-	-	-	-	-	1	-	-	-	16	7.5
Sunnyside	3	-	27	-	1	-	-	-	-	-	-	1	32	15
Cherry Farm	5	-	16	-	-	-	-	-	1	-	-	-	22	11
Lake Alice	6	-	9	-	7	-	2	-	3	-	-	-	27	13
Ngawhatu	1	-	1	-	-	-	-	-	-	-	-	-	2	1
Seaview	-	-	1	-	-	-	-	-	-	-	-	-	1	0.5
TOTALS	56	8	116	0	12	0	2	1	6	1	0	4	207	100%

(27%) (4%) (56%)

- (11%) -

- (2%) -

TABLE 9: Comparison of discharges of special and remand patients from psychiatric hospitals during 1985 and 1986

Current Hospital	Years		Difference
	1985	1986	
Carrington	5	10	+ 5
Oakley	12	66	+ 54
Kingseat	5	4	- 1
Tokanui	16	27	+ 11
Porirua	15	16	+ 1
Sunnyside	14	32	+ 18
Cherry Farm	16	22	+ 6
Lake Alice	7	27	+ 20
Ngawhatu	3	2	- 1
Sea View	0	1	+ 1
Ashburn Hall	1	0	- 1
TOTAL	94	207	+ 113

TABLE 10: Number of persons remanded under Section 121 Criminal Justice Act 1985 during January - June 1987

Remanded	On Bail	In Custody	In Hospital	Total
S121	58	70	61	189

TABLE 11: Number of persons admitted to psychiatric hospitals under the Criminal Justice Act 1985, during January - June 1987

S115	S118	S121	TOTAL
12	7	61	80

TABLE 12: Remands under Section 121 : Criminal Justice Act 1985
January - June 1987 by Age, Sex, Race

	TOTAL	NOT KNOWN		MAORI		CAUCASIAN		PACIFIC ISLAND		OTHER	
		M	F	M	F	M	F	M	F	M	F
15 - 19	36	3	-	6	4	19	2	1	1	-	-
20 - 24	52	2	1	14	4	24	5	2	-	-	-
25 - 29	24	-	-	8	3	9	-	2	1	1	-
30 - 34	29	1	-	3	-	21	1	1	-	2	-
35 - 39	14	-	-	4	-	7	2	-	-	1	-
40+	34	1	-	2	2	28	1	-	-	-	-
Not Known	-	-	-	-	-	-	-	-	-	-	-
TOTAL	189	7	1	37	13	108	11	6	2	4	-
% OF TOTAL	100.0	3.7	0.5	19.6	6.9	57.1	5.8	3.2	1.1	2.1	-
		4.2		26.5		63.0		4.2		2.1	

From Department of Justice 1987

APPENDIX 2

DANGEROUSNESS

If there is one word that provides the key to this report, and what has caused it to be brought into existence, that one word would be "dangerousness". As evidenced by the recent Roper Report, there is a widespread anxiety about violence throughout the national community, and that anxiety surfaces strongly in concern about the security surrounding the mentally ill.

The Concept of Violence

The Oxford English Dictionary defines "violence" as the exercise of physical force so as to inflict injury on, or cause damage to, persons or property; and as "treatment, or usage tending to cause bodily injury or forcibly interfering with personal freedom." A wider viewpoint incorporates more pernicious forms of violence, "including racism, sexism, state and institutional violence and economic policies which create unemployment, deprivation and poverty". Such a view would regard as violent the acts or omissions of social institutions which discriminate against certain sections of the population. The Roper Committee 1987 took "violent crime" to mean unlawful acts of violence against the person, being the sense most commonly accepted by the community.

"Such offences exist in the current law under the headings of murder, attempted murder, manslaughter, wounding and injuring with intent, assault of all types, robbery, aggravated robbery and sexual violation."

Community apprehension associates violence with mental illness, and it is this factor above all others that creates the resistance to the use of facilities in the community, and leads to calls for tighter hospital security and confinement. Traditionally, the mentally ill have been regarded with fear, both because of the attribution of violence to them, and because they are seen as unpredictable and unconstrained by the usual social and moral imperatives. Such fear is perpetuated by the media, particularly television, in which the mentally disordered are fre-

quently depicted as violent. But it is highly questionable whether this fear is justified, i.e. whether mental illness can validly be equated with dangerousness. If the equation can be made, then all dangerous people would necessarily be definable as mentally ill under the DSM III diagnostic system, and all persons labelled as mentally ill would necessarily be dangerous. This is manifestly not so.

Are Psychiatric Patients as a Group Particularly Violent?

It should be noted that DSM III does not list dangerousness as a necessary symptom for mental illness.

There have been a number of studies that have examined the arrest records of patients released from psychiatric institutions. Some have involved comparison with other social groups. One of the studies looked at the arrest rate for violent crime over a period of several years among three groups: the general population, ex psychiatric patients and ex prisoners. The results were as follows:

- general population: 3.62 per 1,000
- ex psychiatric patients: 13.35 per 1,000
- ex -prisoners: 87.50 per 1,000

These figures show that ex psychiatric patients are more likely to be arrested for crimes of violence than the average citizen: and far less likely to be arrested than ex prisoners. When the researchers removed ex-psychiatric patients who had had previous criminal records from their sample, however, there was no longer any

significant difference between ex-psychiatric patients and the general population. The research findings contradict widely held beliefs about psychiatric patients. While a minority of psychiatric patients with criminal records are more likely to commit a crime than the ordinary person, they are no more likely to commit crimes than ex-prisoners without psychiatric histories.

Recent studies in the Federal Republic of Germany and Britain do indicate a greater risk of violent offending amongst psychotic persons suffering schizophrenic disorders. In New Zealand, between 1920 and 1955, 59% of murder suspects either committed suicide, were found unfit to plead on grounds of insanity, or were certified insane following conviction. Comparable figures are found in England. However, while the younger person suffering from an acute schizophrenic psychosis tends to be assaultive, those suffering from the chronic schizophrenic states are less likely to offend than the common population.

At the heart of the matter lies the simple recognition that it is not people as such who are dangerous: it is their behaviour which may be. Their behaviour is a response to particular events. The response is propelled by beliefs, knowledge and desires. Mental illness affects mental states and aspects of our predisposition and self control. While psychosis is rarely sufficient in and of itself to produce violence, it may be a contributory factor by distorting perceptions of reality and affecting belief systems. Psychosis may therefore be called a risk factor rather than a cause of violence. It is particularly important to stress that very few people suffering from mental disorder are violent or dangerous.

Are Special Patients as a Group Particularly Violent?

Since psychiatric patients generally as a group are no more prone to violence than any other group in the overall population, the question arises as to whether or not there is a case to be made that, of the psychiatric population, the group that has the status of special patients is particularly prone to violence.

Suffice it to say that the legal status of an individual patient is not directly correlated to the degree of mental illness or the magnitude of violent behaviour. Singling out special patients as a group is a meaningless exercise for the pur-

poses of identifying the potential for dangerousness.

The Historical Root of the Problem.

If there is no rational link between mental illness and dangerousness, how did the link come to be made in the public mind? Faucault (1978) suggests that the link between psychiatric illness and dangerousness can be traced to 19th century Europe, where the bad and the mad were treated similarly. Psychologists' theories arising at that time suggested that insanity was the cause of apparently senseless violent actions. Criminal psychiatry developed by providing a pathology both of monstrous behaviour, and of insanity with crime as its only manifestation. Thus dangerousness was seen as evidence of insanity.

The Concept of Dangerousness

The association of mental illness and dangerousness has thus developed as a cultural attitude in Western society from the late 19th Century. It is important to recognize that it is not a universally shared perception outside this cultural context.

Dr Peter Scott, a consultant forensic psychiatrist, defined dangerousness as covering "unwanted behaviour which is threatening or disturbing to the public, and may require that the offender be placed in custody to protect the public". What was tolerable would be for the public and the court to decide.

Dr McGrath defined as dangerous, "those who would probably inflict physical harm on others". This would exclude property offenders. The Butler Report has come to equate dangerousness with a propensity to cause serious physical injury or lasting psychological harm, and this is the understanding adopted for the purposes of our report.

Fear induced in others seems to lie at the heart of the concept of dangerousness. What is characteristic of this fear is that it attaches to the social identity of the person feared rather than to that person's actual behaviour. He or she becomes a "dangerous person". What is feared above all else is unpredictability: the propensity to behave violently for no apparent reason.

While the fear is understandable, it is important to recognize that this is an emotion-driven concept rather than one arising out of rational diagnostic criteria. As such it leads to

conditions amounting to very real injustice. People who are mentally healthy but who are also potentially dangerous have their freedom guarded by the law, so that, after their prison sentence is served, they are automatically released and can no longer be detained. However, those who are mentally ill and are adjudged potentially dangerous can be confined indefinitely.

It is futile for psychiatry at this present time to try to escape the link made in the public mind between mental illness and dangerousness. Some statement on dangerousness, and some effort at establishing credible criteria, is necessary.

Those criteria, according to Dr Scott, should be:

- the irreversibility of the damage done;
- the quantity of the damage (including how long it has gone on); and
- the infectiousness of the behaviour (which may be connected with the general climate of opinion)

Anticipated continuation is also an important factor. However hurtful, destructive or grave the behaviour, the label of "dangerous" is likely to be attached only if such behaviour is expected to continue.

The major distortion to be guarded against is that which would perceive "dangerousness" as a constant disposition, like lefthandedness or restlessness. Dangerousness is not a constant disposition. The personality of the subject plays a part: but so do the circumstances of the environment in which he or she lives. Dangerousness is a product of an interaction between character traits and environment. In assessing the future potential for dangerously violent behaviour that a person may exhibit, clinical teams have a responsibility to inquire into the circumstances of the situation the patient will move into on discharge.

Psychiatry in a difficult position

A person found *not guilty* of an offence by reason of insanity is not set free, but is committed by the court and usually hospitalized for an unspecified period, subject to review. The major criteria for discharge of such patients appears to be that the offence is unlikely to be repeated and the release is safe for the community.

The fact that dangerousness is not an actual

condition, observable, testable, able to be falsified as a diagnosis, places the psychiatrist in a difficult, not to say, invidious, position. They are called to be predictors, "crystal ball gazers". If the psychiatrist under-predicts and the patient later commits a violent offence, community anger is directed at the psychiatrist. By over-prediction, a patient may be subjected to treatment and detention much longer than necessary.

Predictions of dangerousness

Given that some mentally ill persons may be dangerous, there are problems in identifying those who are likely to offend in the future. The psychiatrist must not only ask, "in what circumstances is X likely to behave dangerously?", but also, "what is the likelihood of X behaving dangerously under these circumstances in the future?"

