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Ordinary Men and Uncommon Women:  
A History of Psychiatric Nursing in New Zealand Public Mental Hospitals, 1939-1972

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A thesis presented in fulfilment of the requirements for  
the degree of Doctor of Philosophy in History

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## Abstract

This social-cultural history explores the changing context, culture, and identity of psychiatric nurses working in New Zealand public mental hospitals between 1939 and 1972. Primary documentary sources and oral history interviews provided the data for analysis. The thesis is divided into two periods: 1939 to 1959 when asylum-type conditions shaped the culture of the institutional workforce, and 1960 to 1972 when mental health reform and nursing professionalisation challenged the isolation and distinct identity of mental hospital nurses.

Between 1939 and 1959 the introduction of somatic treatments did not substantially change nursing practice in mental hospitals. Overcrowding, understaffing and poor resources necessitated the continuance of custodial care. The asylum-type institutions were dependent on a male attendant workforce to ensure the safety of disturbed male patients, and the maintenance of hospital farms, gardens, and buildings. Although female nurses provided all the care and domestic work on the female side, the belief that psychiatric nursing was physically demanding, potentially dangerous, and morally questionable, characterised the work as generally unsuitable for women. Introduction of psychiatric nursing registration which was a move toward professionalisation did little to change the dominance of a male, working-class culture.

From 1960 to 1972 psychiatric nurses' identity was contested. New therapeutic roles created the possibility of the nurses becoming health professionals. Their economic security and occupational power, however, was tied to an identity as unionised, male workers. As psychiatric nurses were drawn closer to the female-dominated nursing profession through health service changes and nursing education reform, both men and women acted to protect both their working conditions and their patients' welfare. To achieve these ends, they employed working-class means of industrial action.

By accepting the notion that psychiatric nurses' identity was socially constructed, this thesis provides an interpretation that goes beyond the assumption that nursing is a woman's profession. Instead, it presents psychiatric nursing as a changing phenomenon shaped by contested discourses of gender, class and professionalisation. Nursing in public mental hospitals attracted ordinary men and uncommon women whose collective identity was forged from the experience of working in a stigmatised role.

This thesis is dedicated to the memory of

Rita McEwan

(1918 - 2006)

registered psychiatric nurse; nurse educator, administrator and professional leader

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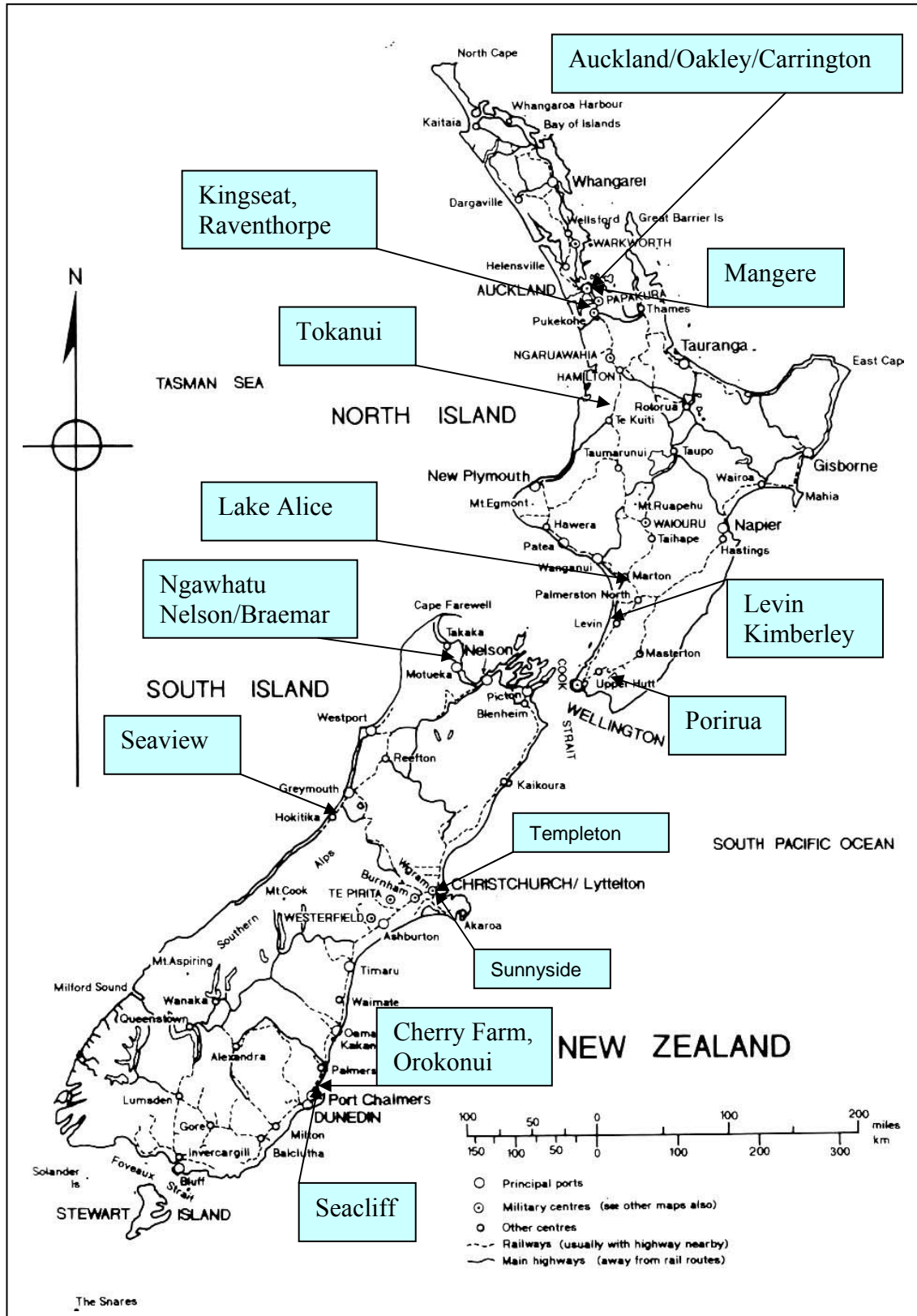
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## List of Abbreviations

ANZ	Archives New Zealand
AJHR	<i>Appendices to the Journal of the House of Representatives</i>
AS	<i>Auckland Star</i>
CS	<i>Christchurch Star</i>
EP	<i>Evening Post</i>
KT	<i>Kai Tiaki, New Zealand Nurses Journal</i>
MPA	Medico-Psychological Association (British association of asylum doctors)
NERF-OHP	New Zealand Nursing Education and Research Foundation Oral History Project
NES	National Employment Service
NZG	<i>New Zealand Gazette</i>
NZNA	New Zealand Nurses Association (title from 1971)
NZRNA	New Zealand Registered Nurses Association (title from 1932-1971)
NZPSL	New Zealand Public Service List*
PNOHP	Psychiatric Nurses Oral History Project
PSA	Public Service Association
PSC	Public Service Commission
PSJ	<i>Public Service Journal</i>
RMPA	Royal Medico-Psychological Association (British association of asylum doctors or psychiatrists: the MPA renamed)
SSC	State Services Commission
TOHP	Tokanui Oral History Project

\* The New Zealand Public Service List (title used in this thesis) was also known as the New Zealand Classification List or List of Persons Employed in the Public Service.

