ABUSE IN CARE ROYAL COMMISSION OF INQUIRY
LAKE ALICE CHILD AND ADOLESCENT UNIT INQUIRY HEARING

Under	The Inquiries Act 2013
In the matter of	The Royal Commission of Inquiry into Historical Abuse in State Care and in the Care of Faith-based Institutions
Royal Commission:	Judge Coral Shaw (Chair) Ali'imuamua Sandra Alofivae Mr Paul Gibson
Counsel:	Mr Simon Mount QC, Ms Kerryn Beaton, Mr Andrew Molloy, Ms Ruth Thomas, Ms Finlayson-Davis, for the Royal Commission Ms Karen Feint QC, Ms Julia White and Ms Jane Maltby for the Crown Mrs Frances Joychild QC, Ms Alana Thomas and Tracey Hu for the Survivors Ms Moira Green for the Citizens Commission on Human Rights Ms Susan Hughes QC for Mr Malcolm Burgess and Mr Lawrence Reid Mr Michael Heron QC for Dr Janice Wilson Ms Frances Everard for the New Zealand Human Rights Commission Mr Hayden Rattray for Mr Selwyn Leeks Mr Eric Forster for Victor Soeterik Mr Lester Cordwell for Mr Brian Stabb and Ms Gloria Barr Mr Scott Brickell for Denis Hesseltine Ms Anita Miller for the Medical Council
Venue:	Level 2 Abuse in Care Royal Commission of Inquiry 414 Khyber Pass Road AUCKLAND
Date:	16 June 2021

TRANSCRIPT OF PROCEEDINGS

INDEX

We'll take the lunch adjournment and we'll come back at 1.30.

Lunch adjournment from 12.25 pm to 1.34 pm

CHAIR: Ms Thomas.

MS R THOMAS: Thank you. The next witness is a Dr Barry Parsonson. He's seated here with his wife Jane-Mary.

BARRY SINCLAIR PARSONSON

CHAIR: Dr Parsonson, thank you for coming and thank you for supporting your husband. It's very brave of you to sit out there in full public glare.

Before we begin, I'm going to ask if you'll take the affirmation. Do you solemnly, sincerely and truly declare and affirm that the evidence you'll give before the Commission will be the truth, the whole truth and nothing but the truth?

A. I do.

Q. Thank you very much.

QUESTIONING BY MS R THOMAS: Thank you. Dr Parsonson, can you please tell us your full name?

A. Barry Sinclair Parsonson.

Q. And you are a clinical psychologist?

A. Yes.

Q. Just confirm for everyone's benefit that you have provided the Commission with a signed witness statement and that the Commissioners and everyone has read that statement and have it before them, so there may be some parts that we will highlight and other parts that we will move over, but just to know that it's been read.

A. Thank you.

Q. In terms of your qualifications and expertise, they are outlined on the first few paragraphs of your statement. They show your qualifications, your career and that you are a New Zealand registered clinical psychologist and you have published a number of articles, reviews and textbook chapters in relation to applied behaviour analysis?

A. That's true.

Q. Would you be able to please start your evidence by telling us all what Aversion Therapy is?

A. Essentially the aim of Aversion Therapy is to provide unpleasant consequences for behaving in a particular way. And in a sense it was developed in relation to Pavlov's theory of the conditioning and in the 1950s it became more popular as an approach to trying to change a range of behaviours, including alcohol consumption in terms for alcoholics, and in terms of homosexuality and some other behaviours that were considered inappropriate and

undesirable in society.

Q. They were considered that way, that was back in the 1950s, did you say?

A. That was the late 40s, 1950s, through into the 60s, it was becoming more increasingly used in that way, yes.

Q. Then into the 70s and 80s, what was the status of Aversion Therapy at that stage?

A. Well, as time moved on, there were a number of issues that arose. Some of them were ethical and some were in relation to the fact that it wasn't as effective as people had hoped. They found, for example, with alcoholics that using drugs to induce an emetic response after the consumption of alcohol, the delay was too great in order to effectively reduce a person's alcoholism. The result's very patchy.

Q. Moving on to paragraph 9 of your brief, could you tell us what types of behaviours has Aversion Therapy been applied to?

A. Typically these were behaviours, again homosexuality, transvestitism, alcoholism and paedophilia were some of the behaviours that were attempted to be treated using Aversion Therapy. Those typically, apart from alcoholism, tended to use electric shocks as the treatment.

Q. So some aversive stimuli have been electric shocks, what other types of aversive stimuli have been used in this treatment?

A. Chemical aversion, which was primarily the method that was used in relation to alcohol, because they use an emetic drug, Disulfiram and even trying to encourage people to have aversive thoughts was another method. Another chemical method was waving ammonia under the nose, a nasty sort of sensation.

Q. Now in your brief you have gone through some of those different types of aversive stimuli, but for today's purposes we will focus primarily on electrical Aversion Therapy?

A. Sure, yes.

Q. So at paragraph 12 of your brief you talk about Electrical Aversion Therapy as a mild but painful electric shock to be used. How are they used, how does it work?

A. Well, the idea was that you had the person either behaving or thinking about the behaviour of concern and at some point when they signalled that they were engaging in that, you gave them a shock because the shock had to be really closely related to the behaviour of concern. So, for example, someone with paedophile or homosexual thoughts had to signal that they were thinking about those things and then they'd deliver a shock.

Q. So that's in a situation where this is set up in a specifically targeted Aversion Therapy programme?

A. Absolutely, yes.
Q. And I think in your statement you've used the word by "pairing" the delivery of the shock. What do you mean by that word?
A. Well, it has to be virtually simultaneous in order to ensure that the person identifies that this shock is being delivered in relation to that specific behaviour, because if you make it too dissimilar in terms of time, some other event may be going on in their head, or they may think it's being given to them for some other reason, and there's no association developed between the shock and the behaviour of concern.
Q. So the shock needs to be given effectively simultaneously with the target behaviour?
A. Absolutely.
Q. So in terms of the delay of minutes or hours or days, for example, if someone is behaving badly during the week and then waits for the Friday to be given an electric shock, how does that impact with the effectiveness of Aversion Therapy?
A. Well, I suspect that what happened is the person comes to -- the person who's given the shocks comes to feel quite antagonistic towards the person who's delivering it, so in fact, you know, you're training them to hate you.
Q. How does it impact on the target behaviour if someone, for example, has wet the bed and then the next morning or hours later they receive an electric shock and they're told this is for wetting the bed, how does that impact?
A. Well, first of all electric shocks for wetting the bed is not an effective bed wetting treatment. So it's inappropriate to deliver shocks for that. But also the delay means it's inappropriate, it's not going to work.
Q. So if someone is caught smoking, for example, and then along comes Friday and they're given some electric shock and told "This is for you smoking", how does that impact on their behaviour, the target behaviour of smoking?
A. Well, I suspect what they might do is learn to smoke in places where that person isn't present or other people aren't going to see them.
Q. It doesn't actually stop that behaviour?
A. It doesn't actually extinguish the smoking behaviour.
Q. Thank you. In terms of moving to paragraph 15 of your statement, you talk about equipment that's used in Electrical Aversion Therapy?
A. Yes.
Q. Can you tell us, take us through what types of equipment would be used when this is a therapeutic programme?