The stark fact is that it is impossible to make certain predictions of future human behaviour. Notwithstanding the greatest care and judgment there can be no certainty in the prediction of human affairs. Subjective judgment, even when based on experience, professional knowledge and available information, is extremely unreliable. That applies as much to psychiatrists as to any other occupational group. Not even a long history of clinical involvement with a patient gives a reliable basis for assessing an individual's future performance with any assurance of accuracy.

While some groups have some very high rates or very low rates of law breaking, or whatever behaviour is in question, it is never possible to predict that any particular individual will inevitably, or never, break the law in future. Actuarial methods can only indicate the probability of future dangerous behaviour in certain categories of people. For individuals within the defined categories the risks cannot be quantified with precision.

The actuarial method of prediction depends on measurable factors such as age, sex, and criminal record. Whilst one can in this way assign individuals to risk groups with very rare behaviours, the relevant factors cannot be weighed even if they can be identified. Many of those who commit the most serious violent crimes tend to have lived normal lives in the community and be without a criminal record.

Thus, dangerousness cannot be decided on

either scientific or legal criteria, and, at best, judgments are based on limited aspects of the criminal history. Studies suggest that the mentally ill who are dangerous have more in common with normal criminals (as regards relationships, background, age and sex) than they have in common with their mentally ill non dangerous counterparts. (Gostin 1979)

In applying the predictive aspect of the assessment of dangerousness, all the psychiatrist can do is to weigh in the balance the unpleasant consequences of confinement for the individual concerned against the possible harm he or she may do to others if released. If the harm is likely to be slight, the decision should be in the patient's favour: if the harm feared is not only great but highly probable (for example, if a sexual offence is accompanied by serious violence), the best that can be done is to make sure that the precautions are as humane as possible.

Doctors, and others who have responsibility for violent offenders, are likely to err on the side of caution in deciding on discharge, and there can be little doubt that, as a result, some people continue to be detained who, if released, would not commit further violent offences. In deciding whether society requires more protection, the question has to be faced: how many probably safe individuals should cautious policy continue to detain in hospital in the hope of preventing the release of one who is still potentially dangerous? A balance must be achieved between the right of the public at large to reasonable protection and the right of mentally afflicted individuals in psychiatric hospitals and in prisons to be returned into the community when their detention can no longer be justified. There are many who say such a balance cannot be achieved.

The Donaldson case, and the subsequent report (1981), clearly illustrated the dilemma facing psychiatrists. If the patient is no longer mentally disordered, they have no legal authority to detain him or her, even if there is considered to be a potential danger. If, during the lengthy delay of transfer from security to open hospital and subsequent discharge, Donaldson had applied to the court under the Mental Health Act 1969 for discharge from hospital, and was reported to be not mentally disordered, an order for his discharge would have been inevitable, regardless of the medical staff's fears that he may reoffend. The fact that their fears were soon

to be realized, with Donaldson's subsequent commission of murder and his own suicide, does not in itself indicate that his discharge from hospital was a mistake.

Various Proposed Solutions

Mulvey Geller & Roth (1987) discussed the proposal of involuntary out-patient committal as a possible strategy for providing mental health services to chronic mental patients. Under this approach, patients meeting certain criteria of dangerousness or need to take treatment could be compelled by the courts to take part in treatment programmes in the community. Such a proposal again involves weighing rights of the individual not to be coerced into treatment, against those of the community not to be harmed.

In New Zealand, the Mental Health Bill, at present before Parliament, contains just such a compulsory treatment clause.

In Britain, indeterminate sentencing for mentally disordered offenders is justified by the argument that the offender presents a danger to the community. The Home Secretary must take ultimate responsibility for protection of the public, and should therefore have the power to detain the patient until reasonably confident that there will be no reoffending.

However, it can be argued that, whilst the mentally ill may pose a nuisance to society if released, and may even present a danger, society takes this same risk each time an offender is released from custody. This leads to the question of whether it is proper to detain such mentally ill offenders longer than ordinary offenders with comparable criminal records, by evoking in the case of the former the concept of "potential dangerousness". When an ordinary offender has served a finite prison term, release follows, and there cannot be recall to prison unless there is a breach of parole. Prisoners diagnosed as dangerous psychopaths, (not considered mentally ill), segregated at Parkhurst Prison, England, similarly serve finite sentences and will be released, even though the probability of their re-offending may be high. This is because the system of justice is based upon the principle that the offender must be liberated after his sentence has been served.

The mentally disordered offenders as a group are no more dangerous than other confined populations. Yet the concept of dangerousness has been the rationale for their indefinite deten-

tion.

The British Aarvold Committee, in 1972, concluded that, early in the course of treatment, certain exceptional cases could be identified which needed special care in assessment. The two relevant factors involved were: an unfavourable or unpredictable psychiatric prognosis; and some indication of potential dangerousness. They considered that only a small proportion of special patients would need identification as requiring special precautions beyond normal discharge procedures. In such cases, a recommendation made by the responsible medical officer or the mental health review team for discharge or transfer should be implemented only after a second opinion by an independent advisory body.

This advisory board would consist of three members: a person with legal qualifications as chairperson, a forensic psychiatrist, and a social worker. These recommendations were adopted and used for 5% of special patients.

The Butler Committee of 1975, however, proposed a modification and an extension of these arrangements to all special patients in special hospitals. Whilst the Aarvold Committee suggested that the classification be not too freely applied, the Butler Committee proposed this extension to all special patients. Such a duplication of the mental health review team is not only expensive, but causes considerable delay in respect of decisions on discharge.

As with the Aarvold Committee, the Donaldson Report recommended the classification of certain patients considered potentially dangerous, so that extra care be taken regarding decisions of transfer and discharge, and assurance of extra control and supervision following discharge. This recommendation has not yet been implemented.

Mental hospitals are for the treatment and care of the mentally disordered. It is highly questionable whether they should be used for the purpose of detaining persons no longer considered mentally disordered but potentially dangerous. Hospitals have long been placed in the onerous position of having to weigh the right of the patient to be discharged when no longer deemed to be mentally disordered, with the right of the public to be protected from harm.

Walker (1982) suggests that a mentally ill offender, regarded as dangerous, should al-

ways be prosecuted, so that what has actually been done could be subjected to the scrutiny of the criminal court. Even the Butler report, which recommended that the prosecution of the mentally disordered be avoided unless there was strong reasons for it, did say that dangerousness was a strong reason. It would also be consistent with their suggestion that a person should not be detained compulsorily for dangerousness to others without a criminal trial.

An Issue of Justice

Since no one group can accurately predict future dangerous behaviour, and thus cannot accurately identify patients whose liberty should be restricted as a result, and the vast majority of persons who commit acts of violence are not mentally disordered, any attempt to indefinitely incarcerate those thought to be potentially dangerous in the future will not achieve its aim of protecting the public, and at the same time, will violate a fundamental principle of justice. (Mental Health Task Force 1987)

The issue was canvassed in *R. v G.H.* (1977) N.Z.L.R. 50 by Roper J., when a 17 year old boy was acquitted on account of his insanity on a charge of murdering his father, stepmother and stepbrother. On the question of disposition, uncontested evidence was given by three doctors that the boy no longer posed any danger to the public, and this was accepted by the Judge. He then went on,

"The fact that an individual poses no threat to the public is not conclusive of the matter. What might be in the best interests of the individual is not conclusive of the matter. All of the circumstances must be considered quite apart from the individual's present mental state which leads me to the belief that while no element of retribution or deterrence is involved for that would be quite inappropriate in considering insanity... there still remains some wider element of public interest quite apart from its safety and quite apart from what might be the best interests of the individual involved where that interest and public's coincide... illogical as it may seem when one is dealing with the insane, I think the gravity of the charge is of considerable importance."

An order was made for the boy to be detained as a special patient. The "wider element

of public interest" was not expanded upon, but this judgment was predicated in part by the gravity of the charge - an approach which is not consistent with trends in other jurisdictions.

For example, in *R v Hay* (Criminal L R 983, 276) the court indicated that a sentence of life imprisonment will not normally be upheld in the absence of psychiatric evidence that a person presents a grave danger to the public in the future. It was stated there that,

"such a sentence will rarely be upheld on the basis only of an inference of dangerousness drawn by the sentencer from the facts of the offence."

The Core Answer

What the Donaldson case, and others, indicate is that there is a desperate need for the integration of decisions for release of potentially dangerous persons with proper supervision and aftercare services, even if the enforcement of the use of such services requires some change in legislation.

Dr Haines, of the Mental Health Foundation, states that, while it is difficult both to predict and to prevent violence, good systems of community care can lower the potential by early intervention. A number of studies on reoffending following discharge from hospital indicate that the first year following the release is the most crucial, and that supervision during this time reduces the likelihood of re-offending. Important findings of recent studies indicate that most mentally disordered offenders who have committed offences following discharge have drifted out of contact with the psychiatric services, or have had inadequate follow-up (e.g. in New Zealand, the Julian case).

Mullen (1987) suggests that, rather than justifying a return to institutionalization, such cases support a need for better, and more, community services for a vulnerable minority. Mental Health law is changing. Deinstitutionalization will probably continue. Society will be pressured to absorb the mentally ill into communities, jobs, housing and education. The rights of the mentally ill will probably be expanded. The effect of expanded rights on the commitment process will make it extremely difficult to institutionalize clients; therefore sufficient resources will be needed to treat mental illness in the community. Weller (1984) suggests that an increase of violence is an indictment of commu-

nity care policies.

In all this, the warning given by Dr Haines needs to be heard: that it would not be possible to prevent all violence no matter how good these services are.

CONTROL AND RESTRAINT OF VIOLENCE

Psychiatric nurses hold a unique position in provision of inpatient care in relation to other health disciplines. We have already commented on this earlier in our report.

Unfortunately, the best interests of the patient, the nurse and the employer do not always merge. Conflicts can occur when, for example, the nurse's right to live and work without threat to personal security is violated by a patient who causes the nurse physical or emotional harm.

There are a number of points which can be made.

1. When physical violence is associated with mental illness, is transient, and responds to effective treatment, psychiatric nurses will continue to be able to manage those persons in psychiatric hospitals.
2. When physical violence is an antisocial manner of coping with conflict in an individual's life, and is not related to psychiatric illness, psychiatric nurses and other health professionals question the need for inpatient care.
3. If physical violence is a major factor in an individual's mental illness, and is frequent and ongoing, psychiatric nurses are unable and unwilling to accept the risk of physical assault over a long period of time in an "open" psychiatric unit. It is the belief of the profession that suitable facilities and environments must be available for such persons.

Along with the provision of better facilities, however, we believe there is a need for the nursing profession to develop more effective and efficient - and humane - methods of managing situations involving violent and dangerous behaviour in the institutional context.