## Map Showing Location of Public Mental Hospitals



Source: Adapted from Denys Bevan, *United States Forces in New Zealand, 1942-45*, Alexandra, 1992.

## Introduction

On 2 July 1971, fifty men and women marched in silence on the New Zealand Parliament through the streets of Wellington. Although a protest march to Parliament was not in itself unusual at this time, the identity of the protesters was noteworthy. They were uniformed psychiatric nurses from Porirua Hospital demonstrating in support of colleagues taking strike action at public mental hospitals around the country. The nurses' protest spoke volumes about their occupational identity, culture, values, and history. Taking industrial action was generally considered anathema to the nursing profession. This was, however, an acceptable option for many psychiatric nurses. They did not fit the stereotypical image of nurses as female, middle-class, compliant, and demure. Rather, their actions reflected an occupational culture influenced by working-class male values.



**Figure 1 Psychiatric Nurses outside Parliament.**  
Source: *Auckland Star* (AS), 2 July 1971, p.1.

The industrial action by psychiatric nurses in 1971 happened within the context of changing occupational identity. During the previous three decades, psychiatric nursing had been challenged by calls for new therapeutic approaches, demands for closer association with the general nursing profession, and moves towards amalgamation of psychiatric with general health services. This thesis examines psychiatric nursing (mental attendance and mental nursing) in public hospitals in New Zealand between

1939 and 1972.<sup>1</sup> The period began with legislative change that took the first step towards the integration of psychiatric nursing education with general nursing. The period ends in 1972, the year that psychiatric hospitals were transferred from central government to local hospital board control. That year, the government also decided to conduct pilot programmes in comprehensive nursing education at polytechnics. In effect, these two changes signalled the end of psychiatric nursing as an occupation that derived its unique identity from its historical association with attendant care in segregated, asylum-type institutions.

The history of psychiatric nursing in this period does not fit tidily within the historical nursing discourse of women's professionalisation, nor does it sit comfortably within the history of psychiatry or mental institutions. Rather it is a story of workers struggling to retain a unique identity in the face of internal and external pressures. In this respect it fits within a broad definition of labour history.<sup>2</sup> It is a study of an occupational group: their work and living conditions; their relationships to the institutions in which they worked and to the union that gave them a political voice. It is also a study of the efforts made to transform the occupation into a profession. Embedded in this story are issues of gender, class, and identity.

### **International historiography**

Histories of psychiatric or mental (health) nursing have proliferated since the 1980s. Initially, they were an add-on aspect of broader nineteenth-century asylum studies but later the focus shifted on to the workers themselves. Social histories of individual asylums by historians such as Anne Digby, Ellen Dwyer, Nancy Tomes, and Patricia d'Antonio produced some of the first comprehensive accounts of the life and work of

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<sup>1</sup> Terms used to describe nursing staff changed over the period discussed in this research. Male staff members were initially called 'mental attendants' and female staff called 'mental nurses'. The terminology began to change to 'psychiatric nurse' after psychiatric nursing registration was introduced in 1945. By the early 1970s, the term 'mental health nurse' was sometimes used. I have, where possible, used the terminology that was used at the time.

<sup>2</sup> Labour history, like that of psychiatry and nursing, has been transformed by social history approaches. Rather than focusing on the political processes of the trade union movement, historians have extended their interest to the lived experience of groups such as workers, women, children, and the unemployed. Topics such as leisure, working-class culture, and family life have also been included under the broad heading of 'labour history'. See: Stephen Garton, 'What Have we Done? Labour History, Social History, Cultural History,' in *Challenges to Labour History*, Terry Irving, ed., Sydney, 1994, p.56.

attendants and nurses.<sup>3</sup> Detailed attention to institutional records and diaries made visible this previously 'hidden dimension' of asylum life.<sup>4</sup> These histories challenge many of the commonly held assumptions about nineteenth-century attendants. As Tomes explains, 'At least in superficial respects, the asylum's attendants hardly conformed to the image of the unskilled, insensitive, morally depraved drudge who figured so prominently in asylum exposes of the period.'<sup>5</sup>

These social histories claim to have filled an empirical gap left by revisionist historians of the 1960s and 1970s. Revisionists had challenged Whiggish histories of psychiatry by arguing that asylums were a product of social and political changes in Europe that had led to the 'great confinement' of madness, poverty, and unemployment.<sup>6</sup> Neither progressivist accounts that focused on great men and their humanitarian achievements, nor revisionist histories that proposed theoretical models of social control had given much more than passing note to the role of attendants and nurses.<sup>7</sup> By 'drilling down' into the detail of asylum life, the new social histories brought to light this group of people who were the mainstay of the asylum workforce.<sup>8</sup>

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<sup>3</sup> Patricia D'Antonio, 'Negotiated Care: A Case Study of the Friends Asylum, 1800-1850', PhD thesis, University of Pennsylvania, 1992; Anne Digby, *Madness, Morality and Medicine; A Study of the York Retreat, 1796-1914*, Cambridge, 1985; Ellen Dwyer, *Homes for the Mad: Life Inside Two Nineteenth-Century Asylums*, New Brunswick, 1987; Nancy Tomes, *A Generous Confidence: Thomas Story Kirkbride and the Art of Asylum-keeping, 1840-1883*, Cambridge, 1984.

<sup>4</sup> Digby devoted a chapter to the attendants whom she referred to as a 'hidden dimension of asylum life': Digby, p.182.

<sup>5</sup> Tomes, p.182.

<sup>6</sup> For example: David J Rothman, *The Discovery of the Asylum: Social Order and Disorder in the New Republic*, Boston, 1971; Andrew T. Scull, *Museums of Madness: The Social Organisation of Insanity in Nineteenth-century England*, New York, 1979. Revisionist histories were influenced by the writings of Michel Foucault who argued that the asylum movement was part of Europe's 'great confinement' of those who were considered 'abnormal' and anti-psychiatry writers such as Erving Goffman and Thomas Szasz: Michel Foucault, *Madness and Civilisation: A History of Insanity in the Age of Reason*, London, 1967; Erving Goffman, *Asylums: Essays on the Social Situations of Mental Patients and Other Inmates*, New York, 1961; Thomas S. Szasz, *The Manufacture of Madness: A Comparative Study of the Inquisition and the Mental Health Movement*, London, 1971.

<sup>7</sup> Until the 1970s, histories of psychiatry focused on internal concerns such as therapeutic innovations, the application of new theories of mental illness, psychiatric leaders, and the establishment of asylums or mental hospitals. For example, see: Albert Deutsch, *The Mentally Ill in America: A History of their Care and Treatment from Colonial Times*, New York, 1937; Richard Hunter and Ida Macalpine, *Three Hundred Years of Psychiatry, 1535-1860*, London, 1963. Most interpreted the history of psychiatry as 'the hesitant but progressive advance of humanitarianism': Mark Sullivan, 'The History of Psychiatric Theories Becomes Self-aware', *Current Opinion in Psychiatry*, 8, 1995, p.351. For an overview of the changing historiography of psychiatry, see: Andrew T. Scull, 'A Quarter Century of the History of Psychiatry', *Journal of the History of the Behavioral Sciences*, 35, 3, 1999, pp.239-46.