A. Certainly. By the late 50s early 60s the type of equipment was usually battery powered. So usually something in the order of 3 C-cell batteries, torch batteries would power the equipment to deliver a painful, an unpleasant shock, of maybe quite a lot of voltage, maybe 700, 1500 volts, but very low amperage, so it wasn't as if they were getting a huge electric shock, but it was enough to be painful and unpleasant.

Q. And whereabouts would that shock generally be delivered to the participant's body?

A. The typical location was on the leg. I don't know which leg, but one leg or the other, most people had two.

Q. In your brief at paragraph 16 you refer to a quote from Marshall?

A. Yes.

Q. Who's written a book on Electrical Aversion Therapy. Could you read out those sentences that you've quoted from Marshall to us please?

A. Sure. "Marshall advises against the use of very intense or very painful shocks as both dangerous and therapeutically ineffective. Marshall notes that 'on no account should electrical stimuli be applied to the trunk of the body or the head'."

Q. Just in relation to Marshall's comment around the trunk of the body, would that include someone's groin and genital area?

A. I should think so, absolutely.

Q. And why, in your opinion, is Marshall saying that an electrical shock as part of Aversion Therapy should never be given to the head or the trunk of the body which includes the groin and genitals?

A. Well, the essence of the concern there I think would be that any cross-body shocking, shocking the brain isn't much -- in any way relevant to the Aversion Therapy. But also across the trunk the potential exists perhaps for disturbing heart rate and maybe causing harm.

Q. If electrodes are placed on a person's groin or genitals to deliver a painful electric shock, is that Electrical Aversion Therapy?

A. No.

Q. What is that?

A. It's a form of torture.

Q. To your knowledge has that ever been used as Aversion Therapy, have you seen any research on that?

A. There is no -- nothing that I've ever read in the literature, and at the time when I was studying as a student this was -- the literature was fairly prominent, and afterwards when I

was teaching in psychology I maintained an interest in the literature, there was never any publication that would have included that. I mean the only people who did that were state Organs of terror, namely the Gestapo is a good example.

Q. That would give someone electric shocks to their genitals?

A. Yes. I've read of people who received that sort of treatment from the Gestapo.

Q. Thank you. There is evidence before the Commission about boys receiving electric shocks to their genitals if they were caught masturbating or for homosexual acts. Can you confirm even when Electrical Aversion Therapy has been used historically to treat homosexuality, that the electrical shock paired with the behaviour, would it have been applied to the person's leg, historically?

A. Well, it certainly wouldn't have been applied to their genitals. The most likely location would be the leg or maybe an arm in some instances.

Q. Thank you. If we could turn to paragraph 17 of your brief. Over the next few paragraphs you outline some criteria that must be met in order to make Aversion Therapy actually therapy. I think you list four key criteria. Can you take us through those?

A. Certainly. I mean obviously the first one is that the person should be fully trained and they need to be both familiar with the literature and/or experienced in the application and in the procedures that are used. So that's a necessary first criterion. Secondly, there needs to be an assessment process so that there's a clear understanding and a definition of a behaviour to be treated, so that everybody's clear on exactly what this therapy is for.

Q. Would that be discussed with the patient in advance?

A. Normally it would require both discussion with the patient and also direct observation where appropriate of the behaviour of concern, so that you actually understand what we call the topography of the behaviour; what does this behaviour look like so that we know what it is we're treating.

CHAIR: Doctor, can I just ask a question, sorry, just intervening. When you say that there must be discussions with the patient and direct observation, is that direct observation by the person administering the treatment or could that person rely on third-hand or second-hand accounts of the behaviour?

A. Ideally it would be the person who's planning the treatment, because they need to understand exactly what it is they're treating. If necessary, under other circumstances, someone who was trained in observing behaviour could in fact observe it, describe it appropriately, but they'd need to be trained in how to do that.

Q. And I take it those observations would have to be carefully documented in a rigorous way?

A. That was my next point. I think there need to be a description, records of the observations, and then there need to be, during the treatment process, data maintained on how effective it is. Because at the end of the day, if it's not effective you stop doing it.

Q. Yes. Thank you.

QUESTIONING BY MS R THOMAS CONTINUED: Thank you Dr Parsonson. So just to clarify, the four key criteria was that there must be a trained therapist, there must be a determination as to whether the treatment is justified and that to be observed and discussed?

A. And consent.

Q. And the third one is this consent?

A. Yes.

Q. Can you tell us about that?

A. Well, the standard procedure is to ensure that the person has given informed consent, that is that treatment has been explained to them, any risks or hazards have been explained to them, and the potential benefits they understand so that in fact they are giving consent to treatment that they believe will be appropriate to their own needs.

Q. And then the fourth is the consideration you've discussed with the Chair, that things -- there needs to be records made and monitoring in terms of checking whether this is working?

A. Absolutely. I mean the essence of, you know, under which Aversion Therapy was developed in the 1950s was that this was a scientific intervention and so that it was essential to have data to demonstrate that in fact the treatment was efficacious.

Q. Just moving on to that as the next point in your brief at paragraph 22. In particular focus on Electrical Aversion Therapy here; does it work, is it effective?

A. Well, it was really being mainly tried on people with sexual deviations, as they were thought of in those days, and also people with very challenging behaviour. And so the outcomes were not necessarily always beneficial to the clients. It became less popular as a consequence of the fact that this lack of ongoing and regular evidence of effectiveness wasn't available. The fact that in essence the social morays were changing, people's understanding of treatment increasingly became the need to develop positive behaviours rather than trying to get rid of problematic behaviours, and also the fact that people in society change their views and opinions in relation to some aspects of sexual behaviour, whereas there wasn't so much of a challenge around transvestitism or homosexuality. It eventually became legal.

Q. In terms of ethical issues, this is at paras 23 and 24, of your brief, what are the ethical issues just in general associated with Aversion Therapy?

A. Well, I think those who were using Aversion Therapy began to realise that it was fairly unpleasant causing people pain. Additionally, in essence there was a concern that a therapeutic relationship typically has to be a positive one between the therapist and the patient, and giving people electric shocks didn't actually contribute much to a positive relationship between the therapist and the client. And I think that basically the lack of consistent effectiveness along with those things eventually made people realise that this wasn't really going to be an effective programme of treatment.

Q. You've said that Aversion Therapy was typically used as a last resort?

A. Yes.

Q. As a form of treatment. Why was that, was that for the reasons you've just outlined?

A. In part, it was a treatment of last resort primarily because people didn't have any idea what else to do. And so sometimes the alternatives were either, you know, a person's behaviour was life-threatening to themselves or others, or causing them personal damage, like serious head banging, huge, high levels of aggressiveness and so forth. And they were trying to manage those using Aversion Therapy where other types of therapy had failed.

Q. If Aversion Therapy is misused in a non-therapeutic way, what ethical concerns does that raise?

A. Well, I think this was another problem, is that it emerged in various places, particularly in the United States, that there was -- people were using aversion therapies in an unscrupulous and inappropriate fashion, and that also led to quite considerable concern about whether this was appropriate.