Background to the Introduction of Control and Restraint Techniques

Throughout the 1970's, it became apparent in Britain that prison officers were having to deal with an increasing number of violent, dis-

turbed and difficult people. Additionally, the media began to focus on the way that prison officers conducted themselves in handling these violent inmates, whilst inmates themselves became more aware of their legal rights and entitlements. Consequently, it became important for the prison service to be seen to be operating in a professional manner, and for the techniques used by prison officers to be officially sanctioned.

At a national level, the physical education branch of the prison service was given the task of devising techniques to enable the officers to move difficult and violent inmates with a minimum risk of injury to either officer or inmate. The techniques adopted were based on the use of three person teams and were designed specifically to require the use of minimum force.

In 1983, the Home Office Prison Service was approached by the management of Rampton Hospital for advice following several serious assaults on nursing staff. The first Control and Restraint (C & R) course following this initial meeting took place at the Prison's Department National Training Centre at Morton Hill in 1983.

Because of the success of C and R at the special hospitals, training is now being undertaken in Regional Secure Units, and certain local authorities are now requesting that programmes for staff who work in the inner city accident and emergency and casualty departments undergo a training programme.

While attending Moss Side Hospital in Liverpool, the C and R techniques were demonstrated to us by a three person training team. We were impressed by the demonstration, and by

the very favourable response of nursing staff towards the use of C and R.

Control and Restraint - The Technique

Much emphasis is placed upon the duty of care to the violent patient, and the need for reassurance and communication at all times. The basic technique of control is a wrist lock applied to each arm. The position of control can be applied and maintained without the patient suffering any pain. If a violent struggle is maintained, severe pain will be experienced. The risk of serious injury to the patient is very low. Emphasis is placed upon the need to protect the head and neck, and to keep airways clear at all times. Trainees are taught how to deal with a one to one confrontation, and how to operate as a team of three in most situations. They are also taught how to use polycarbonate shields in defence of the fiercest attacks and defensively to pin an armed patient against the wall or floor to safely disarm. Once this has been done, the shield is dispensed with and ordinary techniques of control are reverted to. For each of these situations, the results are quick and efficient, limiting the period of distress suffered by the patient, and minimizing the risk of injury to either the patient or staff.

We suggest that staff in the National Maximum Security Unit, the Regional Medium Secure Units and the prisons, be encouraged to participate in Control and Restraint Technique courses.

In order to initiate the scheme, it will probably be necessary to second from Britain a person competent to train others in C and R techniques.

APPENDIX 3

THE PERSONALITY DISORDERED

"Personality disorders include deeply ingrained maladaptive patterns of behaviour generally recognizable by the time of adolescence or earlier and continuing throughout most of adult life although often becoming less obvious in middle or old age. The personality is abnormal either in the balance of its components, quality and expression, or in its total aspect. Because of this deviation or psychopathy the patient suffers or others have to suffer and there is an adverse effect upon the individual or on society."

World Health Organization
Glossary of Mental Disorders 1974

INTRODUCTION

The Difficulties of Diagnosis

This is an extremely wide ranging group of disorders thought to be the result of inadequate or improper formation of the personality in childhood. In contrast, most other disorders are believed by some to result from a breakdown of an intact personality.

This gives little factual basis upon which to distinguish personality disorders from other categories. There was thought to be the possibility that personality disorders are present in the individual from childhood, while the other disorders appear suddenly. This possible distinction does not bear close scrutiny, however, since some individuals who exhibit serious behaviour disorders, e.g. schizophrenia, show a rapid onset of their disorder in adulthood, while others have shown deviant traits since childhood. The descriptions of many of the personality disorders therefore directly overlap with other classifications, making accurate diagnosis difficult.

Personality disorders are defined in DSM III as being broad and enduring maladaptive patterns of behaviour that are gradually acquired over a lifetime. Primary features of these disorders are:

- deeply ingrained, inflexible, maladaptive

patterns of behaviour;

- significant impairment in the person's functioning of the experience of subjective distress;

- onset in early life, usually adolescence or earlier, with a maladaptive pattern continuing throughout most of the person's lifetime.

By definition, these patterns of behaviour are maladaptive, resistant to change and likely to result in poor social relationships.

The classification of personality disorders has not yet gained universal acceptance.

The Personality Disordered in Prison and Hospital

The prisons inevitably accumulate a large number of persons with personality disorders. Smith (1984) stated that, of habitual prisoners, one third have severe mental disorders, and 88% have severe deviant personalities.

Although personality or psychopathic disorder is not a definable mental disorder under the Mental Health Act, a person in prison suffering from such a disorder could be admitted to a psychiatric hospital under Section 43 if that person would benefit from the treatment and care not available within the penal institution.

However, there is a long standing argument as to whether such persons are actually treat-

able. Some argue that many offenders sent to hospital under Section 118 of the Criminal Justice Act are not definably mad but disorganized antinomian personalities referred to as incurable and unmanageable.

The mentally ill or behaviourally disturbed offender has often not been very welcome in the prisons run by the Justice Department or the hospitals administered by the various Hospital Boards. This has been especially true of those who suffer from some sort of personality disorder which brings them only marginally or periodically under the definition of "mentally disordered" contained in the Mental Health Act 1969 and for those who, under normal circumstances, are not mentally disturbed but whose mental condition is undermined by prison conditions.

PERSONALITY DISORDERS : THE ANTI-SOCIAL PERSONALITY OR PSYCHOPATH

Introduction

Antisocial personality disorder, often known as "psychopathic" or "sociopathic" personality disorder, is a pattern of deviant behaviour that is serious both for the individual and for society.

Typically, persons have the following characteristics: they violate social conventions, are violent, dishonest, irresponsible, devoid of guilt; they fail to learn from punishment, seek stimulation, are intelligent (on average), under achieving, socially deviant, socially unconventional, and abuse drugs and alcohol. Many sex offenders fall into the category of "personality disordered".

Studies in the incidence and causes of psychopathy suggest that it occurs in less than 1% of the population, and diagnoses are more common in persons from lower socio-economic backgrounds. It is more common in males than females.

Although the causes are not completely understood there appears to be an interaction between biological and social learning factors. Research suggests the involvement of two biological factors: an inherited predisposition to the disorder, and low levels of autonomic arousal. From a social learning perspective, inadequate parenting techniques, the presence of a parent who models anti-social behaviour, and highly stressful relationships among fam-

ily members, are significant variables.

The Modern Concept

Psychopathic disorders may be referred to as a group of anomalies, or deviations of personality, which are not the result of psychosis or any other illness. The term "psychopath" is preferred in USA, as it emphasizes the psychopathic lack of ability in social relations and the harm this causes others.

The modern concept of personality disorder seems to represent two interlocking notions. The first suggests the disorder is present when any abnormality of personality causes problems either to the subject or to others. The second implies unacceptable anti-social behaviour, coupled with a notion of dislike for the persons showing such behaviour, and a rejection of them. The word "psychopath" is sometimes used for this purpose. One could view the psychopathic disorder as lying at the far end of a spectrum of behaviour disorders.

Travis Brown (1977) stresses that one must remember that it is a concept much influenced by prevailing notions of responsibility and what is regarded as decent behaviour.

The Relationship of Psychopathy and Reoffending

Robertson & Gibbons' (1978) 15 year follow up of expatients indicates that the offender patients who constitute the highest risk of reoffending following discharge are those with psychopathic disorders and mental handicaps, who have also had more previous admissions to psychiatric hospitals, and have had a more extensive criminal career.

Walker & McCabe (1973) also studied discharged offender patients, including psychopaths. Each patient was allotted points depending on the number of previous convictions, prison terms, the diagnosis of subnormality and psychopathic disorder. Within one year of discharge, 20% of patients with a score of nil (low risk) had been convicted for reoffending compared to 70% of those with a higher score (high risk).

From the Robertson and Gibbons study, though, it seems that it is the demographic characteristics of the psychopathic population - their comparative youth, and the fact that they have had more juvenile convictions, and were younger at their first conviction - rather than psychological characteristics, which point

to a poorer prognosis in comparison with offenders suffering a definable mental illness. They found that age was the only significant independent variable in predicting dangerous offending following discharge.

Walker and McCabe showed that aftercare was associated with a lower probability of reoffending, even in the high risk groups who are considered to be less suitable for, or responsive to, follow up.

Mental Health Act 1959 (U.K.)

The Mental Health Act 1959 defines "mental disorder" as meaning "*mental illness, arrested or incomplete development of mind, psychopathic disorder and other disorder or disability of mind.*" Some of the problems discussed in the Butler Report (1975) relate more particularly to psychopathic disorder than to the other conditions.

"Psychopathic disorder" is defined in Section 4(4) of the Mental Health Act 1959 as a "*persistent disorder or disability of mind which results in abnormally aggressive or seriously irresponsible conduct on the part of the patient and requires or is susceptible to medical treatment*".

It is difficult to understand why the Butler Committee should have proposed that the mentally abnormal be dealt with in terms of an indefinite but reviewable sentence, unless this exemplary disposal was intended as a special measure which could be used against psychopaths.

The terms "mentally abnormal dangerous persons" and "psychopaths" have come to be synonymous, both reflecting the circular process by which mental abnormality is inferred by antisocial behaviours, whilst the antisocial behaviours are explained by the mental abnormality.

During the last decade, increased debate has occurred regarding desirability of retaining the term for legal and penal purposes. The Butler Committee suggested the term "psychopath" be deleted from the definition of mental disorder in the 1959 Act and substituted with a much broader term of "personality disorder." It also considered that dangerous antisocial psychopaths who had shown no previous mental, organic or identifiable psychological or physical defect should be dealt with through the prisons rather than the hospital system. Such a recommendation presupposes that the prison system would be able to provide adequate train-

ing and rehabilitation - a presupposition unlikely to be realized for some time.

Mental Health Act 1983 (U.K.)

The Mental Health Act 1983 retains the classification of "psychopathic disorder" in the following form:

"Psychopathic disorder" means a persistent disorder or disability of the mind (which may or may not include intellectual impairment) which results in abnormally aggressive or seriously irresponsible conduct on the part of the person involved." Section 1 (iv)

Because strong feelings have been expressed that the compulsory detention of psychopaths should be dependent on a reasonable prospect of response to treatment, the diagnostic criteria in the definition have been separated from the "susceptibility to treatment" clauses. These make compulsory admission for treatment available only if it can be stated that medical treatment is likely to alleviate or prevent deterioration in the individual's condition. This is an important proviso because it recognizes the difficulties involved in treating psychopaths, but it also keeps the door open for therapeutic optimism. It has also emphasizes the fact that the term "psychopathic disorder" should be used sparingly, and not as an umbrella term for all who are merely difficult, uncooperative, or unlikeable.