<sup>8</sup> Debates continue over the proper approach to nineteenth-century asylum studies. Some argue that social historians have retreated from addressing the important issues of power: Tom E. Brown, 'Dance of the Dialectic? Some Reflections (polemic and otherwise) on the Present State of Nineteenth-century Asylum Studies', *Canadian Bulletin of Medical History*, 11, 2, 1994, pp.267-95.

Substantial works on the history of psychiatric nursing have been produced since the 1980s. Nurse historians such as Olga Church (United States), Peter Nolan (England), Geertje Boschma (The Netherlands), Veryl Trilpiski (Canada), Angela Martin (Canada) and Philip Maude (Australia) explore various aspects of mental health nursing in their own countries.<sup>9</sup> For some of these writers, their work was a deliberate attempt to retrieve their own occupation from historical obscurity. As Nolan explains, 'Having a history confirms the legitimacy of the service one provides'.<sup>10</sup> In this respect, histories of psychiatric nursing have continued the tradition of nurse historians whose primary aim has been to document the story of their discipline for the sake of the newer members of the profession.

Prior to the 1980s, nursing histories in general largely followed a celebratory approach. By outlining the development of the nursing profession and recounting stories of 'great women' nursing leaders and practitioners, they acted as agents of professional identity formation. There was little room in these accounts for the stories of mental nurses and attendants. Olga Church's *That Noble Reform: The Emergence of Psychiatric Nursing in the United States, 1882-1963*, itself a largely progressivist account, can be understood as an attempt to challenge the marginalization of psychiatric nursing while remaining within the dominant discourse of progressive professionalisation. Church claims to trace psychiatric nursing's development 'from custodial caretaking to a legitimate and unique segment within nursing...'<sup>11</sup>

A notable exception to the celebratory approach was Brian Abel-Smith's *A History of the Nursing Profession* published in 1960.<sup>12</sup> Abel-Smith, a professional historian, has been commended for his use of extensive primary sources and for placing nursing in a broader political context. His *History of the Nursing Profession*, however, continues to

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<sup>9</sup> Geertje Boschma, *The Rise of Mental Nursing: A History of Psychiatric Care in Dutch Asylums, 1890-1920*, Amsterdam, 2003; Olga Church, 'That Noble Reform: The Emergence of Psychiatric Nursing in the United States, 1882-1963', PhD thesis, University of Illinois, 1982; Angela Y Martin, 'Determinants of Destiny: The Professional Development of Psychiatric Nurses in Saskatchewan', MA thesis, University of Regina, 2003; Philip Maude, 'The Development of Community Mental Health Nursing Services in Western Australia: A History (1950 to 1995) and Population Profile', Master of Nursing thesis, Edith Cowan University, 1996; Peter Nolan, *A History of Mental Health Nursing*, Cheltenham, 1993; Veryl Margaret Tipliski, 'Parting at the Crossroads: The Development of Education for Psychiatric Nursing in Three Canadian Provinces, 1909 - 1955', PhD thesis, University of Manitoba, 2003.

<sup>10</sup> Nolan, *A History of Mental Health Nursing*.

<sup>11</sup> Church, p.xi.

<sup>12</sup> Brian Abel-Smith, *A History of the Nursing Profession*, London, 1960.



marginalize psychiatric nursing and other nursing specialties by focusing exclusively on general hospital nursing.<sup>13</sup>

Celia Davies' *Rewriting Nursing History*, published in 1980, is often credited with leading the way in a revisionist approach into nursing history.<sup>14</sup> Davies' edited collection of articles deliberately sets out to explore new questions and to find new research materials. By including a wide range of topics, the collection aims to recognize the plurality of nursing. New social histories inspired by Davies' work initially appeared to allow space for discussion of psychiatric or mental nursing. A number of articles were published that presented a view of the uniqueness of the specialty. Mick Carpenter's chapter in *Rewriting Nursing History* positions the occupation of mental nursing and attendance within labour history.<sup>15</sup> Christopher Maggs' edited collection, *Nursing History: The State of the Art* includes a chapter by Olga Church on the emergence of training programmes for asylum nurses in the United States at the turn of the nineteenth to twentieth centuries.<sup>16</sup> Robert Dingwall, Anne Marie Rafferty, and Charles Webster's *Introduction to the Social History of Nursing* also includes a chapter on the history of mental nursing and mental handicap nursing in England.<sup>17</sup> These authors link the changing fortunes of the occupation to those of the mental health sector as a whole and emphasize the fragile connection between general and mental nursing who they describe as 'reluctant spouses'.<sup>18</sup>

Most 'new social histories' of the 1980s and 1990s focus almost exclusively on nursing as a woman's occupation.<sup>19</sup> Historians challenge the view that nursing had progressed from working-class servant-hood to autonomous professionalism. Professionalisation is viewed by some as a woman's struggle for equality within patriarchal systems.<sup>20</sup> The

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<sup>13</sup> Celia Davies, ed., *Rewriting Nursing History*, London, 1980, p.226, p.14.

<sup>14</sup> *ibid.*

<sup>15</sup> Mick Carpenter, 'Asylum Nursing before 1914: A Chapter in the History of Labour,' in *Rewriting Nursing History*, Celia Davies, ed., London, 1980, pp.123-46.

<sup>16</sup> Olga Church, 'Emergence of Training Programmes for Asylum Nursing at the Turn of the Century', *Advances in Nursing Science*, 7, 1985, pp.107-23.

<sup>17</sup> Robert Dingwall, Anne Marie Rafferty, and Charles Webster, *An Introduction to the Social History of Nursing*, London, 1988, pp.123-44.

<sup>18</sup> *ibid.*, pp.143-4.

<sup>19</sup> The influence of social history on nursing historiography is sometimes called, 'new social history' or 'new history'.

<sup>20</sup> See for example, Eva Gamarnikow, 'Nurse or Woman: Gender and Professionalism in Reformed Nursing 1860-1923,' in *Anthropology and Nursing*, Pat Holden and Jenny Littlewood, eds, London, 1991; Barbara Melosh, *The Physician's Hand: Work, Culture, and Conflict in American Nursing*, Philadelphia, 1982; Susan M Reverby, *Ordered to Care: The Dilemma of American Nursing 1850-1945*, Cambridge, 1987.

very possibility of nursing as a profession is also questioned. Barbara Melosh argues that 'the framework of professionalisation can only encompass one part of a wider history ...it distorts that history for nursing [as a woman's occupation] is not and cannot be a profession'.<sup>21</sup> Susan Reverby concludes similarly when she notes that '[n]ursing has always been a much conflicted metaphor in our culture, reflecting all the ambivalences we give to the meaning of woman-hood'.<sup>22</sup> In Celia Davies' critique of the gendered predicament of nursing, she suggests that 'there is a sense that nursing is not a profession, but an adjunct to a gendered concept of a profession. Nursing is the activity, in other words, that enables medicine to present itself as masculine/rational and to gain the power and privilege of doing so.'<sup>23</sup>

Although social histories of nursing have contributed significantly to women's history, their focus has inadvertently overlooked differences within nursing such as race, class, and gender.<sup>24</sup> By looking at the 'grand narrative' and focusing on nursing's subservient relationship with medicine and its internal hierarchies of control, the differences within have been overlooked. In viewing nursing as a woman's occupation, social historians of nursing have largely failed to critique the social and political dynamics of psychiatric nursing, an occupation containing large numbers of men, so continuing its marginal positioning.