Q. Thank you. I'm now going to ask you some questions in relation to the evidence you've put in your brief about Operant Punishment?

A. Yes.

Q. But before I do that, the term that we've heard a bit about in, and the Commission has received evidence on, is this term "Aversion Therapy"?

A. Yes.

Q. Why have you talked about "Operant Punishment" in your brief?

A. Because my reading of the survivors' own descriptions of what was happening to them made it clear that they were in an environment which was heavily imbued with punishment and for some of them, in fact most of them, they associated either the so-called ECT or the shock treatments that they were receiving and the Paraldehyde and sometimes the seclusions, they were perceived as punishments. And so, I thought it was important to include some information in relation to Operant Punishment.

Operant Punishment is derived from Skinner's theory of Operant Conditioning. So, whereas Pavlov's theory of Classical Conditioning was the basis of Aversion Theory. I thought it probably important to introduce the notion of Operant Punishment because it relates primarily to behaviours which are not reflexes or -- but which are voluntary behaviours, like smoking, like fighting, those sorts of acts that were some of those that were punished by electric shocks and Paraldehyde and seclusion in Lake Alice.

Q. So at its simplest level, can you tell us what are the basic elements of Operant Punishment Therapy when it's used as a therapeutic programme?

A. Sure. Some of the people who were engaging in operant -- using Operant Punishment were using electric shocks in the early days. I'm talking here, the publications that I've read and the people that I've talked to, it was mainly somewhere in the late 60s.

The fact is that punishment is part of human life and it's used in a whole lot of environments, but in terms of the Operant Punishment there are a number of techniques that were developed that were to include things like time-out that would include response cost where you'd take something away. "You've been naughty, you can't have access to your bike for a week", that sort of thing, or you can't, you know, "You can't watch your favourite television programme", that's a response cost for being naughty. And there were some other techniques that were used like restitution, where you damaged something you had to help fix it.

Q. Was one of the techniques in terms of Operant Punishment Therapy also electrical --

A. Yes.

Q. -- stimulus?

A. In the early days that was tried. I think I've read probably about three studies in which it was used with young children who were putting themselves at high risk of harm and it was an attempt to try to stop that behaviour and replace it with alternatives.

Q. If we look actually on to paragraph 43 of your brief, you've outlined for us there the equipment used when it's an electrical Operant Punishment Therapy?

A. Yes.

Q. Can you take us through that, how is the equipment used here?

A. What people were using in those days was stock prods.

Q. Like a cattle prod?

A. Cattle prods. They delivered a painful, a brief painful shock, so again, powered by torch batteries typically, and probably somewhere between again, 1100, 1500 volts, but quite sharp and short. And those using them at the time described it as like a painful sting.

I guess my experience has been with electric fences because I've worked on a farm where the farmer thought it was a joke if he turned the fence on while I was setting it up. He didn't enjoy the same joke when I played it back on him, but, you know, it's a painful jolt.

Q. And in terms of that jolt, if this is an Operant Punishment treatment, what about delay in terms of the behaviour, what's the situation with that?

A. It's the same problem as with the Pavlovian conditioning that it has to be contingent on the display of the behaviour. In the studies that I've read they waited for the person to engage in the behaviour that was problematic, then they would deliver the shock while they were engaging in that behaviour to get them to stop behaving in that way.

Q. When this has been set up in a therapeutic programme, whereabouts would these shocks be delivered to the person's body, whereabouts on their body?

A. Well, in this case, as I understand it, it was typically on the legs or arms.

Q. Legs or arms. You've told us already in terms of the Aversion Therapy there were four key criteria that are essential to make sure the actions are therapeutic as opposed to anything else. Does this apply to Operant Punishment Therapy as well?

A. Absolutely.

Q. And are they the same four criteria?

A. Same four criteria.

Q. How effective was Operant Punishment Therapy?

A. Well, the persons who were using it at the time described it as -- one found it had some effect and enabled them to access the person's behaviour in such a way that they could change it in a more positive way, but they found that they didn't like giving a child shocks. In the case of Bimbrauer, who was one of the other authors, he found that it was initially effective but then it failed and so -- because they were trying to improve the circumstances under which a person with very severe disabilities, intellectual disabilities was being very aggressive and it managed to stop it briefly but it didn't continue to maintain that change in behaviour.

Q. And just like your evidence about Aversion Therapy in terms of Operant Punishment, are there any ethical issues with this?

A. They're very much the same ethical issues, because I think the challenges are that you can't build a positive relationship with a client, you can't actually use Operant Punishment as a means of producing positive behaviour. You have to actually start building new behaviours to replace the behaviours that are challenging.

Q. I'm now going to turn to the part of your brief which is at paragraph 49 in terms of

electroconvulsive therapy. Just from the outset you've noted there you are not a psychiatrist and you were not an expert in electroconvulsive therapy but you were asked to and you have made some comments on ECT in this brief to contrast the methods of ECT in comparison to Aversion Therapy and Operant Punishment?

A. That's true, yes.

Q. So just moving to paragraph 51, what was electroconvulsive therapy primarily used for in the 60s and 70s?

A. Well, I was training in a psychiatric hospital in the 1960s as a clinical psychologist and I was supervising students in the 1970s and working in a psychiatric hospital. And essentially, the primary use for ECT was persons with depression, and I suspect from only hearing from other people, that it's sometimes given to people who had some form of psychotic disorder as well.

Q. Turning to paragraph 54 of your brief, in relation to ECT, how was ECT used when its an applied as a standard medical procedure?

A. I didn't actually personally observe this, but I've spoken to former psychiatric nurses in relation to what they would consider to be appropriate ECT procedure, and essentially the person was -- A, they had to sign a consent form to receive the treatment, they had it explained to them what the treatment was about, and they also, prior to the application of the electrodes, they would receive a muscle relaxant injection and an anaesthetic and be on oxygen for recovery.

Sometimes the electrodes were put on both temples and sometimes they were unilateral, like putting it on the forehead on one side. It was sometimes throughout that unilateral had less effect on the person's confusion and memory problems after the application of the ECT.

Q. And when that procedure is carried out in that standard way that you've described, would the person lose consciousness during that treatment?

A. Well, they would lose consciousness with the anaesthetic, so they were unconscious at the time that the electrodes were activated using the equipment. That was regarded as, I guess, modified ECT. Unmodified ECT wouldn't include either the anaesthetic or the injection, the muscle relaxant.

Q. And in terms of unmodified ECT, at what point would the patient lose consciousness?

A. At the point at which a sufficient electrical impulse would pass through the electrodes.

Q. And if that was to be done in a standard procedure would the intention be that would be at the beginning, from the outset?

A. Normally, because, as I gather, people have different thresholds for induction of seizures from my reading of the literature. And therefore, sometimes what they did was they could increase the intensity of the shock just to establish where a person's shock threshold was so that subsequently they could deliver the shock at the threshold that would cause the seizure.

Q. I'm now going to move on to the next part of your brief. You have given us more evidence here in relation to ECT, but we'll just, in terms of time constraints, we'll move on to the next section which is you were asked to review some medical notes and some statements from complainants who had been in the Lake Alice Child and Adolescent Unit?

