

**THE OAKLEY INQUIRY IN RETROSPECT
AND ITS AFTERMATH**

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Between June, 1985 and March, 1986 I did a study of the suicides which occurred in Paremoremo and Mt. Eden Prison during the years 1968 (when Paremoremo Prison first opened) till 1986. Some of the findings from this study form the basis for the paper I present today.

THE OAKLEY INQUIRY

In February, 1982 a patient died following the administration of E.C.T. treatment in Ward M3, the forensic locked ward at Oakley Hospital in Auckland.

As a result of this event a public inquiry was held. In January, 1983 "the Committee of Inquiry into Procedures at Oakley Hospital and Related Matters" released its report.

The details of the Committee's findings and recommendations will not be discussed in this paper. In essence the inquiry confirmed what had been known widely for some years, that overcrowding and inadequate resources in the hospital ward were causing inferior standards of care and treatment for patients. The Committee listed 79 recommendations and moves to implement these recommendations began immediately.

Before the Oakley Inquiry, Ward M3 used to offer ready transfer of inmates from Paremoremo and Mt.Eden Prison, often arranged over the telephone. Out of the 70 patients in the ward, 40 would be inmates transferred from the prisons under Section 42. In addition the ward received a number of remandees from

Mt. Eden Prison. As a consequence of the Inquiry the ward became redefined as a "medium security, short stay forensic ward" with a recommended maximum of 25 patients. The new policy became that only patients for whom specific treatment was required and available should be admitted, and they would be discharged when acute target symptoms were in remission. Patients who represented a greater security risk, or who were likely to require a longer stay in hospital were recommended for the maximum security unit in Lake Alice Hospital, rather than Oakley Hospital.

These new policies caused sweeping changes to Ward M3. During the last couple of years it has been possible to keep patient numbers below the recommended number of 25 patients in the ward, and only few of these would be remandees. Most dramatic is perhaps the change in the yearly number of inmates transferred from the prisons, which between 1983 and 1984 dropped from 40 to two!

The main function of the ward during this time has been:

- (1) to offer acute intensive care treatment to patients referred from acute wards in Carrington and Kingseat Hospitals, and
- (2) on a limited scale to continue some forensic services to the prisons and the courts.

To sum up at this stage, one can say that though there are still several concerning issues relating to Ward M3 and though the future of the ward remains uncertain, the hospital's main problems were solved during the aftermath of the Oakley Inquiry.

However, to let matters rest here would be a great mistake, because I believe that the real issue that was highlighted by the Oakley Inquiry was the complex and often conflicting relationship between the penal system and the mental health system. It is the postulate of this paper that the patient population in Oakley Hospital before the Inquiry essentially consisted of outcasts from both systems, and that the Oakley

Inquiry developed due to the failure of both systems to accommodate the needs of these people. It is the aim of the following section to describe aspects of the relationship between the two systems, and to show how changes to one system affect the other.

THE HOSPITAL AND THE PRISONS BEFORE THE OAKLEY INQUIRY

Fig. 1 shows the yearly number of admissions to Ward M3 from Paremoremo and Mt.Eden Prison. The following three factors contribute significantly to the shape of the graph:

(1) "Pooling" of Disturbed and Disturbing Inmates in Paremoremo Prison

An inmate who shows disturbed or disturbing behaviour somewhere in the prison system is likely to be "shunted" from the periphery of the system (i.e. lower security prisons) towards Mt. Eden and Paremoremo. This is because these are the New Zealand prisons from which there is most ready access to psychiatric services and transfer to psychiatric hospital (Lake Alice Hospital and especially Oakley Hospital).

An inmate who is "a disturbing influence" in Mt. Eden may be transferred to Oakley Hospital (if accepted) or to Paremoremo. This is the end station unless he later can get transferred to hospital. The end result is a pooling of disturbed or disturbing inmates in New Zealand's maximum security prison, usually in segregation wings with lock up in the cells for 18 hours daily!