Attempts have been made to redress the invisibility of men in the history of nursing. Some accounts highlight the contribution of men over hundreds of years.<sup>25</sup> Others provide examples of periods and locations in which men must have undertaken caring roles, even though the historical evidence has not been made visible.<sup>26</sup> In some accounts, the Nightingale reforms are held responsible for redefining nursing as a woman's occupation and psychiatry is portrayed as one of the few areas in which men

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<sup>21</sup> Melosh, p.15.

<sup>22</sup> Reverby, p.207.

<sup>23</sup> Celia Davies, *Gender and the Professional Predicament in Nursing*, Buckingham, 1995, p.61.

<sup>24</sup> The invisibility of ethnic difference has been challenged in recent years, though the topic remains marginal in nursing histories. See, for example: Lynne S. Giddings, 'In/visibility in Nursing: Stories from the Margins', PhD thesis, University of Colorado, 1997; Darlene Hine, 'The Intersection of Race, Class, and Gender in the Nursing Profession,' in *Enduring Issues in American Nursing*, Ellen Baer, et al., eds, 2001.

<sup>25</sup> A detailed study was produced by R. Brown and R. Stones, *Men in Nursing*, London, 1973, see: Davies, *Gender*, p.188.

<sup>26</sup> Barbara Mortimer and Susan McGann, eds, *New Directions in the History of Nursing: International Perspectives*, New York, 2005, p.207, pp.6-7.

have been able to find a place.<sup>27</sup> Bruce Mericle discusses the gendered expectations of how men were used as attendants, and later nurses, in mental asylums.<sup>28</sup> Two South African studies explore the dilemma of men in nursing and its intersection with questions of class and race.<sup>29</sup>

Several historians discuss male nurses in terms of gender relations. Robert Dingwall notes the trend towards a growing role of men in nursing management in England in the early 1970s.<sup>30</sup> Mick Carpenter, in discussing the same period, critiques the Salmon restructuring of nurse management, which advocated the promotion of men at the expense of women.<sup>31</sup> Joan Evans remains one of the few academics to approach the subject of men in nursing from a feminist perspective.<sup>32</sup> Evans agrees that men's participation in nursing has been limited and that men have been channelled into areas such as psychiatry because of stereotyped notions of masculinity. She concludes, however, that masculine traits, and everything masculine, including physical strength, is granted a superior value in patriarchal culture. Evans' analysis is arguably weakened by omitting a discussion of the stigmatized nature of psychiatry.

There is general agreement that there remains a gap in the literature on the historical role of men in nursing. In *Gender Issues and Nursing Practice*, for example, Margaret Miers' suggests that 'The fact that men in nursing also presented a challenge to the gendered order in health care is something that is widely overlooked.'<sup>33</sup> Barbara

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<sup>27</sup> See, for example: B. Brown, P. Nolan, and P Crawford, 'Men in Nursing: Ambivalence in Care, Gender and Masculinity', *International History of Nursing Journal*, 5, 3, 2000; Carolyn Mackintosh, 'A Historical Study of Men in Nursing', *Journal of Advanced Nursing*, 26, 2, 1997, pp.4-13.

<sup>28</sup> Bruce P Mericle, 'The Male as a Psychiatric Nurse', *Journal of Psychosocial Nursing*, 21, 11, 1983, pp.28-34.

<sup>29</sup> Catherine Burns, "'A man is a clumsy thing who does not know how to handle a sick person". Aspects of the History of Masculinity and Race in the Shaping of Male Nursing in South Africa, 1900-1950', *Journal of Southern African Studies*, 24, 4, 1998, pp.695-717; Shula Marks, *The Gender Dilemma in Nursing History: The Case of the South African Mine Hospitals* Online UKCHN, 2001; available at: <http://www.qmuc.ac.uk/hn/history/seminars00.html> (24 August 2002)

<sup>30</sup> Robert Dingwall, 'Nursing: Towards a Male-Dominated Occupation?', *Nursing Times*, 68, 1972, pp.1585-6.

<sup>31</sup> Mick Carpenter, 'The New Managerialism and Professionalism in Nursing,' in *Health and the Division of Labour*, Margaret Stacey, ed., London, 1977. Others have discussed the dramatic increase of men in nursing management after the Salmon Report (1966). See, for example: Sam Porter, 'Men in a Women's Job: The Gendered Experience of Nurses', *Sociology of Health and Illness*, 14, 4, 1992, pp.511-2.

<sup>32</sup> Joan Evans, 'Men Nurses: A Historical and Feminist Perspective', *Journal of Advanced Nursing*, 47, 3, 2004, pp.321-8.

<sup>33</sup> Margaret Miers, *Gender Issues in Nursing*, Houndsmills, 2000, p.88.

Mortimer likewise notes that questions about men's marginal position in nursing remain unanswered as men's studies have yet to make their mark.<sup>34</sup>

A growing body of work on psychiatric nursing has highlighted its ambiguous position between the professions of psychiatry and nursing. Church argues that psychiatric nursing's development as an autonomous profession was impeded by its relationship with psychiatry and mental institutions.<sup>35</sup> Claire Chatterton explores how mental nursing education in Britain was affected by being 'caught in the middle' between the contested interests of the Royal Medico-Psychological Association (RMPA) and the General Nursing Council (GNC).<sup>36</sup> Michael Arton takes this argument further when he suggests that mental nurses in Britain had been unable to 'progress towards professionalisation' because of the domination and control by 'more powerful health care groups'; that is, the RMPA and the GNC.<sup>37</sup> In the Canadian context, Veryl Tipliski recounts the battle between psychiatrists and nursing leaders over the right to control psychiatric nursing education in three provinces. She sees this as a gendered patriarchal conflict between the female nursing profession and male-dominated psychiatry.<sup>38</sup> When Angela Martin interprets the same events, she sees them as a struggle for the professional autonomy of psychiatric nursing. She argues that the introduction of separate registration in Saskatchewan for psychiatric nurses was a victory. It was achieved in spite of constant challenges from 'outside parties', especially female general nursing leaders.<sup>39</sup>

A third interpretation of the situation in the three Canadian provinces by Geertje Boschma, Olive Yong, and Lorraine Mychajlunow provides a different insight into the history of psychiatric nursing in Canada. Their analysis takes into account the gendered nature of the workforce. Unlike general nursing, the psychiatric nursing workforce included a high proportion of men. Boschma, Yong, and Mychajlunow suggest that the movement for separate registration for psychiatric nurses in Canada occurred because of

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<sup>34</sup> Barbara Mortimer, 'Introduction,' in *New Directions in the History of Nursing*, Barbara Mortimer and Susan McGann, eds, London, 2005, p.7.

<sup>35</sup> Church, 'That Noble Reform'.

<sup>36</sup> Claire Chatterton, "'Caught in the Middle?'" Mental Nurse Training in England 1919-51', *Journal of Psychiatric and Mental Health Nursing*, 11, 2004.

<sup>37</sup> Michael Arton, 'The Professionalisation of Mental Health Nursing in Great Britain 1850 -1950', PhD thesis, University College London, 1998.

<sup>38</sup> Tipliski, 'Parting at the Crossroads, The Development of Education'.