A. That's right, there were 11 of them.

Q. In the documents that you reviewed, and the medical notes, what treatments were recorded in the notes and reported in the statements? And you've listed those in paragraph 61(a).

A. Yes, they were sort of, I suppose, termed Ectonus Discussions. They were, you know, referral to Dr Leeks for Ectonus Discussions for Ectonus Therapy, or for Special Therapy, ECT Ectonus Discussions. It was sort of rather, I suppose, hiding the fact that these people were being given electric shocks for one reason or another.

Q. I think you've noted there in your brief that the use of electric shock was identified by Dr Leeks as Aversion Therapy?

A. Yes.

Q. But then these other subsequent -- this terminology was used, was Aversion Therapy like an umbrella term for these?

A. Aversion Therapy may have been what Dr Leeks thought he was using, he wasn't. And I think they were sort of umbrella terms to sort of hide the fact that these young people were being given shocks.

Q. Just on that point, you've talked to us so far about the standard procedure for Aversion Therapy, the standard procedure for Operant Punishment and the standard procedure for ECT. What, if any, of those, or particularly Aversion Therapy and Operant Punishment, was happening at Lake Alice from the information you've read?

A. Neither, neither of those, it was neither Operant Punishment nor did it meet the criteria for Aversion Therapy. It was just plain punishment.

Q. Over the next few pages of your brief you've gone into some detail around the medical notes that you've reviewed, but I'm going to ask you to turn to paragraph 107.

A. I'd just like to say I found those records of people's experiences very harrowing.

Q. Thank you.

CHAIR: You're not alone in that, doctor.

QUESTIONING BY MS R THOMAS CONTINUED: From paragraph 107 you've gone through and talked about the target behaviours that were recorded in the medical notes and in the complainants' statements.

A. Yes.

Q. Can you take us through those -- summarise what the target behaviours for treatment were?

A. Yes, typically misdemeanors like swearing, arguing, fighting, not complying with staff instructions, being cheeky or tardy, not eating meals, kicking a ball near the windows, some reported being punished for leaving the villa, absconding, for bed wetting, and for sexual behaviour such as masturbation and engaging in homosexual acts.

Q. So from your review of the records, those types of behaviours would result in what?

A. They would result in so-called ECT or shocks or Paraldehyde and sometimes seclusion.

Q. When you say so-called ECT, why do you refer to it in that way?

A. Because I think sometimes the equipment was misused.

Q. Now you've referred to punishment by ECT. When there was reference to punishment by ECT, what was that?

A. Well, it was unmodified ECT to the temples, but also shocks delivered to their knees, their thighs, their shoulders, hands or genitals. That doesn't really seem to me to be ECT, it may have been delivered by a machine that was designed for ECT, but it certainly wasn't ECT.

Q. And also, just in terms of Aversion Therapy, receiving shocks to someone's genitals area, is that Aversion Therapy?

A. No.

Q. What did you note from your review of the records, with relation to Paraldehyde?

A. Well, Paraldehyde wasn't given for medical reasons. Paraldehyde is an injectable medication which was used to, tranquillise patients who were either seriously aggressive or seriously disturbed. And it's very painful, it's very oily so when it goes into the muscle it stays there for some time and then begins to be distributed through the body, through the blood system. It was simply used as an instrument of pain, not as a medical treatment.

Q. What did you note in relation to seclusion based on the notes that you reviewed?

A. Well, seclusion was being placed in a bare and shuttered room with a mattress on the floor and a bucket for a toilet if you were lucky. And the behaviours described were for swearing, fighting, food refusal and disobedience, they range from half an hour of seclusion to several days. And sometimes transferred to the hospital's maximum security unit, at least in the case of one patient, for two to three weeks because they escaped. I think, you know, the "therapeutic", in inverted commas, regime itself encouraged escaping. I wouldn't

have wanted to stay there, that's for sure.

Q. In terms of the procedural issues or the treatment at this adolescent unit.

A. Yeah.

Q. You've said that it involved a regime dominated by punishment. Why do you say that?

A. Well, that's simply what it appears to have been. It didn't matter that they -- how they behaved inappropriately in the views of the staff or Dr Leeks, but the result was always some form of punishment. It wasn't until eventually a psychologist was appointed to the unit that they set up a sort of reward programme, which was quite amateurish from my reading of his description, but at least -- so primarily the whole organisation of the way the staff treated these young people was focused on punishing them for what was considered to be misbehaviour or inappropriate behaviour.

Q. And in terms of the four key criteria that must be metaphor something to be therapeutic, so whether it's Aversion Therapy or Operant Punishment Therapy, was there any evidence in the notes that you read to show that those criteria were met at the Lake Alice Child and Adolescent Unit?

A. No, I don't think any proper records were kept. I mean most of what we saw or what I was able to see was from nursing notes. There was no medical notes that I came across. I don't know whether they had somehow passed into the furnace at the hospital or whatever, but there was nothing available that suggested that the word "therapeutic" should be applied to what was happening.

Q. And in terms of ethical issues -- we're on paragraph 114 of your brief now -- did you note anything in relation to ethical issues of what was occurring from your reading of the notes?

A. There's no evidence of formal and proper diagnosis and assessment to justify the treatment that was given. There was no planned intervention. There was no evidence of any treatment data having been systematically recorded, analysed or reviewed in order to monitor the efficacy and to demonstrate benefits or harms of this treatment.

Q. In terms of Aversion Therapy in the 1970s, you said it was becoming a treatment of last resort. What was your opinion about whether that was true for Lake Alice?

A. Well, it wasn't Aversion Therapy, as I understand it. I can't actually believe that Dr Leeks was trained in Aversion Therapy and I don't believe that if he empowered the staff to be able to use this type of approach that they would trained in any way in Aversion Therapy. In fact, one of the nurses who had experienced programmes of Aversion Therapy in the UK made it perfectly clear that from his or her point of view they did not consider that there was anything appropriate about the way it was being done at Lake Alice.

Q. Paragraph 119 you've said that the regime was dominated by punishment -- a regime dominated by punishment cannot be justified as therapeutic.

A. No, because it's more likely to generate fear and anxiety and a wish not to be there. A feeling of hatred and anger towards those who were delivering it, and the fact that those people in authority represent the society out there make it difficult for any adjustment in the future to authority figures or medical services and so forth. So in fact it was preparing them for a life of rather nasty consequences for themselves.

Q. So as a result of this regime, people may subsequently have chosen not to seek out doctor's help, for example?

A. Yeah, I mean I think that -- I think the message at the time in terms of ethics was do no harm. Well, I think they failed on ethical grounds in that purpose. Left behind a whole series of people completely traumatised by their exposure to whatever was offered at Lake Alice.

Q. Just coming on to your summary of these three therapies, Aversion Therapy, Operant Punishment and electroconvulsive therapy at para 120 and 121, how did the procedures of the Lake Alice Child and Adolescent Unit compare with the procedures of a standard clinical application of Aversion Therapy?

A. They were nothing like it. There was no comparison at all.

Q. And is that because none of the elements or the essential elements that you've listed were present?

A. That's right, I mean it failed on all grounds. It could not have been a therapeutic process because it wasn't delivered in a manner which met any standard of therapy.