New Zealand

The Mental Health Act 1969 and the current Mental health Bill do not incorporate personality disorder in psychopathy or any other form into the definition of mental illness. The criteria laid down by the law for measuring levels of diminished or absent criminal responsibility cannot be met by those persons with personality disorders. This results in severely dysfunctional individuals being regarded as responsible, and therefore punishable, for their behaviour.

PERSONALITY DISORDERS - "TREATABILITY"

There has been a longstanding argument regarding the treatment of those disorders which are not covered by the Mental Health Act in New Zealand. Mental health professionals dif-

fer in their views regarding "treatability" of personality disorders.

Some argue that admission to hospital should be based primarily upon the need for psychiatric treatment. One could go so far as to say that a mental disorder in itself is not sufficient justification for admission to hospital. There must also be a reasonable certainty that the person will receive not simply custodial care, but active treatment and rehabilitation.

It is argued that it is not in the offender's interest to be admitted to hospital if treatment cannot be given. If there is no response to treatment, confinement could be for a period of time that is not commensurate with the offence. It could be for a much longer period than if "punished" rather than "treated".

Some state that the antisocial behaviour patterns are so ingrained that treatment is not likely to be effective. Because these persons are not likely to be distressed by their own behaviour, there is little motivation for them to change it. Psychiatric hospitals are not suitable for people who have no identifiable psychiatric illness, and whose presenting complaints are behavioural or personality based. There is also no sense in admitting (for containment only) those with an identifiable psychiatric disease if this is untreatable.

Others state that the cost of hospital treatment is too great to be suitable for psychopaths, whose "craziness" consists only in their offending and/or whose offending e.g. drug taking, is the cause of their craziness. "Such individuals are suffering from self inflicted wounds."

PERSONALITY DISORDERS - CARE AND TREATMENT

It became clear during the Oakley Inquiry (Gallen Report 1983) that treatment modalities useful in treating such psychiatric disorders as schizophrenia could be used inappropriately in an attempt to treat persons with personality disorders. The skills appropriate and necessary to treat the latter are significantly different and not yet recognized as an inherent part of the New Zealand hospital system.

To treat a patient who has entered hospital voluntarily requires willingness on the part of the patient, and failure of treatment may be the result of a deliberate refusal to cooperate. If difficult, uncooperative behaviour is one of the

symptoms of the particular disorder, such as that in many severe personality disorders, it can be very difficult to treat. Often these difficult, uncooperative persons are refused admission.

United Kingdom

In the United Kingdom there are two main treatments for personality disordered psychopaths:

1. therapeutic community treatment e.g. at Grendon Prison and Farth Angharad Hospital; and
2. various methods of behaviour modification by clinical psychologists in certain hospitals.

The latter has been successful in the treatment of selected patients but not suitable for the more aggressive patients who are unwilling to cooperate.

The Butler Report 1975, proposed that psychopaths receive a treatment regime based on a combination of long-term medical, psychological and social management, and that they be segregated from the general prison population in special training units within the penal system. However Bartholomew (1970) argues that treatment and punishment do not go well together and suggested that the best solution was to set up a special prison hospital e.g. Grendon Psychiatric Prison, for those who do not fall within the Mental Health Act. This prison has had some success in taking difficult prisoners out of the system and making them more manageable.

Smith (1984) describes Grendon Underwood, the psychiatric prison that takes voluntary admissions of psychopaths who are difficult to manage. 80% have a record of violence, and 70% a record of suicidal attempts: many were sex offenders. There are 200 patients, seven doctors and psychologists and psychotherapists, with a high staff / patient ratio.

Each of the six prison wings has 30-40 patients, each wing being a therapeutic community. Prisoners are expected to relate to each other and to staff, and to take much more responsibility for themselves and their community than in ordinary prisons. Sex offenders are not segregated, yet there is much less violence than in a normal prison. Evaluative studies by Professor Gunn et al (cited in Smith 1984) indicated reduced neurotic features, increased self confidence and an improved attitude toward

authority figures. These prisoners are now much more manageable. He concluded that Grendon has a place in the prison system and techniques developed there could well be applied elsewhere in the system. (Wormwood Scrubs similarly has an annex with group therapy for sex offenders and drug and alcohol abusers).

Gostin (1985) states that, although Wormwood Scrubs and Grendon prison were created for dissimilar groups, (e.g. Grendon dealt with recidivists and Wormwood with first time offenders), there seems to be evidence from research to suggest that individual psychotherapy in prison is of limited value. Group psychotherapy within ordinary prisons brings some benefit, but the best prison results (in terms of psychiatric improvement and attitude change) come from a total therapeutic community.

United States

Moore Zusman & Roat (1985) describe the availability and characteristics of community based treatment for sex offenders in Florida community mental health centres and similar agencies. Florida is one of sixteen states of the USA with legislation that provides for treatment of all eligible imprisoned offenders. Often treatment is given under court order or referral. The offence categories include rape, incest, child molestation and others. The four referral categories include: those convicted and referred as a condition of probation, referred after incarceration, not convicted but referred by court order, and self referrals.

As most sex offenders in Florida are treated in community based agencies rather than institutions (ten times as many), evaluation studies should therefore investigate community-based rather than only institutional based treatment.

21% of the sex offender patients are self-referrals (dispelling the myth that sex offenders refuse to acknowledge their actions). Community based treatment includes one to one and a half hours weekly. Most offenders live at home and are employed. Institutional treatment is more intensive. Treatment involves four basic approaches: behavioural, psycho-dynamic techniques, social skills training, and organic approaches.

New Zealand

Personality disordered persons are untreatable by New Zealand's present system. Treat-

ments do not exist in New Zealand for the brain damaged, some mentally disordered, many sexual neuroses and chronic psychotics. It appears that psychiatric hospitals prefer only those who will respond to treatment in short periods of time, and the remainder, who would require long term treatment programmes, are neglected.

"Responsive to treatment" may be better defined as "a rapid improvement of symptoms of a clearly defined major mental disorder treatable by drugs". It is questionable as to whether any condition is untreatable. (See Appendix 4) It is more an unwillingness on the part of hospitals to expend the time and skills required in ameliorating certain disorders which may require extensive behavioural interventions.

Currently the length of stay in psychiatric facilities in New Zealand is, on the average, less than one month. Long stay patients who do not respond quickly to treatment are not as popular in the mental health system.

"This policy has aided in the promulgation of myths, such as "people with personality disorders are untreatable", and are therefore not the responsibility of the health system. Some suggest that this is taking the difficulties of treating people with personality disorders to a ridiculous extreme.

Some people with certain kinds of personality disorder are extremely disruptive of hospital routines and may be made worse by undue attention being given to their dysfunctional behaviour. But others may respond very well indeed to a programme which provides an appropriate mixture of limits and support within the context of a long-term therapeutic relationship.

To simply dispense such people to the justice system without this understanding simply condemns them to suffering and the public to huge expense". (McGeorge 1987)

"Some mental health professionals refer to "untreatability of personality disorders" as a specious argument, used to justify excluding these people from treatment facilities if they are not acutely psychotic, because the management of such people is often protracted and difficult. It is argued that personality can be manipulated, and where such treatment has been done, there is an average stay of four years" (Gluckman 1987). Personality or psychopathic disorders are

not referred to in the New Zealand Mental Health Act, 1969 because of the problem of treatability. Personality disordered people have ended up in prisons instead of hospitals where they act out bizarrely and fall apart. Suicide or self-mutilation sometimes follows.

"In many societies the mentally disordered are still held in prison. That was the situation in New Zealand originally. We are in great danger, and indeed seem to be in the process, of returning to that situation". (Gluckman 1987)

PERSONALITY DISORDER - THE SOCIAL INADEQUATES

"Dangerous patients can be cared for in the Regional Medium Secure Unit but the main problem is the larger group who are not dangerous but often difficult, uncontrolled, unsociable. They may be mentally ill, psychopaths, intellectually impaired or personality disordered. This is the group rejected by mental hospitals. Many need long-term care, maybe up to ten years.

They are the social inadequates. They have not managed well in the community and manage even less well in the prison environment. These are the ones who may become desperate enough to commit suicide. Of these persons a disproportionate number are Maori - approximately 75% - whilst the number of Maori in prison lies between 50-60% which is highly disproportionate to their number in the community."

Dr R. Maule 1986

Characteristics

In recent years, there has been increasing public awareness of the considerable number of rootless and often homeless persons who are incapable of living in the community without continuous supervision and support, and who are loosely labelled "inadequates". Among this group are to be found individuals suffering from distinct psychiatric disorders, personality disorders, chronic schizophrenia or organic psychosis; a number who are intellectually sub-normal, and many others on the borderline of mental disorder, or dependent to some degree upon drugs or alcohol. Most have some experience of institutional treatment, whether in prison or hospital, and while some may be by tempera-

ment natural "loners", others are completely institutionalized and quite unable to cope with life on their own.

It should not be supposed that they are therefore always receptive to help. On the contrary, help offered is often rejected. When offered sheltered accommodation to go to on their release from prison, for example, they may well refuse it; or accept it but not turn up; or arrive but leave within a matter of hours. Few are employed, or even employable, and those who are seldom hold down a job for more than a few days. They often come to the notice of the police as a result of petty acts of law breaking, or because their behaviour is offensive or frightening to passers-by or local residents. Sometimes they commit apparently pointless offences in order to secure their return to the familiar surroundings of a prison cell.

No reliable statistics are available. The great majority of these people are permanently socially handicapped and many circulate round the psychiatric hospitals, the prisons and the various types of accommodation provided by the official and the voluntary agencies. Women and some young people of both sexes are among the ranks of the homeless "inadequates", and their needs must be kept in mind when plans are being made as to how best to deal with them.

Reduction in Accommodation

Although the problem of the socially inadequate is by no means new, various factors have combined to make it increasingly acute. The introduction of the "open door" policy in the major psychiatric hospitals in New Zealand, the passage of the Mental Health Act in 1969, and the policy of placing long stay patients in the community, despite the lack of adequate facilities for their continuing care, have all accentuated and accelerated the problem. With the development of psychiatric units in general hospitals, and increasing outpatient care, there has been a gradual diminution in the number of beds available in the larger mental hospitals.

These developments have followed the move away from the concept of locked ward and barred window in favour of therapeutic policies based on the "open door" principle. As a result, the hospitals are unwilling to accept custodial responsibilities for their patients and find it increasingly hard to contain patients who are disruptive or uncooperative. Many hospi-

tals have shed their former role as a sanctuary for patients who are unable to profit from specific short term medical treatment but merely requiring care and control in an institutional setting. The general effect of these policies and developments has been to reduce the possibilities for the socially inadequate of finding places of refuge in the old mental hospitals. In the process the concept of "asylum" has been lost.

