Witness Name: Dr David Baron
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ROYAL COMMISSION OF INQUIRY INTO ABUSE IN CARE

FIRST WITNESS STATEMENT OF DR DAVID BARON

I, Dr David Baron, says as follows:

1. I am a psychiatrist in private practice and live in Melbourne, Australia. I am also a member of the Mental Health Tribunal of Victoria.

2. I graduated from the University of Otago with a medical degree in 1964. My student year at medical school was the first to be taught psychiatry as a 6-week course. This probably explains why quite a few of my fellow students went on to become psychiatrists.

3. After leaving university in 1964 I worked as a medical intern prior to travelling overseas. I returned to New Zealand towards the end of 1965 to take up a registrar's position at Sunnyside Hospital in Christchurch where I remained until 1967. I then travelled to the United Kingdom, was awarded a Diploma of Psychological Medicine (DPM) and obtained a position as registrar at The Warneford Hospital in Oxford which was affiliated with the newly formed Department of Psychiatry, University of Oxford. In 1970 I came back to New Zealand to take up the position of Consultant Psychiatrist at Sunnyside Hospital. I worked in the Ferguson Clinic, a 150 bed admission unit. Responsibility for the unit was divided between myself and Dr Bill Gordon who had also recently returned from the UK.

4. At Sunnyside I employed a model of care known as a Therapeutic Community. This involved patient management being performed almost entirely in groups with patients encouraged to understand both themselves and each other and be involved in their treatment. I learned the Therapeutic Community approach from an Australian psychiatrist called Dr Ron Hemmings who had worked at Sunnyside.

5. In the Ferguson Clinic, as I recall, we were relatively well-staffed with 5 to 6 nurses on duty per shift for 30 to 35 patients in the downstairs unit together with an occupational therapist, psychologist and social worker also on staff. Later on, several psychiatric registrars joined the team while four or so medical students were there on assignment. I worked quite hard to keep bed occupancy down to about 25 patients, as I found once numbers became too great, individuals became lost in the crowd. In this I was greatly assisted by excellent domiciliary staff.

Sunnyside Children and Adolescent Unit

Establishment and administration

6. As medical staffing numbers increased at Sunnyside, I was able to turn my attention to a problem I observed with children being admitted to Sunnyside and mixed in with adults. To resolve this, in the early 1970s, I helped establish an adolescent unit in one of the older wards. I had previous experience in an adolescent unit in Warneford Hospital in Oxford, so had some awareness of how such units should be run.

7. We decided to use the Therapeutic Community approach in the adolescent unit. It was well-funded from the outset and was staffed by me, Charge Nurse Bill Burgess and Staff Nurse Sylvia Anderson. A schoolteacher was appointed, and a school room provided in the hospital grounds. Other staff included trainee nurses and there was always occupational therapy, psychologist and social worker support.

8. I had worked in a Child Health Clinic, but the staff and I did not receive any specialist training in working with children and adolescent patients. We worked it out as we went along. Training was not thought about then as it is today. We were miles from anywhere so instead educated ourselves by talking to each other and reading widely.

9. Running the adolescent unit, I was not required to report to the Sunnyside Medical Superintendent, Dr Edwin Hall because I was seen as an independent consultant. I did in fact discuss most issues with him, but I do not recall him ordering me on some course of action. There was not a hierarchal system. When I ran my area of Ferguson Clinic, I wasn't answerable to anybody. However, as registrars, when Dr Ron Hemmings came, we all answered to him. We had to present each patient to him individually. If I had a problem, I would have raised it with him. The nursing staff was more hierarchal.

10. As I recall we cared for 9 to 10 patients at any one time in the adolescent unit, with the age range of patients being between 12 to 14 years of age. I remember a couple of patients had schizophrenia, one was bipolar, and the rest presented with as yet undifferentiated conditions springing from several social and family circumstances. Frequently adolescents act out their internal distress leading to very difficult management challenges.

11. I don't have a clear memory of the exact admission process for adolescent patients. The first admissions to the unit were the young patients already in the hospital.

12. I visited the Department of Social Welfare (DSW) Kingslea Girls Home in Christchurch once a week. I thought the place was rather horrendous. I felt distressed seeing children locked up at Kingslea which was a routine practice there. I would discuss certain children with the Kingslea nurse and then would go to observe them at the residence. I recall having to admit a couple of very disturbed children to Sunnyside from Kingslea.

Treatments and Informed Consent

13. In our adolescent unit, treatment involved medication (from memory, antidepressants Tofranil, Tryptanol and Chlorpromazine) if relevant, but the focus was on talking with patients, activities and schooling.