Q. And in relation to the delay aspect, you've noted at para 123 that sessions being arranged for the Friday when Dr Leeks was around. What do you have to say about that?

A. Well, you couldn't possibly establish any conditioned responses. And, you know, once a week isn't the way that proper Aversion Therapy, even when it was used, would be delivered. I mean it was done as a treatment over a period of time probably on a day-to-day basis rather than once a week, you can't have somebody anticipating, you know, unpleasant pain and so forth on a weekly basis as a therapeutic model.

Q. So if it wasn't therapeutic, what was it?

A. I think it's torture. I can't think of any other word to describe it. I mean Dr Leeks was an employee of the State, so in fact it probably matches a definition of torture from the United Nations.

Q. In terms of your paragraph 125, that's where you've mentioned in your opinion this was

closer to torture.

A. Yes.

Q. Than any known ethical form of therapy?

A. That's right.

Q. Just before we go on to your summaries in relation to Operant Punishment and ECT, I'd just like to bring up a document please which is NZP000308. This is a document, that's the first page of the document dated 14 September 2009.

A. Yes.

Q. It's sent from the -- it's on Police letterhead. If you could go to the last page just to show the author of the document. So this a document written by Detective Superintendent Malcolm Burgess.

A. Mmm-hmm.

Q. If you could go back please to the paragraph I'd like to bring up. I'll just read these paragraphs out so they're part of the record. "The third treatment which appears in the notes is what has since been charactered as Aversion Therapy. It appears this is referred to in the nursing notes as ECT, Ectonus or Ectonus Therapy. This apparently entailed the ECT machine being used on a different setting to the setting that would be used to deliver ECT. It involved the patient receiving an electric shock at a lower level of electric current as a means of modifying behaviour.

The location in which the electric shock was delivered during these treatments was apparently determined by the sort of behaviour that led to the application of the electrodes in the first instance. For example, boys who ran away might expect to have the electrodes applied to their legs, boys who were caught masturbating or offended in a sexual fashion could expect to have the electrodes attached to their penis or their testicles, and boys who were fighting might expect to have the electrodes attached to their shoulders. These applications of electric shocks are not recorded in the ECT notes but are often referred to in the nursing notes."

So this is a document authored by the officer in charge investigating this case back in 2009. Do you have any comment on these paragraphs which refer to Aversion Therapy?

A. It's not Aversion Therapy. It doesn't -- in fact, you know, it's no point in putting the electrodes on the parts of the body that were somehow related to the behaviour of concern. That isn't a standard procedure in Aversion Therapy and it still doesn't justify using shocks, especially on the genitals. It is not a therapeutic procedure, it's not Aversion Therapy.

Q. I'd now ask to bring up the next document please, which is ending in 19. Thank you. That

document we've just seen was then provided to some legal advisors to provide an opinion for the Police in terms of whether or not to continue with the prosecution. So the document we're looking at here is dated 14 December 2009.

But if you could go to the final page of the document please. So we're actually looking into a legal opinion that was written by a barrister in Christchurch, Mr Pip Hall, and if you could go to the paragraph to call out. I'll just read this into the record. Starting at the second sentence starting with:

"Dr Leeks will be able to call medical opinion that his use of ECT as Aversion Therapy was justified in the treatment of young patients in the 1970s who exhibited the mental and/or behavioural problems of the alleged victims."

Do you have any comment in relation to that statement made by the opinion writer?

A. Well, it concerns me that in fact only medical opinions were being sought, because most medical people, including some psychiatrists but not all, were not actually well informed about the nature of Aversion Therapy. But also, I guess the Mental Health Act 1969 and section 20 of the Crimes Act provided some sort of out in a legal sense. I'm just concerned that opinions were sought from people who didn't probably -- did not themselves use Aversion Therapy, or were not aware necessarily of all of the issues that relate to it.

Q. So reading this sentence, the one I read out and the paragraphs on the previous document, is there anything in those statements that would satisfy you that an Aversion Therapy expert had provided any advice?

A. Well, someone may have provided advice, but I'm not sure how -- I'm not informed enough about sections of the relevant acts to know how you could legally justify or claim immunity in relation to those. There must have been somehow it was seen to be possible.

Q. I'm asking more in relation to, for example, the previous document which referred to if someone is caught masturbating, therefore put the electrodes --

A. That couldn't be justified. I'm sure -- I can't understand how anyone who knew anything about Aversion Therapy could feel that that could be justified.

Q. Thank you. You can take those down now. Just coming back to your brief, your summary of Operant Punishment at paragraph 127, you've said that Operant Punishment involves contingent and contemporaneous application of the punishing stimulus. Is that what occurred at all at Lake Alice that you notice from the --

A. Well, I don't know how immediately sometimes Paraldehyde might have been delivered, but in terms of the electric shocks, certainly not.

Q. So you've said this treatment programme did not correspond or was certainly not Aversion Therapy?

A. It didn't reduce or eliminate the behaviours of concern because they kept doing punishment for it. So if it keeps happening it's not being effective as a treatment.

Q. And what you'd read from the notes, would that meet any of the criteria or the necessary criteria of an Operant Punishment --

A. No.

Q. -- therapy?

A. It would not.

Q. In terms of ECT, were the procedures at Lake Alice consistent with standard ECT procedures? This is at para 135 of your brief?

A. Well, from my understanding, again I emphasise I'm not an expert on ECT, but from my understanding of what would consider to be standard methods, it doesn't seem to be that Dr Leeks was conforming with it, and it seems very atypical that nursing staff were not supervised by a medical officer during the delivery of ECT, if that's what was being given.

Q. And you've talked about the use of unmodified ECT to deliver repeated and varied intensity shocks?

A. Yes.

Q. From your understanding does that conform with the standard ECT procedure?

A. No, it does not. So and also putting electrodes on other parts of the body than either the temples or unilateral is not ECT, it's delivering shocks to the person as an attempt to induce pain and discomfort as punishment.

Q. As punishment?

A. Yes.

Q. At paragraph 136 you've referred to the term "Ectonus Therapy" and "Ectonus Discussions"?

A. Yes.

Q. "Special Therapy". What have you noted about those terms?

A. Well, I thought it was just a cover term for the interventions that Dr Leeks was providing young people to justify this therapy.

Q. What do you mean by a "cover term"?

A. Well, I mean anyone reading the notes wouldn't necessarily know that this was a matter of delivering shocks to other parts of people's body as punishment.

Q. As punishment?

A. Yeah.

Q. A staff member from the Lake Alice Child and Adolescent Unit has provided the Commission with a signed statement. In that statement the staff member refers to a behavioural modification therapy described as the Ectonus. This staff member says that the Ectonus did not involve being shocked into a seizure or being rendered unconscious. The staff member said that Dr Leeks had said the electric shock was below the level of pain, and was therapeutic. And that staff member went on to say they are sure in their mind that what they saw during the sessions of Ectonus was not torture or punishment. Do you have any comment to make about that statement given your evidence about Ectonus being a cover term?