Resettlement in the Community

Resettlement in the community, with whatever support may be necessary, is the ideal to be aimed at. Inadequate offenders and discharged offenders should not be regarded as a race apart from other inadequate people. On the contrary, their needs are often identical or very similar. It is often only a matter of chance whether a homeless, inadequate person is at any particular point of time strictly to be regarded as an offender or a discharged offender, or neither. The lack of accommodation and supporting resources generally means that the needs of mentally disordered "inadequate" people are not met, despite obligation to provide for them. Supportive accommodation, if possible offering sheltered employment, is particularly important for the inadequate.

Prison Disposal

The offences the "inadequate" mentally disordered commit are usually trivial but, in practice, prison is the only sanction at present available to the court which will ensure a period of care and containment. This will, in many cases, benefit the patient, who may be in need of nourishment and medical care in addition to shelter. Moreover, the formal structure and regular routine of prison life provide an environment which "inadequate" people tend to find reassuring and acceptable. The need for special arrangements to cater for this class of offender is apparent.

Although prison is likely to continue to be the most common disposal for "inadequate" offenders, and it does at least provide the structured and disciplined environment which many of them require, there are substantial objections in principle to the incarceration in penal institutions of those whose primary need is for long term support rather than for punishment.

Sanctuary

It is to be regretted that the provision of a modest, protected environment in local psychiatric hospitals for this type of offender has disappeared. Many such hospitals would still be in an excellent position to provide sheltered lodging and working conditions well within the patient's restricted capabilities, and certainly would be appropriate in many cases even on an informal basis. Where an "inadequate" offender displays a recognizable psychiatric disorder, it should be the responsibility of the hospitals to provide appropriate treatment. Hospitals also have a role in the continuing care of those who cannot be discharged into the community without a serious risk of relapse through self neglect.

The reintroduction, to some extent, of a sanctuary role would particularly serve those people who are already so damaged that they are unable to take advantage of the rehabilitation measures which hospitals normally pursue.

Some of the people being discussed will be in need of special services and treatment as alcoholics or drug takers. Clearly there is a need for the provision of treatment, supportive accommodation and other assistance.

Midway Type Institution

What is also needed is some form of institution mid-way between the psychiatric hospital and the prison, where custodial, as opposed to penal, control could be exercised. Such an institution would deal with cases where the court was satisfied that there was evidence of some mental disorder, and that some form of appropriate custodial care was required, but the medical authorities were unwilling or unable to provide it in hospitals. Although the primary aim of the institution would not be therapeutic, except on a long term basis, it is envisaged that it would have adequate medical provision so that psychiatric treatment could be followed up.

Where there is agreement to informal admission, no problem exists. Otherwise the person would need to come under the provisions of the Mental Health Act.

Entry into such an institution would only rarely be by court order. It is unacceptable, on general penal principles, to commit a person to any form of indefinite detention except for a grave offence, whereas indeterminacy in the

hospital context may be justified on medical grounds where there is a prospect of treatment or cure of the psychiatric condition.

The Dilemma

In discussing appropriate treatment and facilities for inadequates, it is difficult to draw a line between those measures that may properly be imposed by a court when sentencing a person found to have committed a particular offence, and those which, although they may appear desirable in the interests of the long term rehabilitation and support of that patient, or the protection of society against possible future law-breaking, can scarcely be justified in terms of the offence. It is obviously right that a person suffering from mental disorder should be given

the opportunity to receive appropriate treatment and access to such after care facilities as may be available, and that society should take steps to protect itself against those who otherwise may commit offences which may do serious and irreparable harm. But in cases where treatment and facilities are offered but repeatedly rejected, and where any future law-breaking is likely to be minor, or solely of nuisance value, it may be right to accept that, in the end, the particular offender is not susceptible to rehabilitation by the efforts of the official agencies, and that, apart from the courts imposing any penalties appropriate to offences committed, the official services can fulfill no useful purpose by continuing attempts to induce acceptance of their help. (Butler p.107)

APPENDIX 4

TREATMENT AND TREATABILITY

P.S.A. Statement on Offender Patient Rights vis-a-vis Community Rights

"The questions underlined in this Inquiry are seen by the Association (PSA) to be centred on the balancing of the rights of the individual to care and treatment for mental health problems, with the right of the community (including staff working within the institutions) to protection from people who exhibit recurrent criminal or violent behaviour.

"The first right to consider is the person's right to treatment. That right is not limited to hospital services but also applies to community based services. Services need to be available at a level which is adequate to provide treatment for those who require it. The statutory authority whether Area Health Board or Hospital Board has a responsibility to provide services at such a level. Whether the person comes from the general community or through the court or prison, they have that right to treatment.

"The second right to consider, is a more global one; the right to minimal restraint while receiving treatment. Put in another way, a patient's loss of civil rights should be restricted to the level appropriate to their need for treatment and their mental health status. In practical terms, hospitalization for any patient, whatever their origin should be based on the seriousness of their condition. If an individual would normally receive treatment from community based mental health services, apart from their current status as a prisoner, then they should receive treatment in their community. The Justice Department can be expected to make adequate provision for the mental wellbeing of prisoners by attention to mental health issues. Also, that they are able to provide ongoing after care for psychiatrically dis-

turbed offenders in remission.

"The community has a right to expect protection from those people who exhibit recurrent criminal behaviour. Nearly all of these people can be described as psychologically impaired. Some can be described as having an antisocial personality disorder. The community itself must decide what balance it wants between the right it has for protection and the right the individual has for treatment. In the case of people with an antisocial personality disorder, the psychiatric professions have little to offer in the way of successful treatment and even less in the way of guarantees to the public that such a person will not re-offend. The balance in these cases must surely swing predominantly toward the protection of the community."

(Northern Region P.S.A. 1987)

The Treatability Criterion

One of the recommendations of the Report of the Percy Committee in the United Kingdom was that civil committal standards should incorporate a "treatability" criterion providing that no person should be committed unless there is:

"a good prospect of benefit to the patient from the treatment proposed - an expectation that it will either cure or alleviate his mental disorder or strengthen his ability to regulate his social behaviour in spite of the underlying disorder."

The Mental Health Act 1959 (U.K.), upon which the Mental Health Act 1969 (N.Z.) is based, was passed following the publication of this report. The recommendation was not adopted in the 1959 Act. It has now been partially incorporated into law by the provisions of the more recent Mental Health Act 1983 (U.K.).

The "treatability" criterion is founded on the principle that no person should be hospi-

talized against his or her will who does not present a condition which is susceptible to treatment in hospital. Unless the disorder of the person detained is treatable, his or her confinement is little more than preventive detention, as there is no prospect of benefit from treatment.

Without a treatability criterion there is a deep inconsistency in our approach to preventative detention. Preventative confinement in a prison (i.e. the incarceration of people in case they commit a crime) has always been regarded with suspicion. Yet preventative confinement in a hospital is permitted when a person is detained, ostensibly for treatment, but it is known that he or she will not benefit from treatment.

There are no limits which can define how long an untreatable person will remain in hospital. The patient is detained without trial or conviction ostensibly in his or her own best interests, yet there is nothing the hospital can do to treat the patient.

The "treatability" criterion suffers from one serious drawback, however. It fails to provide for the needs of a significant group of mentally disordered persons whose conditions are not treatable, and who could not cope adequately if discharged from hospital, but who are not willing to accept care offered on a voluntary basis. Persons suffering, for example, from chronic organic brain syndromes may be included within this group. In the absence of adequate alternative facilities, some of these persons will continue to require compulsory care in psychiatric hospitals.

The concept of "asylum" is still valid, necessary and essential in modern hospitals. There will always be some people who cannot function effectively without professional care, often in situations where the concept of treatability is quite unrealistic. Such people have a right to supportive maintenance. Even if overt responses are negligible and prospects of recovery are nil, they still have a right to good care.

Present New Zealand Law

Section 15 of the Mental Health Act 1969 provides informal psychiatric patients with the right to treatment. The section authorizes the superintendent of the hospital to admit any person for "treatment", or to permit a person to remain in hospital for "treatment". Treatment is

thus specifically stated to be the purpose of the hospitalization of informal patients.

The position of committed and special patients is quite clear. Although both "mental illness" and "mental infirmity" are defined in terms of "requiring care and treatment", no duty is placed upon hospital staff to provide detained patients with adequate treatment. Section 25 merely provides that the superintendent "may give him care and treatment and where appropriate, training and occupation in the hospital". The Act thus gives the superintendent a discretionary power to provide treatment with or without the consent of detained patients, but places no duty on the superintendent to offer adequate treatment to those who are in need of it.

This situation raises serious questions of ethics. An offer of effective treatment must be the *quid pro quo* for society's right to confine mentally disordered persons who have not been convicted of an offence in accordance with the strict procedural requirements demanded by the criminal law.

Meaning of "Treatment"

"Treatment" is an ambiguous term. It may perhaps be generally understood to mean a measure calculated to cure or ameliorate a disorder. But it can be given a wider meaning, so as to cover all measures employed in the management of a case.

"Medical treatment" includes nursing and also includes care and training under medical supervision.

Section 147(17) of the Mental Health Act 1950 U.K.

The "appropriate treatment" for an offender suffering from mental disorder will always be to provide the best prospects of recovery, or the most substantial improvement possible if full recovery cannot be attained, subject to considerations of public safety. If even a modest degree of improvement cannot be attained, the person concerned should nevertheless be within the scope of treatment, in the sense of nursing, or care and training under professional supervision, provided that the required facilities are available.

The Right to Treatment

In the famous *Wyatt v Stickney* case, it was stated,

"To deprive any citizen of his or her liberty upon the altruistic theory that the confinement is for humane, therapeutic reasons, and then fail to provide adequate treatment, violates the very fundamentals of due process".

The detention, against the will of the persons concerned, of those who have committed no criminal offence, can only be justified on the ground that they will be offered treatment for the disorder which underlies the behaviour which precipitated the committal. Unless adequate and appropriate treatment is provided at the specific hospital to which a person is committed, his or her confinement is no more than preventative detention.

An exception to this principle arises in relation to persons for whom no recognized form of treatment is available, but who are not capable of surviving safely in freedom, and who would, if discharged, be gravely incapacitated. Such persons may be hospitalized for "asylum" if no adequate, less restrictive placement is available. The right to treatment only extends to treatable patients. It does not require that those who are not treatable should have treatment forced upon them.

The Right to Refuse Medical Treatment

The recognition of a right to treatment, however, does not place a corresponding duty upon the patient to accept the treatment offered. A competent refusal of treatment offered relieves the therapist of the obligation to provide treatment except insofar as he or she should explore alternative means of treatment to which the patient will consent.