(2) High Inmate Numbers (Muster-numbers) in the Prisons

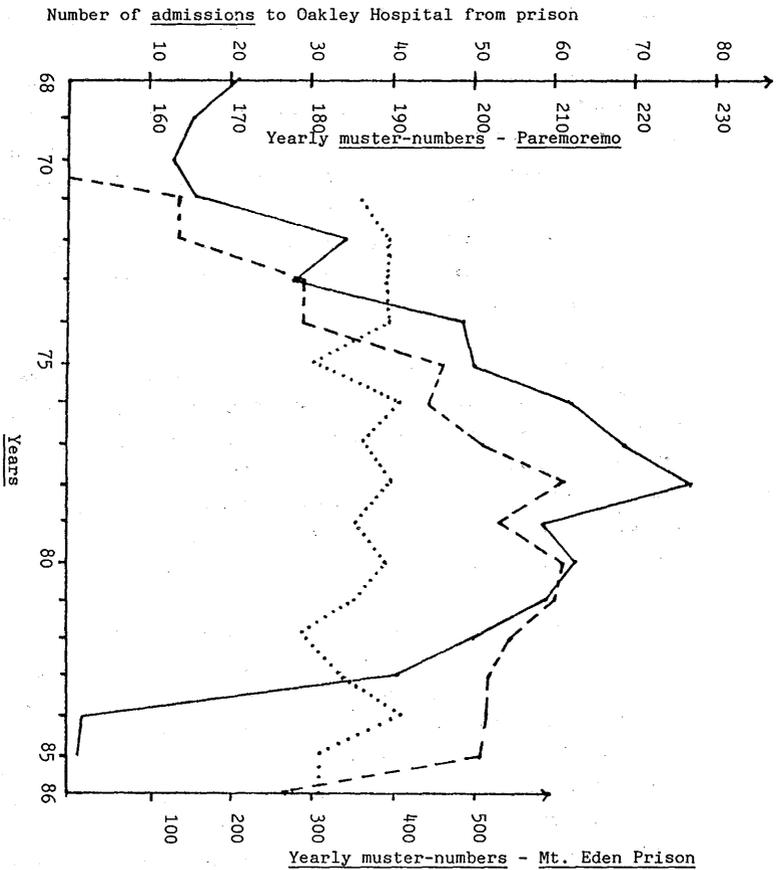
Examination of Fig. 1 shows a remarkable correlation between the "admission graph" and the rising muster-numbers in Paremoremo as the prison fills up after its opening in 1968. The graph of the Mt. Eden muster-numbers shows some correlation with the other two graphs between 1977 and 1982 but the relationship is less clear. This is not surprising when one considers Paremoremo Prison's function as a buffer between the hospital and the prison system.

GRAPHIC PRESENTATION OF:

- (1) Yearly number of inmates transferred from Paremoremo and Mt. Eden Prisons to Oakley Hospital = _____
- (2) Yearly average muster-numbers (number of inmates at a given time) in Paremoremo Prison = - - - -
- (3) Yearly average muster-numbers in Mt. Eden Prison =

Please Note: Because different units are used for the various graphs, the presentation gives a distorted picture of the actual numbers. The aim is to portray possible correlation between the graphs.

Fig. 1



It is difficult to escape the conclusion that the admission graph primarily is shaped by the muster-numbers in Paremoremo Prison up until the early 1980's.

(3) The New Hospital Policies after the Inquiry

CONCLUSION: From the opening of Paremoremo Prison in 1968, there is a steady steep increase in inmate numbers till the peak is reached between 1978 and 1982. This creates problems in the prison because of the combined effects of:

- (1) high numbers, which will affect the environment adversely and create increased tension and violence, with less staff supervision,
- (2) the selective processing of disturbed and disturbing inmates into this prison.

Overloading in Paremoremo creates a backlog in Mt.Eden Prison where similar problems are likely to develop.

During the same period the Oakley administration offers to help out by accepting increasing numbers of inmates for admission. It is not known from this study to what extent these inmates were seriously ill or just a "disturbing influence" in prison. It would appear that Oakley Hospital during these years, to a large extent functioned as an overflow or safety valve to the prison in terms of easing the increasing pressures in these facilities. This well intended gesture did not work out in the long run. The high admission rate from the prisons created overloading in the hospital and set the stage for inferior standards of care, accidents and the 1983 Inquiry.