<sup>39</sup> Angela Y. Martin, *The Other Nurse: Seeking Validation*, BA Honours essay, Saskatchewan Psychiatric Nurses Association, 1999; available at: [http://www.rpnas.com/public/jsp/content/publications/papers/other\\_nurse.jsp](http://www.rpnas.com/public/jsp/content/publications/papers/other_nurse.jsp) (19 June 2005)

male attendants' resistance to being excluded from the opportunities for education and professionalisation. Links with the trade union movement gave the attendants the political power to organize themselves and successfully demand professional recognition.<sup>40</sup>

Gender and cultural analysis has created a more comprehensive view of the history of psychiatric nursing in several recent studies. Boschma's research into mental health nursing in Dutch asylums between 1890 and 1910 emphasises the importance of gender construction. Boschma argues that the rise of scientific psychiatry and the introduction of somatic treatments led to a redefinition of asylum work as 'nursing', an occupation more suitable for women than men. The development of new roles and nurses' training created opportunities for women but limited the men's role.<sup>41</sup> Chris Dooley's analysis of nursing services at Brandon Hospital for Mental Diseases, Manitoba during the 1930s also provides a critique based on the concept of the social construction of identity. Dooley traces changes in the nursing workforce as a result of economic strictures that forced women from middle-class and farming backgrounds to seek work in the hospital. This new class of nurse rejected the union connections of the earlier nurses and attendants and 'constructed mental nursing as a skilled craft based on propriety knowledge...'<sup>42</sup> They claimed that the care they delivered was 'caring care' rather than the clinical care provided by general nurses.<sup>43</sup>

Other historical accounts have highlighted the male-dominated, working-class identity of psychiatric nurses. In 'Women in Mental Health: Angels or Custodians?', Claire Chatterton suggests that images of nurses as 'caring angels' sat uneasily beside the reality of large numbers of men in mental nursing in England. Women mental nurses' role in labour struggles of the inter-war years also did not fit well the dominant image of angelic nurses. Carpenter's 'Asylum Nursing Before 1914' and Vicky Long's thesis, 'Changing Public Representations of Mental Illness in Britain, 1870-1970' also

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<sup>40</sup> Geertje Boschma, Olive Yonge, and Lorraine Mychajlunow, 'Gender and Professional Identity in Psychiatric Nursing Practice in Alberta, Canada, 1930-75', *Nursing Inquiry*, 12, 4, 2005, pp.243-55.

<sup>41</sup> Geertje Boschma, 'The Gender Specific Role of Male Nurses in Dutch Asylums', *International History of Nursing Journal*, 4, 3, 1999, pp.13-9.

<sup>42</sup> Chris Dooley, '"They gave their care, but we gave loving care": Defining and Defending Boundaries of Skill and Craft in the Nursing Service of a Manitoba Mental Hospital during the Great Depression', *Canadian Bulletin of Medical History*, 21, 2, 2004, p.229.

<sup>43</sup> *ibid.*, p.246.

emphasise the importance of trade union involvement for mental nurses in Britain.<sup>44</sup>

John Hughes' "'Country Boys Make the Best Nurses": Nursing the Insane in Alabama, 1861-1910' focuses on the role of young men in providing nursing care at Bryce Hospital, Alabama.<sup>45</sup>

'New cultural' approaches have provided opportunities to consider psychiatric nurses and the institutions in which they worked in different ways. Diana Gittins' *Madness in its Place: Narratives of Severalls Hospital, 1913-1997* is structured around the concepts of space and place. Through an analysis of the spatial and social 'great divide' between the two sexes, Gittins explores, in some detail, the cultural differences between the male and female staff.<sup>46</sup> Lee-Ann Monk's study of attendants in nineteenth-century Victoria, Australia is unique in that it situates itself within labour and work history. It identifies 'attendance' as an occupational category and an identity.<sup>47</sup> By engaging in a social and cultural study of the asylum as a workplace and the male and female attendants as workers, Monk has been able to explore how they 'crafted' their occupational identities. She concludes that the male attendants did this by differentiating themselves from the patients and by defining their occupation as masculine.<sup>48</sup>

### **New Zealand historiography**

Prior to the 1980s, there were very few historical accounts of New Zealand psychiatric nurses. One early description of the nursing on the female side of a mental hospital during the 1940s is included in the novel, *The Wrong Side of the Door*. Written by an ex-mental nurse, Marion Kennedy, the novel is thought to be an autobiographical reflection on her experiences at Porirua Hospital.<sup>49</sup> During the 1970s, several psychiatric nurses contributed to articles reflecting on their experiences.<sup>50</sup> Others wrote brief historical overviews. Margaret Bazley, who was at the time Principal Nursing Officer at Sunnyside Hospital and President of the New Zealand Nurses' Association

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<sup>44</sup> Carpenter, 'Asylum Nursing'; Vicky Long, 'Changing Public Representations of Mental Illness in Britain, 1870-1970', PhD thesis, University of Warwick, 2004.

<sup>45</sup> John S. Hughes, "'Country Boys Make the Best Nurses": Nursing the Insane in Alabama, 1861-1910', *The Journal of the History of Medicine and Allied Sciences*, 49, 1994.

<sup>46</sup> Diana Gittins, *Madness in its Place: Narratives of Severalls Hospital, 1913 - 1997*, London, 1998.

<sup>47</sup> Lee-Ann Monk, 'Artisans of Reason: Crafting a Gendered Occupational Identity in the Asylum in Victoria, 1848-1886', PhD thesis, La Trobe University, 2001, p.1.

<sup>48</sup> *ibid.*, p.iii.

<sup>49</sup> Marion Kennedy, *The Wrong Side of the Door*, London, 1963.

<sup>50</sup> See for example: N. M. Ames, 'What a Psychiatric Nurse Says', *Kai Tiaki, New Zealand Nursing Journal* (KT), 63, 6, 1970, p.23; E. Holland, 'Change – Rehabilitation Nursing', *KT*, 68, 9, 1975, pp.24-5.

(NZNA), included an historical overview in her 1973 article entitled, 'Psychiatric Nursing in New Zealand'.<sup>51</sup> A few years later, M. Van Lier, Senior Nursing Officer at Carrington Hospital, wrote of the changes in psychiatric care and psychiatric nursing from the 'dim dark past' of pre-asylum conditions through to more recent developments at his hospital.<sup>52</sup>

In New Zealand, psychiatric nurses (mental attendants and nurses) have been given most attention in histories of psychiatric hospitals and mental health services. Comprehensive histories have been produced on two mental hospitals: *Out of Mind Out of Sight* by Wendy Hunter Williams on Porirua Hospital and *Sitivation 125* by Warwick Brunton on Seaview Hospital.<sup>53</sup> Both include detailed discussion of nurses in relation to changing roles, education, workforce issues, and lifestyle. Williams' account includes lengthy, though unidentified, excerpts from oral history interviews. A 1968 study focuses on Auckland Mental Hospital between 1867 and 1926. Although discussing the place of attendants and nurses, the author's reliance on official reports and parliamentary debates results in a limited portrayal of the workers as a scarce resource and a source of complaint.<sup>54</sup> Two dissertations on selected periods in the life of Seacliff Hospital have also included analysis of the mental nursing and attendant workforce, their conditions of service, and changes in their education and role.<sup>55</sup> A more recent examination of deinstitutionalization uses Kingseat Hospital as a case study and includes a discussion of the role of the nurses.<sup>56</sup> Other, much briefer histories of psychiatric hospitals have been produced, usually by hospital committees to commemorate a special anniversary. These often include lists of senior nurses, photos, and short excerpts from interviews.<sup>57</sup>

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<sup>51</sup> Margaret Bazley, 'Psychiatric Nursing in New Zealand', *International Nursing Studies*, 10, 1973.