In respect of the mentally disordered offender who is compulsorily detained, the Butler Committee 1975 (paras.3.50-3.62) reached the general conclusion that treatment (other than nursing care) should not be imposed on any patient without that patient's consent, if there is an appreciation of what is involved. Ideally, patients gain enough from the services to be compliant, and are given enough information to be able to make informed and clear choices about the interventions, including medical interventions. This ideal scenario does not taken into account, however, the impact of psychiatric disorder on motivation and insight to disorders, and it is the clinical experience of many practitioners in New Zealand that many patients are non-compliant with both medication

and other treatment programmes.

The Butler Committee maintained that three exceptions should be allowed to the principle of no treatment without consent. Treatment may be given without such consent:

(a) where (not being of a hazardous or irreversible character) it represents the minimum interference with a patient to prevent violent behaviour or otherwise being a danger to self or others;

(b) where it is necessary to save the patient's life; or

(c) where (not being irreversible) it is necessary to prevent deterioration in situations where, by reason of disability, the patient is unable to appreciate what is involved, despite the help of an explanation in simple terms. Special considerations apply to treatment involving irreversible procedures.

Compulsory Treatment: Developments in New Zealand law

In New Zealand, a psychiatric patient who has been discharged from committal is no longer obliged to participate in treatment programmes or to attend outpatient clinics. The Mental Health Bill currently before Parliament proposes alterations to the existing law, with the introduction of a compulsory treatment order which will allow the patient to be treated while still living in the community or as an inpatient.

We believe that community treatment orders will be important in the community management of those who are psychiatrically disturbed, so as to ensure ongoing cooperation with the after care services.

Ideally, patients should consent to their taking part in after care services. In the United Kingdom, some discharged patients are subject to restriction orders, and experience there and in New Zealand suggests that the ideal we have referred to is not one that can be relied on.

We received several submissions pointing out that psychiatrically disturbed people who do not require hospitalization and who are able to manage reasonably well in the community, may occasionally nonetheless require judgments to be made on their behalf. John Holloway, a district psychiatric nurse in Wellington, told us of a patient whose condition had deteriorated because of his refusal to accept medication. That deterioration escalated into yet another psychotic episode following which the patient was

readmitted to hospital. He said that a compulsory treatment order under these circumstances would enable an immediate response to a clearly developing crisis, and thereby prevent increased disability to the patient and save the expense of inpatient hospital treatment. There is much to be said for that observation. The compulsory treatment order would also be of value in ensuring that those patients who fail to recognize the nature of their illness and the need for continuing treatment are adequately supported so that they can maintain good mental health. We see the compulsory treatment order as being useful in this area.

There is no universal agreement that the compulsory treatment procedure is the right direction to take. Professor Paul Mullen has told

us that, if a patient continues to need the degree of supervision and care implied by a committal order, discharge into the community is anomalous. He says that if a patient is well enough to take care of himself/herself in the community, liberties in other areas should not be curtailed.

It will be important to remember, when considering the proposed changes, that the rights of the patient must be adequately defined and reserved, that the question of patient advocacy must be addressed, and that a review structure protecting the patient's rights must be incorporated into the compulsory treatment legislation.

The Mental Health Bill addresses all these matters. Only time and debate will decide the final outcome.

APPENDIX 5

TE TAHA HINENGARO : MAORI MENTAL HEALTH

This appendix provides some insight into the way in which Maori people, the tangata whenua of Aotearoa/New Zealand promoted and maintained their health. It also looks at the question of accessibility and acceptability of mental health services to meet the health needs of the tangata whenua. That is one of the major problems facing them today.

This appendix does not pretend to be a comprehensive review of Maori mental health. It does however offer some explanations for past failures in the health system and it suggests some challenges for the future.

HISTORICAL BACKGROUND

Asylums or psychiatric institutions were established in New Zealand after the arrival of the British settlers. The first one was established in 1844, in Wellington and was attached to a gaol. This was four years after the Treaty of Waitangi which laid the foundations for the development of a bi-cultural society. Abbott and Haines 1985 report that psychiatric institutions were not established to meet the needs of Maori people but rather to provide asylums to new settlers who were considered mentally disturbed. For many dislocation from their cultural roots and support structures was a cultural alienation they were unable to cope with.

Very few Maori people would have been in need of psychiatric care. If so, they were cared within their whanau (family) hapu (subtribe) or iwi (tribe).

At that time, the tangata whenua were culturally strong. Almost all would have known their whakapapa (genealogy) and their turangawaewae (a place to stand and an economic base). Most would have been able to speak their iwi dialect and communicate with other iwi through their mother tongue. Most would also have had access to their own healers and herbal

medicines. The rules of tapu and noa would have helped provide and maintain social order. Through everyday practises such as karakia (incantations) most would have know ways of promoting and maintaining their health and if they were sick they would probably have known of a remedy. The maintenance of good health was an individual, whanau, and iwi responsibility.

Today, a different picture exists. Many Maori people are no longer culturally strong. The effect of colonization is well recorded in a number of reports one of which is Puao-Te-Ata-Tu.

As with the early British settlers, one of the major health problems now facing the tangata whenua is cultural alienation. Rankin states that "Maori health is about alienation as is all mental health".

Dr Mason Durie, a Maori psychiatrist, has identified the main social institutions of Maori society. They are: whanau (family), whenua (land), te reo (language), and the marae (meeting place). He also notes that whereas the general thrust of mental health policies is aimed at supporting the process of deinstitutionalization, Maori people are perhaps moving in the opposite direction by advocating reinstitutionalization to achieve good health and overcome cultural alienation.

WAIORA : HEALTH FROM A MAORI PERSPECTIVE

Ngata states that the,
"foundations of health from a Maori view-

point have their roots in Te Ao Tawhito: the old world where the spiritual, social, cultural and economic circumstances of the Maori were governed by the law of tapu. As a concept tapu means more than "sacred" or "religious"; it is a means of social and behavioural control that maintains the harmony, balance and unity of the mind, body, soul and family of man. It protects people and their existing resources and ensures continuity with the past and future through systems of tribal kawa (rituals) tikanga (customary practices) aroha (love) Karakia and fearsome respect. It fosters an integrated set of values, beliefs and attitudes that promotes and maintains behaviour conducive to the ongoing health, wellbeing and welfare of the community."

The tangata whenua also identify four cornerstones which are essential to promote and achieve their good health. They are: te taha wairua (spiritual wellbeing), te taha hinengaro (mental wellbeing), te taha whanau (family wellbeing) and te taha tinana (physical wellbeing). It is believed that all of these cornerstones are interrelated and together form an integrated whole.

These cornerstones will be briefly explained:

Te Taha Wairua

Te Taha Wairua is the intangible, spiritual soul of a person. It determines who one is, where one has come from, where one is going to and is perceived as present all the time and everywhere. It provides a dynamic link with one's tupuna (ancestors) and between members of a whanau group. It strengthens the taonga (treasures)/tikanga values of one's cultural system.

Te Taha Hinengaro

Te Taha Hinengaro is the mental and emotional aspect of a person. Central to the concept of Hinengaro is the principle of Maori, the vitality spark or life essence of a person. It is the principle that determines how one feels about oneself. Confidence and self esteem are important ingredients for good health.

Te Taha Whanau

Te Taha Whanau is the extended family system that embraces all whakapapa and present day neighbourhood and support ties. It is

still the principal social, living and learning unit in Maori society. Whanaungatanga provides a sense of belonging and collective strength.

Te Taha Tinana

Te Taha Tinana is that dimension which recognizes the physical or bodily aspect of a person. It is that part of a person which Western medicine predominantly focuses upon.

The tangata whenua believe that the mind, body and soul are all closely interrelated and influence one's physical state of wellbeing. Physical health cannot be dealt with in isolation nor can the individual person be seen as separate from one's family. A healthy person is thus not someone who stands tall alone, but rather as a member of a strong collective group.

In summary, good health "requires a sense of spiritual, mental and physical wellbeing which depends on the security of one's self in relation to one's family and community, as well as the knowledge and comfort from one's roots and cultural background". It also involves living in harmony with one's physical environment and having a sufficient income to participate in society with a sense of belonging and dignity.

PRESCRIPTION FOR MENTAL HEALTH

A prescription for Maori mental health has been quoted by Durie 1984.

"E tipu, e rea, mo nga ra o tou ao.
Ko to ringa ki nga rakau a te Pakeha, hei ora
mo to tinana,
Ko to ngakau ki nga taonga a o tipuna, hei
tikitiki mo to mahunga,
Ko to wairua ki te Atua, nana nei nga mea
katoa."

Grow up, o tender plant, for the days of your
world,
Your hand to the tools of the Pakeha for the
welfare of your body,
Your heart to the treasured possessions of
your ancestors, as a crown for your head,
Your spirit to God, the creator of all things.

This whakatauki (proverb) was composed by Sir Apirana Ngata, in 1949, for a young girl. He had a number of dreams for her.

Firstly, that she would be nurtured so that she could grow up to be able to accept the challenges of a changing world. Secondly, that she would be able to take advantage of the knowledge and skills of the Western world. Thirdly, that she would take with her the treasures of her ancestors and fourthly that she would remember the importance of spiritual sustenance to ensure that she was totally enriched in her life.

This whakatauki can also be looked at in another way. It also provides a prescription for the development of a bi-cultural society. Both Maori and non-Maori people should be encouraged to share their gifts to enrich their development.

Utilization of Mental Health Services

Gluckman in "Tangiwai - Medical History of 19th Century New Zealand" provides some insight into the treatment and possible incidence of mental illness amongst the tangata whenua, at the time. He suggests that the sight of mentally disabled Maori people was rare, possibly because they were expelled out of sight. In contrast, the insanity rate in the non Maori population in 1900 was approximately three times more than in the Maori population.

Since the beginning of this century the rate of Maori mental illness has increased. Blake-Palmer reports that in 1951 the incidence of Maori admissions to psychiatric hospitals was 20.61 per 10,000 compared to 47.73 per 10,000 for the non Maori population. He considered that the youthfulness of the Maori population explained the difference in the rates between the two groups. He also commented on the relatively high numbers of Maori people in borstal and prisons.

Blake-Palmer noted the low use of mental health services by Maori people, a number of whom would have benefitted if these services had been accessible and culturally appropriate.

The picture has not changed significantly since then. Durie 1987, suggests that hospital admissions alone do not give a true indication of the degree of mental illness and mental distress amongst Maori people. We need to take a broader view of the problem and to identify those who use the various services and those who are placed in various institutions. The use of such services and institutions is well documented in a report released by the New Zealand

Planning Council. The council notes that, Maori people are likely to be significantly over represented in institutions which provide some degree of custodial care. Some examples are:-

(a) The proportion of Maori and Pacific Island children in residential schools for children with learning difficulties is alarmingly high in relation to their numbers as a proportion of the total population.