A. Well, it concerns me. If it's not going to be a painful shock, if it's below the threshold of pain it's not aversive, so it's not Aversion Therapy, that's for sure. And if it's below a certain level, it's not going to induce a seizure so it's not ECT. So I'm just wondering what that person thought they were providing in the way of a therapeutic outcome for this person.

I think the term Ectonus came from the company itself because the founder of the Ectron company, Dr Russell, included in the machine a way of varying the intensity of the shock which probably was meant to enable one to establish the threshold of -- at which one could induce a seizure. And I think the Ectonus Therapy was part of the process of altering the intensity to see at what level a shock could be induced.

Q. During that process the person's awake?

A. Possibly.

Q. Moving on to just finally now your conclusions at para 144. What is your opinion about the Lake Alice procedures that you've noted there?

A. Well, I've said there from a clinical and ethical perspective there are no scientific medical or therapeutic justifications for the use of electric shock, Paraldehyde or seclusion in the practises adopted and abused by Dr Leeks and the senior nursing staff at the unit in their treatment of children entrusted to their care.

Q. Have you made that statement from today's perspective or is it also reflective of the medical treatment standards of the 70s?

A. It should be considered in relation to the 70s as well, because the Hippocratic Oath requires people not to do harm, and harm is being done.

Q. If you could go on to read your conclusions at para 145 for us?

A. "At the very least, the actions of Dr Leeks and the unit staff was an abuse of power and

medical authority, an unjustified assault on the human dignity and rights of the young persons and an inhuman regime of maltreatment that induced fear, anxiety and terror as well as causing lasting emotional and physical harm to those forced to suffer the ordeal of Lake Alice Hospital at that time. In my opinion, the intended aim of these actions by Dr Leeks and senior nursing staff was not therapeutic, but as a means to punish a range of behaviours they deemed as undesirable, through the intentional use of force to induce pain as a punishment."

Q. Just if you could read through para 146 for us.

A. "In summary, there's no evidence in the Lake Alice documentation available to me that the procedures to which these children and young persons were in any way consistent with either Aversion Therapy or Operant Punishment procedures available from the published literature of the time. One way to describe what was done to these young persons in the name of treatment is that it was cruel and unusual punishment applied in ways that fit the UNCAT definition of torture set out below." **[Applause]**

Q. You've outlined the definition of torture from the UNCAT in your brief here. I won't get you to read that out, but can you read out paras 147 to us please.

A. "In my opinion, one issue for deliberation is where on the scale from maltreatment to torture does this unjustified exposure to institutional violence reside."

Q. And para 150.

A. "This is a matter for the Royal Commission of Inquiry to consider as it determines the outcome of its deliberations in respect of the treatment of the young persons sent to Lake Alice Hospital and the consequences of that maltreatment on each of them."

Q. Thank you Dr Parsonson. If you could just remain there, I understand that Ms Feint has a few questions for you.

A. Thank you.

QUESTIONING BY MS FEINT: Tēnā koe Dr Parsonson. My name is Ms Feint and I'm appearing for the Crown. I want to thank you for your helpful evidence. It's illuminated a lot of the background on Aversion Therapy and Operant Punishment and other psychological therapies.

And I was interested in what you said about the development and evolution of psychological research and academic thinking over the decades, and if I take you to paragraph 6 of your evidence, this is where you're giving some of the background into the development of Aversion Therapy and you say it was first developed in the late 1920s, and then you go on to say there was a resurgence which peaks between 1950 and 1970.

And then you say, "By the 1980s Aversion Therapy had become controversial on ethical and humanitarian grounds. You've already explained a bit about why that happened in answers to questions from my friend, but I wanted to ask you about how that happened. Is it a cumulative process of knowledge being developed by the academics and research scientists?

A. I think what began to happen was that, you're correct, it was a cumulative process of realisation that the consequences of Aversion Therapy weren't as therapeutic as had been hoped in the initial rush to actually try to introduce a new and scientific approach to treatment, and that there was an increasing level of ethical concern both within the profession and in the community in relation to using painful shocks as a way of treating people. And the consequences for the therapist and the patient weren't always the sort of outcome that anyone would have wanted.

Q. So I'm interested that both in your evidence and in what you've said today, you quite often compare the ethical concerns with developing social norms. Do the two go hand in hand? Do changing social and community attitudes drive changes in understanding about what's ethical over time?

A. I think there's two things. One is that the therapists themselves found that being a person that's delivering unpleasant painful stimuli doesn't endear one to the client or make one feel good necessarily about one's self. But yes, I think then once the community began to get information on what sort of treatments were involved, there became a sort of wider discussion, that led to changes in ethical standards and concerns.

So certainly, most ethical standards at the time in the 1970s mentioned not doing harm. They didn't necessarily ban at that time Aversion Therapy, but they did say do no harm, which meant you had a responsibility to demonstrate that you weren't doing harm.

Q. Well, I guess that's why I ask, because looking at it through today's eyes, the idea of giving electric shocks to anyone as a means of modifying their behaviour appears abhorrent, I think everyone in this room would agree that. But it wasn't necessarily regarded as unethical until it seems the thinking coalesced by the 1980s; would that be accurate?

A. It certainly became much less evident in the 1980s. But I think really the question I've got is that Dr Leeks didn't use Aversion Therapy, Dr Leeks -- it doesn't match any of the criteria that one would consider appropriate for either Aversion Therapy or Operant Punishment. So we can't be talking about whether, you know, Aversion Therapy was becoming less talked about or was okay at the time, we have to think if he was doing Aversion Therapy it should have met at least basic criteria for being Aversion Therapy,

which it never did.

Q. And your evidence is that the methods he applied did not equate to the understanding of what Aversion Therapy was?

A. Absolutely. At no point did I see in any of the medical evidence any concern expressed about whether or not he had ever had any training in it.

Q. So if I can take you to paragraph 41 and 42 of your evidence. These paragraphs weren't referred to by you earlier. Could I ask you to take us through what you say there please?

A. In 41 I say, "The emergence and efficacy of alternative operant reinforcement and punishment procedures along with ethical and societal changes effectively led to the termination of the use of electric shock as a means of punishing behaviours of concern in published Applied Behaviour Analysis research and treatment programmes by 1972. It's doubtful that in the 1970s medical professionals, including psychiatrists, would have been aware of the extant Operant Conditioning research or of the fact that behavioural psychological research was increasingly demonstrating that behavioural alternatives to aversive shock therapies were more effective in facilitating behaviour change.

Q. So if I could summarise my understanding of what you're saying there, you're saying that there's a lag effect in terms of clinical practitioners adapting to the research that's coming out of the research scientists and academics who are publishing in the field, would that be right?

A. What I'm saying there is actually that in relation to Operant Punishment, is that Dr Leeks wouldn't have been any way informed by that research, because typically the research was published in journals that wouldn't have been read by the medical profession.

Q. Right. But also in terms of the timing, is it right to think of the late 1960s, the early 1970s as being on the cusp of change in psychological methods in terms of moving towards more positive behavioural modification therapies?

A. Yes, there were practitioners who went on using aversive shock in one way or another into the 80s and even into the 90s. But those were pretty, either infrequent or in common or only used in life threatening behaviours. I don't think anyone at Lake Alice was in a life-threatening situation.