<sup>52</sup> M. Van Lier, 'The Care of the Psychiatric Patient Today', *KT*, 69, 11, 1976, pp.22-6.

<sup>53</sup> Warwick Brunton, *Sitivation 125: A History of Seaview Hospital, Hokitika and West Coast Mental Health Services 1872-1997*, Hokitika, 1997; Wendy Hunter Williams, *Out of Mind Out of Sight: The Story of Porirua Hospital*, Porirua, 1987.

<sup>54</sup> M.S. Primrose, 'Society and the Insane: A Study of Mental Illness in New Zealand, 1867-1926 with Special Reference to the Auckland Mental Hospital', MA thesis, University of Auckland, 1968, p.44 & 51.

<sup>55</sup> Susan Fennell, 'Psychiatry and Seacliff. A Study of Seacliff Mental Hospital and the Psychiatric Milieu in New Zealand 1912 to 1948', BA Hons dissertation, University of Otago, 1981; Caroline Hubbard, 'Lunatic Asylums in Otago, 1882-1911', BA Hons dissertation, University of Otago, 1977.

<sup>56</sup> John Berks, 'The Effect of Deinstitutionalisation on Kingseat Hospital, 1961-1999', BA Hons dissertation, Massey University, 2003.

<sup>57</sup> See, for example: Kingseat Hospital, *Kingseat Hospital 50 Years, 1932 - 1982*, Auckland, 1982; Bob Baird, *Lake Alice Hospital 40 Years*, Palmerston North, 1990; Seaview School of Nursing Reunion

Two studies have situated mental hospital nursing in a broader policy context. Kathy Truman's sociological study of the history of mental health services in the Wellington region 1945-78 complements Williams' Porirua history. The study includes detailed analysis of the effects of changing policy, treatment, and professional environments on the nurses' role.<sup>58</sup> Brunton's doctoral thesis on mental health policy between 1840 and 1947 also includes discussion of policy and workforce issues related to nurses and attendants. His study illustrates the effects of centralized control by a government department over the network of mental hospitals.<sup>59</sup> Both Truman and Brunton note the chronic problem of understaffing in mental hospitals.

Although gender issues have been addressed in several New Zealand studies of psychiatry and mental health, most have focused their analysis on patients. Bronwyn Labrum's research into women patients at Auckland Lunatic Asylum was the first major study in this genre.<sup>60</sup> Barbara Brookes followed with studies of both women and men patients at Seacliff Hospital.<sup>61</sup> Gender in relation to staff has had less attention. Two exceptions are Paula Cody's oral history study of women psychiatrists and Jennifer Styles's study of the influence of men and the construction of manhood on psychiatry in the 1920s and 1930s.<sup>62</sup> No studies to date have focused on gender issues within the mental hospital nursing workforce.

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Committee, *'Memories': Marking the Closure of the School of Nursing, Seaview Hospital, Hokitika*, Hokitika, 1992.

<sup>58</sup> Katherine M Truman, 'The Development of Mental Health Services in the Wellington Region 1945 - 1978', MA thesis, Victoria University of Wellington, 1984.

<sup>59</sup> Warwick Brunton, 'A Choice of Difficulties: National Mental Health Policy in New Zealand, 1840-1947', PhD thesis, University of Otago, 2001.

<sup>60</sup> Bronwyn Labrum, 'Gender and Lunacy: A Study of Woman Patients at the Auckland Lunatic Asylum 1870-1910', MA thesis, Massey university, 1990. See also: Bronwyn Labrum, 'Looking Beyond the Asylum: Gender and the Politics of Committal in Auckland, 1870-1910', *New Zealand Journal of History*, 26, 2, 1992, pp.125-44; Bronwyn Labrum, 'A Women's World in a Male Universe: Treatment and Rehabilitation at the Auckland Lunatic Asylum, 1870-1910,' in *New Countries and Old Medicine: Proceedings of an International Conference on the History of Medicine and Health, Auckland, New Zealand, 1994.*, Linda Bryder and Derek A Dow, eds, Auckland, 1995, pp.196-203.

<sup>61</sup> Barbara Brookes, 'Men and Madness in New Zealand, 1890-1916,' in *New Countries and Old Medicine: Proceedings of an International Conference on the History of Medicine and Health, Auckland, New Zealand, 1994.*, Linda Bryder and Derek Dow, eds, Auckland, 1995; Barbara Brookes, 'Women and Madness: A Case-study of the Seacliff Asylum, 1890-1920,' in *Women in History 2*, Barbara Brookes, et al., eds, Auckland, 1992; Barbara Brookes, 'Women and Mental Health: An Historical Introduction,' in *Folding Back the Shadows*, Sarah Romans, ed., Dunedin, 1998.

<sup>62</sup> Paula Cody, 'Women Psychiatrists in New Zealand 1900-1990,' in *'Unfortunate Folk': Essays on Mental Health Treatment 1863 -1992*, Barbara Brookes and Jane Thomson, eds, Dunedin, 2001; Jennifer Styles, 'Men and the Development of Psychiatry in New Zealand in the 1920s and 1930s', MA thesis, Canterbury University, Christchurch, 1997.



Psychiatric nursing has been rarely mentioned in histories of nursing in New Zealand. The few nursing publications prior to 1980 focus almost entirely on the development of general nursing as a profession, with no more than a passing comment on nursing specialties.<sup>63</sup> Joan Rattray's *Great Days in New Zealand Nursing* published in 1961, does afford two pages to psychiatric nursing.<sup>64</sup> Rattray reflects the dominant nursing discourse of her time, focusing on the feminisation and professionalisation of psychiatric nursing; even omitting to name the one man in her list of the first psychiatric nurses to pass the State Final Examination in 1946. Parts of her narrative sound like a recruitment text as she assures the reader that psychiatry has changed and that the work 'offers a peculiarly rewarding career to the dedicated nurse'.<sup>65</sup>

Since the 1970s, there has been a growing body of historical work on various aspects of New Zealand nursing history. This includes autobiographies, biographies, and histories of individual nursing schools and nursing organizations.<sup>66</sup> These largely celebratory accounts have been augmented by the publications of short biographical articles based on oral history interviews.<sup>67</sup> Although these types of nursing history are sometimes criticized as lacking contextual and analytical critique, they arguably remain an important part of the process of identity-formation for the profession. As Sioban Nelson has commented, '...we must take care not to miss their function and the benefits to all kinds of historical endeavours that accrue from these efforts. First and foremost, these histories provide a record...'<sup>68</sup>

Another strand of nursing histories in New Zealand is that of specialty nursing groups. Military nurses have received substantial historical attention.<sup>69</sup> Various aspects of the

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<sup>63</sup> Histories prior to the 1980s included autobiographies and reflections by nursing leaders, for example: Mary Lambie, *My Story: Memoirs of a New Zealand Nurse*, Christchurch, 1956; Hester Maclean, *Nursing in New Zealand: History and Reminiscences*, Wellington, 1932. Histories also included reminiscences by nurses about their clinical experiences and adventures, for example Frances Hayman, *King Country Nurse*, Auckland, 1964; Edith Lewis, *Joy in Caring*, Christchurch, 1963.