(b) A third of all children referred to Child Health Camps are Maori.

(c) Maori people make up 10% of total population, commit 37% of all offences but comprise 50% of the prison population.

More than half of all prisoners are under 25 years of age. The likelihood of imprisonment, however, seems to decrease as a person or a population ages. This point needs to be remembered when considering the imprisonment rate for Maori people. In the 1986 Census, of the approximately 400,000 people who identified themselves as having some degree of Maori ancestry, 70% were under 30 years of age. In 1984, the Maori male imprisonment rate was 13.8 times greater than the non-Maori male imprisonment rate. It is predicted that this rate will not fall significantly in the next few years due to the youthfulness and socio-economic and cultural circumstances of the Maori population.

This view is also supported by the findings of the Committee which produced "Puaote-Ata-Tu". It reported that 62% of all Maori children leave school without passing at least one subject of School Certificate examinations. When the report was released in 1986, 14% of the Maori labour force was unemployed. This figure has probably increased with the effects of corporatization and the downturn of the rural and manufacturing industries. Maori males also on average earn \$2,039 less than non-Maori males.

All of these statistics provide some insight into the degree of socio-economic and cultural stress that Maori people are experiencing and which directly affects their health. In 1985 Maori admissions to general hospital psychiatric units occurred at twice the rate population ratios would have predicted. Although the rate of utilization was twice as high in comparison to

the non Maori population, the use of these services by Maori people was still lower than their needs. Information collected by the National Health Statistics Centre also shows that in less than two decades Maori psychiatric hospital admission rates have trebled, the greatest increase being in the 20 - 29 year age group.

In 1986, just under 40% of the Maori population was under 14 years of age and 30% between 15 to 30 years. It is expected that in the next decade the admission rates will not fall but will probably increase. Blake-Palmer's idea of youthfulness explaining the under utilization of mental health services no longer holds true, but rather is one of the factors, along with cultural alienation, which explains the continuing increase. Mental illnesses such as schizophrenic psychoses and affective psychoses are likely to first arise when people are in their late teens and early twenties and because the Maori population is predominantly youthful it follows that Maori admissions to psychiatric hospitals will probably increase.

Craig and Mills, note that the disorders which result in Maori people being admitted to psychiatric hospitals are similar to those in the non Maori population but that they occur at a greater rate. Both non Maori males and Maori males are admitted to psychiatric hospitals for alcohol dependence, substance abuse or schizophrenic psychoses. In contrast, women are admitted due to depression, schizophrenic psychoses or affective psychoses. The validity of these diagnoses is often questioned by Maori people. Men have a higher admission rate than women in both populations. Maori women, however, are more likely to be admitted to a psychiatric institution than either Non Maori men or women.

Dawson in 1987 examined the committal process:

The general picture that emerged was that committed patients were significantly more likely to be aged 20 - 39 years, male, of Maori or Pacific Island ethnicity, and have a diagnosis of schizophrenia or affective disorder. The Pacific Island population is the group most likely to be committed (37%) followed by Maori people (28%) and others (20%).

Beaglehole suggests that Maori people with drinking problems tend to end up in prison rather than alcohol treatment facilities as a result of their alcohol abuse. In contrast, Pakeha

people with alcohol related problems tend to be dealt with by the medical system. Since Beaglehole's study in the 1960's the problem has expanded. Many prisoners suffer not only from alcohol abuse but also poly-drug abuse. The issue is a matter of concern to prison authorities and some efforts are being made to assist prisoners overcome their addictions. This approach, however, does not give prisoners the opportunity of being relabelled from "bad" or "violent", to perhaps "sick" or "mad".

In 1985, only 74 (1.7%) of first admissions to psychiatric hospitals were special patients, compared to 577 (13.26%) of committed patients and 3,641 (83.3%) of voluntary patients. Maori people account for (50%) of all special patients, a ratio which is similar to their numbers in the prison population.

Mounting evidence shows that health services are neither accessible nor culturally appropriate to meet the needs of Maori people. When ultimately a Maori person does acknowledge the need for help and seeks advice it is often too late and that person may then require hospital care. Be that as it may, the system does at least provide help when it is eventually sought.

In contrast those who end up in the justice system may not be given the treatment and care they need. Their access to appropriate health care depends upon a recognition of need by one or more of a number of persons; the Judge, the prison superintendent, the Secretary for Justice and medical staff. Access also depends upon suitable facilities being provided by Hospital and Area Health Boards. If facilities are not provided, care and treatment is likely to be declined.

Because of the disproportionate numbers of Maori people in the prisoner/remandee population, these factors are of particular importance in a consideration of Maori mental health. A significant number of Maori male prisoners who are psychiatrically disturbed are sent to Paremoremo Prison or to the National Security Unit at Lake Alice Hospital near Marton. The lack of secure facilities means that they are removed considerable distances away from their families from whom they could reasonably expect support in helping them to overcome their problems.

The difficulties of access in both the justice and health systems means that there are a significant number of Maori people in the commu-

nity and in Justice Department and other institutions who are mentally ill, or mentally distressed. They are being denied the opportunity to obtain appropriate mental health care.

It is the tangata whenua who are at present paying a disproportionate price for the changed philosophy as to what is a "treatable mental illness", at least in the Auckland area and also the policies of deinstitutionalization. There are unfortunately very few community services available and for the mentally disabled those that exist, do not cater for the full needs of Maori people.

MAORI MENTAL HEALTH INITIATIVES

Since the late 1970's, inspired by the Tu Tangata philosophy and programme, many Maori health initiatives have been developed. They include marae based health centres, the use of Maori community health workers, Matua Whangai, the Waiora programme and a number of Maori health promotional programmes. Maori people now wish to define health in their own terms, to define their health problems and to propose appropriate solutions. They also wish to be involved in all decisions that affect their wellbeing so that they can determine their own destiny. Many of the initiatives described above are linked to tribal development and also aim to rebuild long recognized social institutions in Maori society. As Maori people view health in a holistic sense, all initiatives which have been developed can be considered as health initiatives.

In the mental health area there are several specific initiatives which are in the process of development. Since the 1980's a series of wananga have been held at Tokanui Hospital near Hamilton. These wananga have been important in that they have raised people's awareness of Maori health issues, they have supported Maori health initiatives and have suggested ways and means by which health care organizations can develop and assist in programmes relating to Maori mental health. The wananga have also provided the impetus for the establishment of Te Ropu Awhina O Tokanui.

This group has pioneered the establishment of Whaiora which is a Maori unit within Tokanui Hospital. The philosophy and goals of the unit incorporate the Ngata/Durie prescription

for Maori mental health.

The objectives are:

1. to provide an environment for patients which fosters their sense of pride in their cultural heritage;
2. to reduce their readmission rates and average length of stay;
3. to help health personnel gain a greater understanding of Maori cultural values and beliefs.

The unit has a definite kawa, e.g. the saying of karakia at the beginning and end of each day and before each meal. Maori language classes are held and staff and patients work together on an egalitarian basis.

Setting up the unit has not been easy. Te Ropu Awhina O Tokanui has had to overcome many problems and setbacks. Some of these have been:

1. antagonism from other staff;
2. a shortage of staff due, in part, to uncertainty as to the future of the unit;
3. trying to overcome the effects of previous care received by the patient;
4. trying to overcome the suspicions of patients and their families so that they are willing to participate in activities in the unit.

Notwithstanding these problems the unit is still operating and is providing patients an alternative way of dealing with their mental health needs. The Whaiora group would now wish to see the unit operating with its own separate facilities based in the community.

The establishment of the Whaiora unit has been an important milestone in the treatment of Maori mental health. It has helped pave the way for the development of a similar ward at Carrington Hospital and it has also provided a vision for Maori groups in other psychiatric hospitals who may wish to establish similar units.

The challenge that Whaiora poses is whether its philosophy or kaupapa can be incorporated in to all wards, in all mental hospitals, and in all community mental health services.

The management at Tokanui, Lake Alice, Sunnyside and Carrington hospitals have already taken a small but significant step forward in advancing Maori mental health. In each, Maori health coordinators have been appointed. Their success will depend upon the amount of support and recognition they receive both from management and their own people.

FUTURE CHALLENGES

Many changes will need to take place in the health service to incorporate the values, beliefs and aspirations of the tangata whenua. The Standing Committee On Maori Health, an advisory body to the Board of Health, has issued a number of challenges for the future development of a bi-cultural health system and the development of a bi-cultural health workforce.

These challenges are:

1. that the Treaty of Waitangi be regarded as the foundation for good health in New Zealand;
2. that Maori tribal authorities be regarded as the proper trustees for Maori people;
3. that resources be made available to those authorities to enable them to include health initiatives in their own development programmes. Improvements in Maori health are likely to come about through whanau, hapu and iwi development;
4. that Maori health issues be addressed by involving a greater number of Maori people in the delivery of health services and the setting of priorities;
5. that health teams must have the support of the Maori community and must include both Western trained health professionals and those people trained in Maori schools of learning;
6. that training programmes should reflect the bi-cultural nature of New Zealand society. If

teaching institutions are unable to adequately prepare people, they should contract out to those organizations equipped to do so.

In support of these challenges, the Department of Health has given its commitment to the Treaty and the principles it embodies.

The health services in New Zealand are at the crossroads of change. Within the next two years it is expected that the various Hospital Boards and health development units will amalgamate to become Area Health Boards. These boards will then have a wider brief than the existing Hospital Boards and will be responsible for promoting and encouraging the good health of all people.

In the process of setting up Area Health Boards, decision-makers will be challenged to acknowledge the Treaty of Waitangi and incorporate it in to the development of new organizational structures, administrative procedures, planning and policy making mechanisms, and the allocation of resources. These challenges will also need to be included in the future development of mental health services in New Zealand. The issue is succinctly stated by the Mental Health Foundation of New Zealand:

"Bi-culturalism is one of the most challenging and immediate issues in New Zealand's mental health service and requires that many changes be made in control, planning and delivery of services"

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APPENDIX 6

LIST OF INDIVIDUALS AND ORGANIZATIONS WHO MADE SUBMISSIONS

This list is not exhaustive. It does not include the names of some who appeared in support of a group submission or as part of a whanau at marae or hui we attended. Nor does it include those whom we met with informally in hospitals, prisons and at several seminars and conferences we attended.