Q. Can I take you now to a document that's in the document bank and I'll give the number for the sake of the record, it's CRL000827900011. When you prepared your evidence, did you look back at the opinions provided by psychiatrists in 1977 concerning Lake Alice?

A. I looked at -- well, I was given some, for example by -- one by Dr McLachlan, but I wasn't given this particular document.

Q. So this document, if we just orientate ourselves, it's from the psychiatric unit of Wellington Hospital dated 18 November 1977. And then if we go down to the end we can see it's signed by Professor FJ Roberts who's a professor of psychological medicine. So you haven't reviewed this document?

A. I've read it, I was only given it today.

Q. If we can go to the bottom of the first page please and maybe if I read this out, to read it into the record. I wanted to ask you to comment on what he says here, so he's been asked by the Medical Council to prepare an opinion based on a complaint from a Lake Alice patient. And he says here:

"There are a number of comments which I would make on the account which we have of the particular treatment in 1973. Around the time when this treatment was carried out, there were still a number of enthusiastic practitioners of these methods around the world. The majority of leaders in this field worked in university situations where they were able to bring a degree of scientific rigour to their methodology. Various claims were being made around this time which led many psychiatrists to believe that this form of treatment was indeed effective for a number of conditions, including homosexuality. There are few people today who are writing in the same enthusiastic way and many of the previous enthusiasts now write with great caution, pointing to the many other factors which have an effect in this kind of treatment situation."

I should have said, so that I don't completely confuse everyone, that it's clear from the body of the letter that he's talking about Aversion Therapy. So what I wanted to ask you was, do you agree with his summation of the position as at 1973?

A. I'm sure he was well-informed in relation to that. The only question I've got is of course that Dr Leeks wasn't providing Aversion Therapy, he was providing electric shocks, but wasn't in any therapeutic sense, it didn't meet any of the criteria of therapy. So I can't dispute the good professor, but he's also a bit concerned in this letter about some of the things that Dr Leeks has done.

Q. So if I understood your answer correctly, you're not disputing what he's saying about Aversion Therapy, but your argument is that's not what Dr Leeks was applying?

A. Exactly.

Q. Although it's not clear that Professor Roberts thinks that, is it? He seems to have some concerns, but he's not --

A. I'm not sure that Dr Roberts had read anymore than one or two of the survivors' documentation, so I don't know from which base he's giving his opinion. He's obviously

not enthusiastic himself about Aversion Therapy, but I think he's set out very clearly that in fact what should happen if you were doing Aversion Therapy, it's just that Dr Leeks wasn't.

Q. But he also -- let's just step through this. If we go to the next paragraph, so Professor Roberts goes on to say:

"Dr Leeks talks about the amount of current which he used as the noxious stimulus. Unfortunately he does not tell us of the voltage concerned and therefore we cannot make any accurate assessment of the amount of energy which was used at any one time. The amount of energy is the critical factor in producing the stimulus."

That's correct, isn't it, that we absolutely -- we actually don't know what current Dr Leeks was using in his treatment?

A. Well, he has, Dr Leeks in various places has said it's between 120 and 170 volts, but not in some of the other documentation when he's made statements. But I don't know what the amperage would be, so again, it's the intensity of the shock that is important. But Dr Leeks typically says that it's below the threshold of pain. That's not consistent with what the survivors say.

Q. Did you review Dr Leeks' statements in preparing your evidence?

A. Yes.

Q. So were you aware that in his letter to the Medical Council he identified aversive stimulus of between 5 and 10 milliamperes?

A. Yes, that's the amperage, yeah.

Q. So if he's telling the truth about that -- and I accept that's a big if -- would that be an appropriate stimulus in terms of --

A. It's probably consistent with what the equipment would deliver. Because you're not really trying to give people powerful -- it's not like sticking your fingers into the, you know, into the light fitting without the bulb there and turning the switch on. So the amperages are managed in order to not deliver huge electric shocks, but that didn't -- the intention is that while the voltages are high, they're painful and unpleasant, but it's not life-threatening.

Q. So is it your understanding that between 5 and 10 milliamps is consistent with the research?

A. That's probably reasonably consistent with what others were using, yeah.

Q. All right, thank you. So then my next question was if we go down two paragraphs to the bottom of the page he goes on to say:

"I think it is also of some significance that the boy identified the machine used by Dr Leeks as the ECT machine. That this machine was modified to give a different kind of electrical stimulus was not clear to the boy from his account and this of course raises the

problem of exactly what the boys thought they were doing."

So are you able to explain for us whether its known that the machine was modified, because there seems to be some suggestion or some evidence that's been put forward to the effect that there were two different modes of operating the machine?

A. I think, you know, one would really want to see the machine itself. Dr Leeks implies that there was a different aspect to it. The boys describe turning the voltages up and down, so that was part of the Ectonus-type treatment component. But I don't know what other variations there would have been in the equipment, so I'm not really a competent person to answer that.

Q. Right. But when you analysed -- you've analysed the treatment of 11 of the survivors?

A. Yes.

Q. And so you've reviewed their statements and also the medical notes to the extent that they are available; correct?

A. I've had mainly nursing notes, very little in terms of medical notes, yes.

Q. And that's because many of them are missing?

A. Exactly, yes.

Q. And the medical notes that were available, how -- they were -- the ones I've seen are very sparse, there's no information on the way the treatment's administered; correct?

A. No, and one worries, you know, sparse notes suggest not much wants to be disclosed.

Q. Yes, because there's no information on what current was used in the notes, is there?

A. Exactly, yeah.

Q. And in fact it's not even really possible to tell, is it, whether ECT was being administered or so-called Ectonus or Aversion Therapy, because the notes don't appear to distinguish terribly well between those?

A. Exactly.

CHAIR: Are you going to leave this document Ms Feint?

MS FEINT: I have left the document.

CHAIR: But it's still here, so before it runs away, before it's gone might I ask a question?

MS FEINT: Yes of course.

CHAIR: I'm going to have trouble finding this, but, yes, in the centre of that page I wonder if you could call up the paragraph that says "It should be clear." Can you read that doctor?

A. Yes, I can thank you.

Q. Would you like to read it out?

A. "It should be clear from these comments that the actual technical requirements for this kind

of treatment are far from straightforward. Personally, I believe it is absolutely essential in treatments of this kind, and I am not alone in my belief, that in order for the treatment to be effective, then the subject needs to give his agreement to the treatment and to desire to change." I think that's a very important point.

Q. Thank you. Do you agree with that?

A. I agree entirely.

Q. Thank you.

QUESTIONING BY MS FEINT CONTINUED: I think I only had one more question, Dr Parsonson. That was when you prepared your evidence, did you review the staff witness statements?

A. Yes.

Q. You did, all right. Thank you very much for your very helpful of the, no further questions.

CHAIR: Is there any other counsel who wish to ask questions of this witness? Thank you.

MS R THOMAS: Perhaps if we take the afternoon tea adjournment.

CHAIR: If that would suit you, before we excuse this witness?

MS R THOMAS: Yes, sorry, we're finished with this witness now.