<sup>64</sup> Joan Rattray, *Great Days in New Zealand Nursing*, Wellington, 1961, pp.55-6.

<sup>65</sup> *ibid.*, p.55.

<sup>66</sup> Examples include: Margaret Brown, Diana Masters, and Barbara Smith, *Nurses of Auckland: The History of the General Nursing Programme in the Auckland School of Nursing*, Auckland, 1994; Clive Lind, *Step by Step: The History of Nursing Education in Southland*, Invercargill, 1982; Valerie Smith, *Charge of the White Brigade*, Wellington, 1991; Valerie Smith, *Nurse at Large*, Wellington, 1992.

<sup>67</sup> See, for example: 'Herstory. Time Brings Change: Reintroducing Joan Hamilton, R.Comp.N, Dip.N', *Nursing Praxis in New Zealand*, 9, 2, 1994, pp.46-8; 'Herstory: M. Banks', *Nursing Praxis in New Zealand*, 1, 1, 1989, pp.46-8.

<sup>68</sup> Sioban Nelson, 'The Fork in the Road: Nursing History Versus the History of Nursing?' *Nursing History Review*, 10, 2002, p.179.

<sup>69</sup> Of the following works, Kendall's and Corbett's is celebratory in style, rather than being an example of critical or well-documented history. Jennifer Bryan, 'Women who Cared: The Experiences of New

history of Plunket (infant care) nursing have also been researched.<sup>70</sup> Maori 'backblocks' nursing in the early twentieth century has also been the focus of both historical research and debate.<sup>71</sup>

The psychiatric nursing specialty, in contrast, has received minimal attention. My own article on the contested place of mental health in contemporary New Zealand nursing education is based largely on historical analysis.<sup>72</sup> Sandra Matheson's research paper on the same topic includes a thorough historical background based on secondary sources.<sup>73</sup> Chris Walsh provides personal reflections on the recent history of psychiatric/mental health nursing as she considers what the future might hold for the discipline.<sup>74</sup> In a more theoretical mode, Anthony O'Brien draws on New Zealand and international sources to inform his discussion of the historical and contemporary significance of the 'therapeutic relationship' in mental health nursing.<sup>75</sup>

Although some studies have addressed issues or events that encompass all types of nursing, there has been little acknowledgement of psychiatric nursing's unique position and identity. Kim Filshie examines educational developments between 1960 and 1973, a period in which, she argues, nursing engaged in a 'struggle to attain professional status

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Zealand Nurses and VADs in the First World War, 1914-1918', MA thesis, University of Auckland, 2001; Carolyn J Hyde, 'The Benefits of War? An Investigation into the New Zealand Nurses who Served Abroad, 1939-1945', MA thesis, University of Auckland, 2003; Sherayl Kendall and David Corbett, *New Zealand Military Nursing: A History of the R.N.Z.N.C., Boer War to the Present Day*, Auckland, 1990; Jan Rodgers, "'A Paradox of Power and Marginality": New Zealand Nurses' Professional Campaign During War, 1900-1920', PhD thesis, Massey University, 1994; Anna Rogers, *While You're Away: New Zealand Nurses at War, 1899-1948*, Auckland, 2003.

<sup>70</sup> Linda Bryder, *Not Just Weighing Babies: Plunket in Auckland, 1908-1998*, Auckland, 1998; Linda Bryder, *A Voice for Mothers: The Plunket Society and Infant Welfare, 1907-2000*, Auckland, 2003; Lynne S. Giddings, 'MacKinnon, Joanna 1878 - 1966' Dictionary of New Zealand Biography; available at: URL: <http://www.dnzb.govt.nz/> (20 September 2006); Lynne S. Milne, 'The Plunket Society: An Experiment in Infant Welfare', BA Hons dissertation, University of Otago, 1976.

<sup>71</sup> Maureen Holdaway, 'Where are the Maori Nurses who were to become those "Efficient Preachers of the Gospel of Health?"', *Nursing Praxis in New Zealand*, 8, 1, 1993; Alexandra McKegg, "'Ministering Angels": Government Backblocks Nursing Service and Maori Health Nurses, 1909-1939', MA thesis, University of Auckland, 1991; Pamela J Wood, 'Efficient Preachers of the Gospel of Health: The 1898 Scheme for Educating Maori Nurses', *Nursing Praxis in New Zealand*, 7, 1, 1992.

<sup>72</sup> Kate Prebble, 'On the Brink of Change? Implications of the Review of Undergraduate Education in New Zealand for Mental Health Nursing', *Australian and New Zealand Journal of Mental Health Nursing*, 10, 3, 2001, pp.136-44.

<sup>73</sup> Sandra Matheson, 'Psychiatric/Mental Health Nursing: Positioning Undergraduate Education', MA Applied dissertation, Victoria University, Wellington, 2001

<sup>74</sup> Chris Walsh, 'Reclaiming Our Space: Reflections on Psychiatric Mental Health Nursing from the Past to the Future,' in *Nursing in New Zealand: Critical Issues, Different Perspectives*, Elaine Papps, ed., Auckland, 2002.

<sup>75</sup> Anthony J. O'Brien, 'The Therapeutic Relationship: Historical Development and Contemporary Significance', *Journal of Psychiatric and Mental Health Nursing*, 8, 2001.

for the New Zealand nurse'.<sup>76</sup> Although acknowledging divisions within nursing, Filshie pays little heed to the views or actions of psychiatric nurses.<sup>77</sup> In Patricia French's Foucauldian analysis of nursing regulation, she suggests that specialties within nursing created domains of power/knowledge. French uses the example of the handover of psychiatric nurse training to the Nurses' and Midwives' Board in 1945 as an example of contested power relations. This idea is not, however, developed further.<sup>78</sup> Another thesis that applies Foucauldian and feminist analysis to nursing history is Debra Wilson's 'Transforming Education: The Legitimacy of Difference'. Wilson interviewed 15 women nurse educators who were involved in the early stages of comprehensive nursing education. She concludes that the women possessed traits that equipped them to 'successfully negotiate' the construction of the new programmes as a 'legitimate and transformative' preparation for nursing registration. Psychiatric nursing is discussed, but only in relation to resistance from clinical areas to adapt to the educational and clinical reforms.<sup>79</sup>

In the same way that international histories of nursing have usually assumed that it is a woman's occupation, New Zealand histories of nursing have positioned themselves as women's history. Nurses' success or otherwise in achieving professional status, establishing educational reform, or achieving equitable working conditions have all been interpreted as a product of belonging to a woman's profession.<sup>80</sup> Sandra Wallace concludes that nurses' moves towards professionalisation between 1900 and 1930 were impeded by nursing's status as a woman's occupation and the constraining imperatives of the Nightingale ethos.<sup>81</sup> Patricia Sargison's research on the first one hundred years of

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<sup>76</sup> Kim Filshie, 'Nursing Education in New Zealand: 1960-1973 - "The Struggle to Attain Professional Status for the New Zealand Nurse"', MA dissertation, Canterbury University, Christchurch, 1985.

<sup>77</sup> *ibid.*

<sup>78</sup> Patricia French, *A Study of the Regulation of Nursing in New Zealand 1901-1997*, Victoria University of Wellington Graduate School of Nursing Monograph Series, Wellington, 2001.