14. I found the needs of all the patients required me to be there almost daily which meant I got to know them very well. Nurses Bill, Sylvia and I would see the children as a group for about an hour before they went off to school. I would discuss with the children how they were, what was going on in their lives and the ward and what they were complaining about, such as issues with staff. The sessions would commonly involve discussions about their family issues at home. Families had regular access to the unit and sometimes parents would also be invited to attend therapy.

15. Sylvia used to spend a lot of time with the parents. Patients could also visit their parents at home as they were mostly from the local area. The children would also be taken out for trips and activities. One example I can recall is when Sylvia and I took the children to Hanmer Springs for a week. As part of this trip, we took the children on a tramp.

16. The children would often stay at the unit for a long time, in many cases, over a year. This was due to the complexity of their conditions which required a lot of treatment and often because there was nowhere else for them to go. In those days, we did not aim to get them out of the unit as quickly as possible. We tried to resolve their issues and get them settled.

17. While we had seclusion rooms in our unit, we usually kept these unlocked where possible. We aimed to keep the patient in a seclusion room for as short a time as possible. Once they had settled down, we would organise another patient to be with them. That was consistent with the Therapeutic Community approach in which the patients participated in the care of each other.

18. It took considerable skill to look after adolescent patients and we tried to keep them busy with activities such as sport, group therapy and schoolwork. We coped by keeping the numbers down but, even then, it was not easy. Working with distressed children requires exceptional levels of skill, training, endless patience and a special type of person. In my view, our society still does not value or reward such people.

19. I can recall Bill Burgess, a veteran of the Second World War, saying to me that sometimes he would have preferred to be back fighting the Germans in the Western Desert then dealing with the patients in our unit. It was certainly the most difficult job I have ever had. The work could be so challenging I would ask myself whether we were doing any good for the young patients. However, after some were discharged, they would come back to visit me, and it was reassuring to see how helpful some of them had found us.

20. I remember discussing the discipline difficulties of running such a unit with another psychiatrist called Dr Roy Muir who ran a similar facility in Dunedin at the time. He resolved his problems by closing his unit down and making it a day unit. I think this is what eventually happened at Sunnyside although many services closed over the years due to the financial pressures known as "the sinking lid."

21. Reflecting on that period, I don't recall informed consent being taught at medical school when I was a student in the early 1960s. I also don't remember any process for obtaining consent from DSW staff for treatment of state wards at Sunnyside.

22. I believe that informed consent, as a concept, only entered mainstream practice in recent decades. For compulsory treatment of young patients in the unit I would usually have made an application to the court. A magistrate would visit Sunnyside once a week to see any patients compulsorily treated. I would explain the patient's situation, and then he would speak to the patient. Following that, he would give his approval for the treatment. I don't recall the magistrate ever declining one of my applications. In many instances, we would let an initial treatment order lapse.

23. In those days, psychiatrists used to have a lot of unspoken power with respect to how we managed patients and it is fair to say medical practice was more freewheeling in nature than it is today. On issues likes treatment orders lapsing, we didn't talk about it with patients. It was just the way it was. Patients often did as we directed without the need for a compulsory treatment order.

24. All sorts of things that are widely discussed now like privacy and human rights were not an issue in the 1970s. Patients have never been comfortable with compulsory treatment but once a pattern of treatment is established and continuity of both treatment and providers is established compulsion ceases to become an issue. Human relationships become the most important factor rather than compulsion. There is now a much greater awareness and emphasis on patient rights. The sad consequence of this is that there is much mental illness in the community that could be much better treated. Patients "rot with their rights on."

ECT and other treatments

25. We did not use Electro-Convulsive Therapy (ECT) with young patients at the unit. It has not been an appropriate treatment for children or adolescents in my care and I have never used it with this age group. In the 1970s ECT was usually specifically indicated for major biological depression for which it is very effective. Children can be disturbed and miserable and acting out but can be nursed through.

26. I would have been horrified if I had known one of my contemporaries was routinely using unmodified ECT on children or adolescents. I would question what the purpose of such treatment was.

27. I did use ECT with adult patients at Sunnyside but only if other medication or treatments hadn't worked. About three times a week, we would give ECT to about 3 to 4 adult patients. When I began psychiatry in 1965, just about everybody who came into Sunnyside Hospital received ECT. When the psychiatrist in charge of the acute ward went on holiday leaving me in charge, I stopped giving ECT because I believed it was overused. As I recall, only 2 or 3 newly admitted patients received it prior to his return.