CHAIR: We're finished with this witness?

MS R THOMAS: We are.

CHAIR: There may be some questions from the Commissioners. Just a few questions from the Commissioners if you don't mind.

COMMISSIONER GIBSON: Thank you, Dr Parsonson, it's been intriguing to listen. Looking at the international context, from your reading, you've described what's happened as torture, you've made comparisons with Gestapo. Are you aware of any other health or therapeutic environments where this kind of punishment regime has happened and has there been a defence of therapy of different kinds?

A. As I understand it, there was an institution in Alabama, a youth institution which was mainly for youth who had been involved in criminal offending, and this is probably again in the 1970s, where the maltreatment was not too dissimilar in terms of the way that shocks were used, and there was an inquiry into that and I understand great concerns were expressed and the institution was closed down. I don't have a clear -- I spoke to a colleague in the United States who had some familiarity with the events, but I don't have, you know, a clear personal understanding. That was one institution.

There was another called the Judge Rotenberg Centre in the United States which was treating people with autism and they were using electric shocks up into the 1990s,

mainly in an attempt to change behaviours like fighting or aggressiveness and so forth. And they had little devices that staff could hold that gave a shock to the person on their arm or leg. That became the subject of a number of court cases in the United States and restraining orders were imposed. So I think it eventually closed down probably around 2000. Those are some of the problems with the use of aversive shock is that people misuse it.

Q. Were you aware of criminal prosecutions or anything to that effect?

A. They did happen, as I gather in the United States, yes. Criminal prosecutions were undertaken, but again, I say I'm not absolutely clear on the nature and terms of that.

Q. Thank you.

COMMISSIONER ALOFIVAE: Thank you Dr Parsonson, just a couple of questions, and thank you for providing such a clear explanation in your evidence around Aversion Therapy and ECT. Doctor, we've heard in evidence both in this hearing and in our private sessions the ages of the children and you would have seen some of this in the notes that you've reviewed.

A. Yes.

Q. The ages were on one occasion as young as five years old?

A. Yes.

Q. And you may not be able to answer what I'm asking, but certainly appreciate your opinion if you're able. First of all, as young as 5 and then at another end we've heard evidence today that a friend of a patient or a survivor that was in Lake Alice, one of their friends passed away, they felt as a result of the ECT. Just your views on the plausibility?

A. I think that those are very frightening events. I've never heard of ECT ever being given to children, I mean how do you assess depression or psychosis or whatever sorts of things you might medically justify the treatment for in someone that young. It's not possible. And I think that misuse of the equipment could lead to someone dying, you're giving electric shocks. And people do die with epilepsy in the midst of seizures, so you're imposing a seizure on a person. So who's to know, there may be other reasons, swallowing your tongue and not breathing, you haven't had a proper anaesthetic, you're not given oxygen afterwards. So those are real risks I would have thought.

So I'm sorry, but I felt really concerned -- I thought too one of the people who gave evidence today via film said they were being given ECT for epilepsy. I mean you're causing an epileptic seizure for someone who has epilepsy and you think it's going to cure them? I couldn't see any possible justification for that unless the person was misinformed

and that was used as an excuse to give them ECT.

Q. Thank you, that was my next question was around epilepsy, much appreciated.

CHAIR: It was also going to be mine so you've trumped both of us. The only question I have for you, doctor, is the use of the unmodified treatment. And in a part of your evidence, which you didn't read out, but you refer to the fact that initially when it was first started, ECT was given in unmodified form.

A. Yes.

Q. But over the time effective anaesthetic muscle relaxant drugs had been developed and used since the late 1950s in modified form?

A. Correct.

Q. So is it your evidence that since the 50s modified ECT has been the norm rather than unmodified?

A. Well, I was training in psychiatric hospital in 1960s, in the mid 60s and the normal procedure for ECT there was still to use an anaesthetic and provide oxygen afterwards, muscle relaxants as well. So those were the standard treatments back in the 1960s. I can't see why in the 1970s, if you were giving ECT for depression or some properly diagnosed process, you wouldn't have given modified ECT. In fact, some young people describe having been given modified ECT but not by Dr Leeks. So obviously other psychiatrists were using ECT in what was considered then to be an appropriate therapeutic mode.

Q. So, just to state the obvious, are there any circumstances in your mind, whether in the 60s, 70s, or today, there is a justification for using unmodified ECT?

A. I can't honestly answer that question because I'm not an expert on ECT, I don't want to pretend to be, so I would be cautious in responding.

Q. You'd be cautious about that. Just one last thing, that is that you said in your evidence that you can't believe that Dr Leeks was trained in Aversion Therapy. It may be that everything you've said subsequently supports that, but I think it's an important point. Can you just succinctly state why you believe that he was not trained?

A. Well, first of all there's one point in some of his own statements that he says he was trained in Psychodynamic Therapy and that he was only doing this, the job of a psychologist, until they got one in the unit. And I'm assuming that what he was referring to was the fact that psychologists were probably better trained in having some understanding of Aversion Therapy than he was.

And anyone who had been properly trained in Aversion Therapy would have done things very differently, in fact even one of the nurses who had experienced that in the UK

noted that what was happening didn't actually meet any adequate standards of therapy. So I think I've got someone else out there who agrees with me.

Q. Who agrees with you. All right. I just need to thank you sincerely. I appreciate this evidence comes at a long career, you're long retired and you have put this work into this and I'm very grateful to you for bringing your expertise to us.

A. I have to say I'm not retired.

Q. Oh you're not retired?

A. No.

Q. I assumed all people with white hair were retired. Sorry.

A. I've been threatening to retire but no-one will let me.

Q. What I want to say is that this evidence, and you will have noted from the applause, has given some comfort and validation to the witnesses who have given their evidence, and whose reports you have read and accounts you've read, and so I'm sure on their behalf I'm going to give thanks, but you've also added a level of expertise which is essential to us in our deliberations. So thank you very much and again thank you to your wife for being a loyal companion during this difficult time.

A. Thank you. I'm pleased to have been able to give any assistance that I could, thank you.

Q. Lovely thank you. **[Applause]**. On that note we'll take the afternoon adjournment.

Adjournment from 3.16 pm to 3.33 pm

MS FINLAYSON-DAVIS: Good afternoon, Commissioners. The next witnesses are Mike Ferris, Victor Boyd and Bruce Gibson, who are members of the Citizens Commission of Human Rights. They're represented today by Moira Green. I'll allow her to introduce them.

MS GREEN: My name is Moira Green and I'm counsel for the Citizens Commission on Human Rights. I'll make a very brief opening. The Royal Commission is now going to hear from the Citizens Commission on Human Rights, or CCHR to use the abbreviated title. The witnesses are Mr Bruce Gibson, Mr Victor Boyd and Mr Mike Ferriss. And they will talk about their personal experiences about events regarding Lake Alice and the Lake Alice survivors, from the period 1976 until the present day. You will hear about their meetings with child patients at Lake Alice and their support of survivors throughout the decades from the 70s to today.

You will hear about their persistent efforts and their work through the various legal processes and institutions throughout the decades culminating in their submissions to the United Nations, and you'll hear first from Mr Bruce Gibson.