The recommendations from the Oakley Inquiry solved the hospitals problems. However, it also blocked a long established flow of disturbed and disturbing inmates from all areas of the prison system, via Paremoremo and Mt. Eden Prisons to psychiatric hospital. These inmates got stuck, particularly in Paremoremo, where staff had to cope with an increasing number

of disturbed and difficult inmates in inadequate segregation facilities.

The only way out for these inmates was now Lake Alice Hospital, and indeed the transfer rate of inmates to this hospital has increased. The exact figures have been underway for twelve months, but are unfortunately not yet available. However, given the low bed numbers (37) and the generally long stay of patients in Lake Alice Hospital, I am certain that this hospital could not have fully compensated for the changed admission policy at Oakley Hospital.

THE AFTERMATH OF THE OAKLEY INQUIRY

(1) The Prisons

Fig 2 is a graphic presentation of the yearly transfer rate of inmates to Oakley Hospital (identical to Fig 1), the yearly number of suicides in the two prisons and the yearly rate of major self-inflicted injuries in Paremoro Prison. The possible relationship between these 3 graphs will be discussed in the following.

Regarding the rate of self-inflicted injuries in Paremoro Prison:

The major self-inflicted injuries are injuries sufficiently severe to have become documented by the prison's nursing staff. Minor injuries are usually not recorded.

Similar figures from Mt.Eden Prison are not included because only records from 1981 to September, 1985 could be found. These show 12-17 injuries yearly.

The rate of self-inflicted injuries could be seen as an arbitrary measure of distress within the inmate population. The graph shows a steady rise co-inciding with the significant drop in admission rate to Oakley Hospital. This trend may reflect negative effects on the prison population of the hospital's new policy. However, any interpretation of this graph must be very cautious.

Regarding the Suicide Rate:

There are no officially documented suicides in these two prisons between 1968 and 1979.

Two suicides, one in 1979 and one in 1983, which both occurred in Mt. Eden Prison's Remand Section, are excluded in this presentation because the situation for remandees would have been relatively unaffected by changes within the general prison and the hospitals. Of the presented 9 suicides, one occurred in Mt. Eden Prison and eight occurred in Paremoro.

There are two suicides in 1980 which I believe are intimately linked to each other. They were two brothers, both members of a small political group named "The Suicide Squad". The older brother committed suicide in the context of the younger brother's funeral. (A third brother attempted suicide three days later in Napier Prison). On this background the increasing number of suicides from 1983-85 is alarming (total of seven suicides). This co-occurs in time with the new admission policies at Oakley Hospital (and with the increased rate in self-injury in Paremoro Prison).

There have been no suicides in either of the two prisons for twelve months, until a suicide occurred one month ago in Paremoro Prison. It is also reported from Paremoro Prison that during the same period of time there has been a noticeable reduction in "tension within the prison" and reduction in violence and self-inflicted injuries.

While there have been no changes to the service provided by psychiatrists from outside the prison system during this period, a number of important changes have taken place within the prisons, as outlined below:

- (a) A change to the Criminal Justice Act from 1.10.85 allows for prisoners to be released from prison much earlier during their sentence than before. In anticipation of this change in legislation, prison authorities

started to release prisoners already at the middle of last year. This has already caused inmate numbers in prisons to be greatly reduced (in Paremoro Prison reduced from 212 inmates last year to 177 this year).

Another effect of the new legislation might be that inmates can see "light at the end of the tunnel" and make greater efforts not to jeopardize their early release.

- (b) Segregation of the various gangs was introduced at both Paremoro and Mt. Eden Prison at the start of last year, ("Mongrel Mob" placed in one Standard-block, "Black Power" in another, etc.). This is reported to have greatly reduced violence and "tension".
- (c) From the middle of 1985 inmates were allowed to have private T.V. sets in their cells at Paremoro Prison. Though the prison officers initially were rather sceptical of this idea, they now appreciate the arrangement very much because television appears to have the same "sedating" effect on the inmates as it has on the general population.
- (d) Both staff and inmates are now much more alert to the risk of suicides. Inmates now report far more frequently to the staff if they think that another inmate is troubled. Previously, there were examples of inmates encouraging other inmates to kill themselves. This change may reflect that many inmates at some stage feel that they are at risk themselves of committing suicide and fear a "domino effect".
- (e) At the middle of 1985 a new psychiatric wing was opened within Paremoro Prison which provides seven beds and a day program for up to 10 inmates. This has replaced the old "psycho-block" which consisted of three cells where inmates could be segregated under the care of nursing staff. The main value of the new psychiatric wing is probably that a larger group of vulnerable inmates can be segregated under far more humane conditions than before. It is also believed that the experience with this new facility has alerted prison officers to the fact that some inmates have special needs and can't tolerate the stressors in prison as well as others.