28. At Sunnyside we never considered giving ECT without anaesthetic or muscle relaxant. As we did not have anaesthetists, we administered the anaesthesia ourselves and became quite skilled in this respect.

29. In response to the argument that using an anaesthetic with ECT increases the risk of mortality, I would say that the mortality rate with an anaesthetic is incredibly low and those patients that did die were generally very sick already. I never had any such difficulties giving ECT with an anaesthetic and am not aware of any psychiatrists who did. I believe that in the 1970s, the prevailing method of ECT administration in New Zealand would have been to give it with anaesthetic.

30. While working at Sunnyside I had regular contact with Dr John Dobson who ran the nearby Princess Margaret unit in Christchurch. We would often have meetings and were on good terms. Our units were largely independent of each other. I recall him using more ECT than we did but I do not believe he would have supported the use of ECT with children.

31. At Sunnyside, ECT was not used ever on any patients in response to them absconding or assaulting another patient or staff. Instead, we would medicate them. When I first worked at Sunnyside in 1965, ECT was administered forcibly. I remember that the nurses would go into the day room and bring out a patient forcefully with a nurse on each arm. The patient would then be restrained and anaesthetised and ECT applied. It was not a practice I supported, and I do not recall how we ceased the practice. I suspect it was better nursing, appropriate use of medication and patience.

32. Giving ECT with anaesthetic requires the patient to lie down, be still, and have a tourniquet put on them in order to be anaesthetised. This would not have been possible if the patient was struggling or protesting. Looking back, I suspect that it was a more rational use of ECT and better nursing (and I suppose doctoring) that led to improved practice.

33. The use of the sedative paraldehyde was phasing out when I first started in psychiatry in the mid-1960s. It was not in common usage by the 1970s. I never used it in our adolescent unit and cannot remember it ever being used with children. It used to be given to extremely psychotic adult patients by some doctors. In such situations I would normally use medications such antipsychotics, Chlorpromazine or Haloperidol and sedate the patient with an antihistamine. These were administered orally as soon as possible with minimal injections. I don't believe it would ever have been normal medical procedure to administer paraldehyde by injection to a children's leg or buttocks.

34. Around 1976 or 1977 I presented a paper to a Christchurch meeting of the New Zealand branch of the Royal College of Australian and New Zealand Psychiatrists. The paper described my concerns having observed drugs such as Chlorpromazine being injected into patients by some staff as discipline disguised as treatment. This occurred in all parts of Sunnyside including in the adolescent unit. This drug was known as a "chemical straitjacket". It should be acknowledged that management of patients in the adolescent unit was much more difficult than the adult unit. As I said earlier, you needed considerable skill to work with disturbed children and adolescents and unfortunately at that time there weren't many people around with this ability. It was noticeable that following the opening up of the wards, the mixing of sexes and the introduction of active programs, under the direction of the Principal Nursing Officer (Dame) Margaret Bazley, patient behaviour greatly improved, and management became much easier.

35. I would never have considered using aversion therapy. I believed it to be a well out-of-date treatment by the 1970s. When I was being taught psychiatry as an undergraduate in 1961, aversion therapy was not widely taught. There was a lot of ECT used at that time. This was due to the common belief, held by some psychiatrists that you should give patients a lot of ECT, "wiping the slate clean" to be followed by "rebuilding their brain". For obvious reasons this was not a view I subscribed to as it sounded like rubbish and did not correspond to what one saw in practice.

36. I was not aware of any electrical aversion therapy being used in any of the hospitals I worked at in England, Australia or New Zealand. I believe most of my professional contemporaries would have been horrified if we knew this was happening with children or adolescent patients.

37. In my experience working in mental health, ill-treatment of patients was often contributed to by underfunding of hospitals and unreasonable expectations being placed on ordinary clinicians who are presented with incredibly challenging patients. It took very able and gifted people to work well under these circumstances and often they would burn out and simply leave the health system. Some of the staff who remained would fall back on some of the shocking behaviours we hear about now.
38. I worked in the Sunnyside adolescent unit for a couple of years. Dr Noeline Walker eventually took over from me. I left Sunnyside in 1978, when I moved to Australia where I have since worked mainly in Community Mental Health.

Statement of Truth

This statement is true to the best of my knowledge and belief and was made by me knowing that it may be used as evidence by the Royal Commission of Inquiry into Abuse in Care.

Signed GRO-C GRO-C

Dated: 20-11-2020