Abbott, Dr Max	Bourke, Glenda	Management Group
Ainsworth, Marney	Bowling, Mrs Vera	Carrington Hospital medical
Aitken, Claire	Boyack, Jon	staff
Aitken, Michael	Bracey, O.	Carroll, Anne
Allan, Kevin	Brady, Wilma	Carroll, Laurie
Anderson, Dr E.D	Brandt, Stuart	Carson, Rhona
Anderson, John	Bratt, Andrew	Cartwright, Jeff
Antcliff, Dr D L	Bremner, Judge F.W.	Cash, Mrs Pat
Arai Te Uru whanau, Dunedin	Brett, Tracey	Casley, Bill
Asher, Senior Constable Diane	Bright, Judy	Cassidy, Bill
Ashmore, A.	Brimblecombe, John R.	Catton, Kerry
Attrill, Mrs J.K.	Brinded, Dr Phil	Chambers, Helen
Auckland Council for Civil	Bristowe, Sue	Chapman, Dixon
Liberties	Brookbanks, Warren	Cherry Farm Social &
Auckland Council of	Broughton, Miss Diana	Rehabilitation Centre
Psychiatrists	Brown, Beverley	Child Protection Team,
Auckland Hospital Board	Brown, Judge M.J.A.	Hamilton
Avery, Dr T.L.	Brown, Keith	Clark, John
Bailey, Jennie	Brown, Katrina	Clark, Larry
Bakker, Leon	Brown, William	Coates, Rosemary
Barclay, M.	Brunton, Warwick	Comcare Charitable Trust/
Barnett, Pamela	Burke, Tara	Pegasus Trust, Christchurch
Bassett, Mrs Judith	Burrell, Dr Richard	Commandeur, Pat
Beattie, Andrew	Burrell, Edward	Conn, Stephen
Bell, Sylvia	Burrell, Pamela	Conradson, Jim
Berendsen, Dr Keith	Byron-Wood, Mrs R.M.	Cooper, L.K.
Berry, Lewis	Callander, Judge Russell	Cooper, Professor Michael
Bichan, Dr Helen	Cameron, Duncan	Coote, Gabrielle
Bingley, William	Campbell, Dr A	Corcoran, Chappy
Bluglass, Professor Robert	Campbell, I.A.N.	Coster, Miss Dorothy
Bolitho, David	Campbell, Terry	Court, Michael
Booth, Ngaire	Candler, G.	Cranstoun, Lorrina
Borodin, A.D.	Canterbury Hospital Board	Crawley, Louisa
Borry, Reverend Don	Carrington Hospital	Crawshaw, Dr John

Creighton Mrs G.
 Cribb, Doug
 Cribb, Mrs Oma
 Criglington, Ivan
 Cummings, Stuart
 Curtis, Corran
 d'Entremont, Dr Philip
 Davenport, Bruce
 Davey, Mrs J.F.
 Davidson, Karen
 Davis, Dr Peter and Soljak, Dr
 Michael A. on behalf of 5th
 Year medical students,
 Auckland
 Dawson, John
 Day, Elva
 Day, Russell
 Day, Tony
 de Gilio, Sue
 de Jonge, Mrs Anna
 Delatour, Pat
 Department of Health
 Auckland staff
 Department of Health,
 Wellington
 Department of Justice,
 Wellington
 Dephoff, John
 Dicker, Pauline
 Ding, Dr Leslie
 Dixon, Brian
 Dixon, Ron
 Donovan, Dr Martin
 Dornan, Mrs Y.
 Douglas, Robert
 Douglas, Sandy
 Dowden, Eleanor
 Dowling, Alan
 Downes, John
 Driver, Sue
 Du Fresne, Dr Stephanie
 Duell, Warwick
 Dunlop, John
 Durie, Dr Mason
 Dyall, Ms Lorna
 Dyer, Judith
 Eames, Penny
 Early, Mrs S.
 Edney, Ken
 Elliott, Christine
 Ellis, E.V.
 Ellis, Mrs Shirley

England, Dr R.W.
 Executive Committee of
 Council of Psychiatrists,
 Auckland
 Exeter Health Authority
 Faed, Dr Julia
 Fairley, Nigel
 Fairgray, Dr R.A.
 Faulk, Dr Malcolm
 Felgate, Dr Jed
 Fenwick, J.
 Fergusson, Jack
 Fernando, Dr Noel
 Fish, Mrs Jocelyn
 Fleming, Kevin
 Fletcher, Russell
 Flewitt, Wendy
 Fogarty, Chris
 French, Murray
 French, Peter
 Fuller, Julian
 Gabor, Dr Omvari
 Gallop, Pat
 Garlick, Glen
 George, Timoti
 German, Frank
 Gibb, Dr I.A.McL.
 Gies, Phillipa
 Gilbert, Judge R.J.
 Gillespie, James
 Glen Innes Health & Social
 Welfare Group
 Gluckman, Dr Laurie
 Goldberg, Professor, David
 Goids, John
 Goodall Dr Marire
 Goodare, W.J.
 Goodex, Dr Bob
 Goodward, Charles
 Grady, Tom
 Grant, Lorraine
 Gray, Hinerua
 Gray, K.
 Griffin, Neville
 Grigg, T.C.
 Gulliver, Maryanne
 Gunn, Dr J.
 Gunn, Professor John
 Haines, Dr Hilary
 Haken, Jack
 Hall, Dr John
 Hall, Mrs K.P.

Hamilton, Dr John
 Hamilton probation staff
 Hand, Kerry
 Harding, John
 Hardy, R.J.
 Harrison, Henry
 Harrison, Nelsonian
 Harrison, Paul
 Harrison, Tom
 Harvey, Alistair
 Harvey, Dr Sue
 Haslam, Jean
 Hassall Dr Ian
 Hawkins, Andy
 Hearn, Andrew
 Heckler, Mrs Pat
 Heeney, Paul
 Henare, Diane
 Henry, Rex
 Henry, Terry
 Hereora, Mrs Margaret
 Hewland, Dr Robyn
 Hewitt, Paul
 Hicks, Colin
 Hillview Clinical Team
 Hippolite, John and whanau
 Hirsh, Wally
 Hobbs, Dr Paul
 Holden, Kay
 Hollands, G.N.
 Holloway, John
 Honeyman, Dr A.L.
 Hood Mr C.C.
 Hood, Charles
 Hooper, Michael
 Hoppood, Dr Catherine
 Hopkins, J.
 Hornblow, Associate Professor
 A.R.
 Hornsey, Pamela
 Hotere, Jane
 Hounslow, Keith
 Housing Corporation of NZ,
 Wellington
 Hudson, Dr Lloyd
 Human Rights Commission,
 Auckland
 Hunter, Alan
 Hustler, Eunice
 Hutchinson, David
 Hutson, Mrs Joan
 Hutt Regional Community

Mental Health Services

Hutton, Gareth
 Jackson, Moana
 James, Dr Basil
 Joery, Tara
 Johnson, Derek
 Johnston, Moana
 Jones, Dr A.V.
 Jones, Stuart
 Joychild, Frances
 Judge, Mary
 Julian, Rae
 Kahau, Sam and whanau
 Kahu, T.
 Kahui, R.S.
 Kapua, Prue
 Kaumatua Council, Wanganui
 Keelan, W.
 Keenan, J.F.
 Keenan, James
 Keenan, Pat
 Keith, Mrs Jocelyn
 Kelly, Catherine
 Kelly, Mrs Valda
 Kerr, Judge Robert
 Kimber, Macey
 King, David
 King, Mr B.
 Kingi, Hemi and whanau
 Kingseat Hospital Consultant
 Psychiatrists
 Kingseat Hospital Nursing
 Staff
 Kirkwood, Vera
 Knipe, Yvonne
 Kolo, Finau
 Kydd, Dr R.R.
 Lacey, Ron
 Lafeso, Eti
 Lafeso, Philip
 Laird, Eric J
 Lamb, Dr P.R.
 Lamb, John
 Lance, Judith
 Large, Dr R.G.
 Larsen, J.H.C.
 Lassiter, Barry
 Latham, Judge F.F.
 Lawson, Diane
 Leafa, Celia
 Leathem, Peter
 Lee, Graham

Lee, Pamela
 Leicester, Yvonne
 Lelielveld, Hennie
 Lillas, Janet
 Lindsay, Barbara
 Liota, Tuna
 Longmuir, Trevor
 Low, Mrs J.
 Lowry, Ian
 Lythgoe, Margaret
 MacCann, Robin
 Macdonald, Dr M.
 MacIntyre, Sylvia
 MacKay, Dr Milan
 MacKeith, Dr James
 MacKenzie, Judith
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 Malpress, Bruce
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 Maniopoto, Winston
 Mariner, Brian E.
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 Martel, Jill
 Marvin, Gwen
 Mason, E.J.
 Mason, Tom
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 Matthews, Tim
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 Mawson, Dr David
 McBride, Tim
 McCarthy, Charles.
 McCarthy, Mary
 McCully, Bob
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 McEntegait, Wendy
 McFadyn, Sheryn
 McGeorge, Dr Peter
 McInnes, Dr E.J.
 McInney, Mack
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 Milne, Deidre
 Milne, Pauline
 Mitchell, Judge W.J.
 Moar, Barry
 Mogallapu, Dr H.
 Monck-Mason, Tim
 Moore, Greg
 Moran, Tony
 Morgan, Frances
 Morgan, Hinewairangi
 Morgan, Mrs M.
 Moroney, Helen
 Morris, Dr Brenda
 Morrish, Frank
 Moulson, Monica
 Muir, Dr Roy
 Mullen, Professor Paul E.
 Murphy, Miss Ann
 National Council of Women of
 N.Z. Inc.
 Neilson, Miss Nancy
 Nelson Area Health Board
 New Zealand Nurses
 Association (Inc.)
 New Zealand Police
 Newton, Dr Ken
 Ng, Grace
 Ngata, Dr Pat
 Niania, Pare
 Novak, Linda
 Nutley, Peter
 NZ Association of
 Occupational Therapists
 Inc.
 NZ Prisoners Aid &
 Rehabilitation Society,
 Christchurch
 NZ Prisoners Aid &
 Rehabilitation Society,
 Wellington
 NZ Public Service Association
 (Inc), (Auckland Region)
 O'Connell, Michael
 O'Hagan, Mary
 O'Regan, Tipene

O'Shea, Eileen
 Oakley, Ron
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 Conciliator, Auckland
 Otago Hospital Board
 Pack, Margaret
 Pashley, Dennis
 Patchett, Bob
 Patients Rights Advocacy
 Waikato
 Patterson, John
 Patterson, Vicky
 Paykel, Mrs A.D.
 Perae, Ronna
 Perefini, Regina
 Perkins, Mrs Patricia
 Perry, R.F.B.
 Peterson, Justine
 Phalo, Michael
 Phillips, Carol
 Phillips, Moehau
 Pierson, Henry R.
 Pitman, Harry
 Plaw, L.A.
 Pleydell, Pamela
 Ponnappa, Dr K.
 Pool, John
 Potaka, W.
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 Association
 Pt Chevalier Community
 Committee
 Pugmire, Neil
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