Conclusion:

I believe that some of the suicides were, at least in part, precipitated by the sudden introduction of the new hospital policies after the Oakley Inquiry, which involved:

- (a) An increasingly chaotic situation in prison because inmates no longer could get out.
- (b) Inmates being returned to prison faster and more vigorously than before.
- (c) The vast majority of psychiatric assessments were now taking place in prison and not during observation in hospital. A study of the individual suicide cases shows that it is very difficult to accurately assess an inmate's mental status in prison.

The experience from the last twelve months may indicate that the penal system after 2-3 years has managed to adjust to or compensate for the changes arising from the "1983 Oakley Inquiry". Certainly there is a strong indication that the penal system has significant powers to reduce tension and suicide rate in prison. This indicates at the same time that the prison environment has pathogenic effects and may precipitate suicide.

In support of these claims I can add that six out of the nine inmates who committed suicide probably were significantly disabled by mental disorders at the time of their death, but only one had a documented mental illness prior to entering the prison system.

One may even wonder if the former easy access to transfer inmates to hospital could not have been a two-edged-sword. While that system undoubtedly ensured that some mentally ill patients were appropriately treated in hospital, it might also have encouraged a high number of other inmates to engage in dangerous parasuicidal behaviours, in attempts to get to hospital (where life and escape were "easier"). The current drop in the rate of self-inflicted injuries and suicides may reflect that inmates have got the message that there is "no easy out" from Paremoremo Prison.

Finally, I wish to draw attention to the fact that the sudden

increase in suicide numbers in Paremoremo Prison could in part be related to "epidemic" effects. I have already suggested that a "suicide pact" or epidemic effect was the cause of the second suicide. Likewise, a paper by Coid describes "epidemics" of self-mutilation in certain institutions and quotes one study where 86% of the girls in a particular penal institution cut themselves, whereas none had done so before.

P.S. On my last visit to Paremoremo Prison in April this year, a random inquiry showed that:-

- (1) Eight inmates were currently on 1/2 hourly observations (= 4.5% of the total population).
- (2) Two inmates were considered acutely psychotic (by the prison psychiatrist) and unmanageable in prison. They were awaiting assessment by visiting psychiatrists with view to transfer to hospital.

This shows that there is still a considerable pressure on both the prison staff and the psychiatric profession.

(2) The Hospitals

The major changes in M3, Oakley Hospital after the inquiry have already been mentioned.

However, events during the last year have shown that old habits die hard. The following issues contribute to an increasing pressure on Oakley Hospital and threaten to recreate Oakley as it was before the Inquiry:

- (a) P.S.A. policies dictate that all patients under the Criminal Justice Act (Section 121, 118 and 115) or under Section 42 and 43 of the Mental Health Act, must be placed in Oakley Hospital. This means that former Oakley patients tend to return to this facility and a high number of so-called de-institutionalized patients from other hospitals end up in Oakley via the courts, often after petty crimes.
- (b) During the last five months Ward M3 has received 4-5 times as many remandees as were received during the same period last year. This is contrary to what was expected from the new Criminal Justice Act, and may in part reflect the appalling conditions, including overcrowding at Mt. Eden Remand Section.
- (c) Lake Alice Hospital is now applying significant pres-

asures to return patients to Ward M3. This may in part be a consequence of the increased referral rate of inmates from the prisons to Lake Alice as mentioned earlier.

- (d) There continues to be a significant reluctance in acute wards of other hospitals to receive patients from Oakley Hospital, even if they are "ordinary" committed patients (Section 19 or 21) and no longer require a locked secure environment.

I believe that these trends can and must be changed. If they are not, I am concerned that another Oakley Inquiry will eventuate'.

WHAT IS THE PSYCHIATRISTS ROLE WITH REGARDS TO THE DISTRESSED OR MENTALLY DISORDERED OFFENDER.

There is no convincing evidence that prisons can rehabilitate the criminal to a better adjusted life-style in community, and it appears that the main function of the prisons is to punish by inflicting emotional pain.

Punishment or revenge may well be sufficient justification for maintaining some sort of prison system. Lack of punishment may shake the morale of community - and may be associated with delayed or maladaptive rehabilitation amongst the victims of crime and their families. However, one should bear in mind that a four year prison sentence to Paremoremo Prison delivers very different punishment to different people:

- (1) It may mean a return to a "safe environment", unpleasant - but nevertheless "home".
- (2) It may be a welcomed or unwelcomed opportunity to complete a computer course or a Masters Degree.
- (3) It may be a sentence to intense emotional suffering or mental illness.
- (4) To some it is a sentence to brutal physical and psychological molestation and perhaps death (from accident, homicide or suicide).

If the public fully realized these facts and no longer lived with the illusion that prisons are useful rehabilitation centres, where doctors and other experts make sure that nothing

goes wrong, then it may turn out that people want a totally different system of punishment. It may also turn out that they want to keep it exactly as it is, but then it must also be accepted that the emergence of mental distress, perhaps mental illness or suicide, sometimes is part of the bargain. If society puts people in prison to inflict suffering and misery, then it seems illogical to call on the psychiatrists to make them happy again - or even worse, request that the psychiatrist decides when an inmate is suffering too much.

In the existing facilities in Paremoremo and Mt. Eden Prison, the "average" inmate is favoured, while the inmate who is mentally ill, not coping or otherwise endangered (e.g. sex offenders), is segregated under inferior and often quite inhumane conditions. Prison administrators cannot rely on other professions to compensate for this gross discrimination or its consequences:

On this background I believe that the psychiatrist is faced with a wide range of ethical dilemmas in his relationship with the penal system. I shall briefly outline some:

- (1) Should the psychiatrist "rescue" the vulnerable or fragile inmate or remandee from prison by diagnosing him as ill (e.g. dysthymic disorder or adjustment disorder) when the person is otherwise legally responsible and would not "normally" have required hospitalization. This certainly does happen, particularly when the remandee has a history of self-mutilation in prison. However, this practice is inconsistent with official hospital policies and it may breach the spirit of the law.
- (2) Should the psychiatric profession offer incarceration in hospital as a more humane alternative to imprisonment? This has been done quite extensively in the past - and there are still some people who in reality are serving their prison sentence in hospital, to be discharged when their sentence expires.

However, if we offer our psychiatric skills as an instrument for punishment, our role may be similar to that of the surgeon, who in some Islamic countries offers surgical

amputation of an offender's hand as a humane alternative to the executioner's axe.

- (3) Should the psychiatrist accept responsibility for "treating deviations from social norms. In its extreme form, some of our Russian colleagues are being strongly criticized for doing just that to political dissidents.
- (4) Should we offer to treat psychotic inmates in hospital, so they will become well and fit enough to return to prison for more punishment. I often find this strikingly similar to the role of the army surgeon who patches up a wounded soldier so he can return to the front line and get shot again.
- (5) Does the psychiatrist wish to take part in deciding where in the penal system an offender should be placed for punishment (e.g. does he deserve/tolerate punishment in a high or low security prison or should he be placed in a special prison - or in a "special hospital").
- (6) Where does the psychiatric profession wish to allocate the limited resources:
 - (a) with the offender, or
 - (b) with the victims of crime.

This last group is often being appallingly ignored!

I believe it is essential that these issues are being looked at before the psychiatric profession can somehow deal with its strong ambivalence towards the penal system - and before a much needed policy can be formulated.

The psychiatrist working in the public health system is by law and by public expectation obliged to offer his services to the penal system when it is required, and it is assumed that his availability will guarantee humane standards of care.

The reality is that the psychiatric profession repeatedly is disappointing these expectations, which we have often contributed to ourselves with unrealistic promises about our capabilities and commitment.

For example, the literature on forensic psychiatry states time and time again that more psychiatrists are needed urgently to work in the prisons. Likewise the Director of Mental Health clearly states in a document from June, 1983 that he expects hospital psychiatrists to assure themselves that adequate care is available in prison before an inmate can be returned from hospital to the prison. However, I believe that both statements are based on unrealistic assumptions about the psychiatrists capabilities in the prison system. The reality is that the prison environment itself imposes enormous limitations on the use of the conventional tools of the trade, such as the use of diagnostic instruments, medication and psychotherapy. There is no way that psychiatrists can guarantee adequate care with the existing facilities in Mt. Eden and Paremoremo Prisons, and I doubt that a simple increase in numbers of psychiatrists working there would make any difference. When an inmate starts to crack up under the combined effects of incarceration, sensory deprivation, peer pressure and perhaps developmental or genetic vulnerability, the only realistic option is often to get him out of the prison. Unfortunately, the only way out of the current system is by transfer to psychiatric hospital. In hospital the inmate's distress may cease overnight or he may recover from his depression or psychosis within a month or two - and what do you do then? While it is contrary to contemporary hospital policies to keep the inmate in hospital to protect him from the adverse effects of imprisonment, it is to me equally unethical to return him to a potentially pathogenic prison environment.

I believe that psychiatrists must make themselves available to treat and manage the acutely mentally ill offender in prison or in hospital, but more importantly psychiatrists must at the same time strongly address the issues of primary and tertiary prevention of mental illness in prison - and this can only be done by recommending drastic changes to the present prison system and facilities in New Zealand!

It is most important that the psychiatric profession finds out for itself what it can and is prepared to do with regards to the distressed or mentally ill offender and the penal system - and then informs the Justice Department and the public about what services the profession realistically can provide.

The lesson I have learnt from the Oakley Inquiry and its aftermath is that if the psychiatrist concentrates solely on treating or rescuing individual inmates/patients, he may not be helping anyone at all - he may in fact be contributing to perpetuate a system which creates both suffering and illness.

On 16.5.86 The Governor-General and former Archbishop of New Zealand, Sir Paul Reeves, made the following statement in an address to the Royal New Zealand College of General Practitioners:

"The responsibility of the medical profession is not only to treat illness. It may also be to speak out about the nature of a society which is having such a dire effect on people".

With specific reference to the distressed or mentally ill offender and his fate in the penal system - I agree whole-heartedly!

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Commentary by Dr Rodney Harrison, barrister and solicitor, on behalf of the Auckland Council for Civil Liberties. Dr Harrison represented the Council at the inquest into the death of Michael Watene, and before the 1982 Committee of Inquiry into Oakley.

For the most part, rather than comment directly on Dr Jensen's paper, which I understand Dr Maule intends to do in some detail, I propose to attempt to provide in a series of necessarily brief comments some further dimensions to the overall topic. These comments are, I acknowledge, so unrelated as to risk incoherence - a series of tangential trots past the subject matter, which limitations of space will mercifully prevent me from attempting to synthesise.

1. THE BACKGROUND TO THE 1982 OAKLEY INQUIRY

The Committee of Inquiry into Procedures at Oakley Hospital and Related Matters, chaired by R G Gallen, Q.C. (as he then was) arose essentially out of the death at Oakley on the 22nd February 1982 of Michael Percy Watene, following upon the administration of Electroconvulsive Therapy (ECT); a subsequent Coroner's Inquest which concluded that the death of Mr Watene was due to failure to adequately observe him following ECT; and subsequent Affidavits making allegations of misconduct relating to Mr Watene's treatment while at Oakley which were brought to the attention of the Auckland Hospital Board. The Gallen Committee commenced its hearings on the 10th August 1982, and concluded these on the 12th November 1982, sitting for a total of 34 days. Its report was released on the 9th of February 1983.

As most participants in this Seminar will know, the Gallen Committee was by no means the first inquiry into conditions at Oakley Hospital. There had been a previous Royal Commission of Inquiry (the Hutchinson Commission) in 1971, and the Gallen Committee comments that its inquiry was the Fourteenth undertaken in respect of Oakley/Carrington since 1971.