<sup>79</sup> Debra Wilson, 'Transforming Nursing Education: A Legitimacy of Difference', PhD thesis, Canterbury University Christchurch, 2001.

<sup>80</sup> See, for example: Margaret McDougall and Annette Stevenson, 'The Interdependence of Nurse Training and Nursing Service,' in *New Countries and Old Medicine: Proceedings of an International Conference on the History of Medicine and Health, Auckland, New Zealand, 1994.*, Linda Bryder and Derek A Dow, eds, Auckland, 1995; Victoria Jane Cullens, "'Not Just a Shortage of Girls": The Shortage of Nurses in Post World War Two New Zealand, 1945 - 1955', M.A (Applied) thesis, Victoria University of Wellington, 2001; Deborah Dunsford, "'The privilege to serve others": The Working Conditions of General Nurses in Auckland's Public Hospitals, 1908-1950', MA thesis, University of Auckland, 1994; Jan Rodgers, "...A Good Nurse ... A Good Woman". Duty and Obedience in Early New Zealand Nursing Education,' in *Reinterpreting the Educational Past. Essays in the History of New Zealand Education*, Roger Openshaw and David McKenzie, eds, Wellington, 1987.

<sup>81</sup> Sandra Wallace, 'The Professionalisation of Nursing', BA Hons dissertation, University of Otago, 1987.

nursing in colonial New Zealand comes to a similar conclusion, that nursing was considered 'essentially a woman's work'.<sup>82</sup> Jan Rodgers argues that the dominance of the Nightingale ethos both helped and hindered the development of nursing education between 1883 and 1930. Nursing, she claims, was seen as an extension of a woman's role; attributes of forbearance, endurance and obedience were valued.<sup>83</sup>

This focus of women's history has largely resulted in the omission of a discussion on the role of male nurses and psychiatric nurses. Sargison, for example, explains that her reason for omitting psychiatric nursing was that because it was a male-dominated occupation it 'seldom overlapped with general nursing'.<sup>84</sup> Psychiatric nursing, understandably, did not fit Sargison's analysis of nursing as 'essentially women's work'.

Thomas Harding's 'Constructing the Other: On Being a Man and a Nurse' is a recent exception to the usual focus of nursing history in New Zealand.<sup>85</sup> The thesis does not pretend to be a historical study but does include a section on the history of men in nursing since the ancient civilisations and up to and including nineteenth and twentieth-century New Zealand. Although Harding includes a discussion of psychiatric nursing later in the thesis, his historical narrative does not mention this field of nursing. Apart from his qualitative interviews of New Zealand nurses, Harding's analysis of psychiatric nursing is largely based on overseas secondary sources. Some of his reflections on male nurses in New Zealand appear to be speculative rather than grounded in historical analysis. His suggestion, for example, that male psychiatric nurses joined trade unions because they were denied entry to professional nursing organisations, is questionable.<sup>86</sup>

Psychiatric nursing was a male-dominated, working-class occupation. Labour history, not surprisingly, is one place that New Zealand psychiatric nursing has been represented. Bert Roth's history of the Public Service Association includes several

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<sup>82</sup> Patricia Sargison, 'Essentially a Woman's Work': A History of General Nursing in New Zealand, 1830-1930', PhD thesis, University of Otago, 2001.

<sup>83</sup> Jan Rodgers, 'Nursing Education in New Zealand, 1883 -1930: The Persistence of the Nightingale Ethos', MA thesis, Massey University, 1985, p.ii.

<sup>84</sup> Sargison, 'Essentially', p.9.

<sup>85</sup> Thomas Harding, 'Constructing the "Other": On Being a Man and a Nurse', PhD thesis, University of Auckland, 2005.

<sup>86</sup> *ibid.*, p.293.

sections on the actions of the union's Mental Health Group.<sup>87</sup> A high proportion of the group's members were psychiatric nurses.

### **Methodology, sources and chapter structure**

This thesis is a study of 'ordinary', working people. It is also a story of how this group of workers interacted with discourses of professionalisation. It aims to reflect not only the 'official' story of the changes that occurred to psychiatric nurses between 1939 and 1972 but also to explore the everydayness of the nurses' working lives. It is not just a 'history from above' but also a 'history from below'.<sup>88</sup> In this respect, it is a social history of labour.<sup>89</sup>

My research is also informed by theories that emanate from 'new cultural history'. Foucault's criticism of the core principle of social history 'that society itself is the reality to be studied' has been influential.<sup>90</sup> Theories and methods from disciplines such as anthropology, literary theory, feminism and linguistic studies have contributed to the development of a cultural history that looks for ascribed meanings rather than intrinsic reality.<sup>91</sup> Rather than asking how do they live their lives or how do they experience their lives, cultural history questions how do people understand their lives?

Foucault's major influence on social and cultural history is his interpretation of how power works in society. He saw power as permeating every aspect of social life; power and knowledge, for Foucault, are inextricably connected. Power, he believed, 'creates truth and hence its own legitimation'.<sup>92</sup> This interpretation has influenced my analysis of the history of psychiatric nursing in New Zealand between 1939 and 1972. I have approached the subject with the belief that there was no unitary, continuous identity of an occupational group called, 'psychiatric nurses'. In exploring the meaning ascribed to those who worked with the mentally unwell, I have assumed that there were contested

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<sup>87</sup> Bert Roth, *Remedy for Present Evils: A History of the New Zealand Public Service Association from 1890*, Wellington, 1987.

<sup>88</sup> The term 'history from below' is usually attributed to the labour historian, E.P. Thompson: Edward P. Thompson, *The Making of the English Working Class*, London, 1963.

<sup>89</sup> John Tosh and Sean Lang, *The Pursuit of History: Aims, Methods and New Directions in the Study of Modern History*, Fourth edn, London, 2006 (first published 1984), pp.131-33.

<sup>90</sup> Patricia O'Brien, 'Michel Foucault's History of Culture' in *The New Cultural History*, Lynn Hunt, ed., Berkeley, 1989, p.27.

<sup>91</sup> For a discussion on cultural history and its challenges to social history, see: Lynn Hunt, 'Introduction: History, Culture, and Text,' in *The New Cultural History*, Lynn Hunt, ed., Berkeley, 1989, pp.1-22.

<sup>92</sup> O'Brien, 'Michel Foucault's History of Culture,' p.35.

discourses that changed over time.<sup>93</sup> Discourses such as ‘professionalism’, for example, vied with those of ‘work’ and ‘custody’.

A cultural history approach to gender has also been important in this study. Gender, like identity, can be understood as socially constructed. Here, I draw on the work of Denise Riley, Joan Scott and others who have questioned the assumption that sex differences can be considered essential or natural.<sup>94</sup> Scott claims, as a historian, to be,

...particularly interested in historicizing gender by pointing to the variable and contradictory meanings attributed to sexual difference, to the political processes by which these meanings are developed and contested, to the instability and malleability of the categories 'women' and 'men', and the way these categories are articulated in terms of one another.<sup>95</sup>

By accepting that gender is historically constituted and socially-constructed, I have also subscribed to the idea that there are multiple masculinities and femininities. Lynne Segal’s analysis suggests that these can and do change over time.<sup>96</sup> At any one moment or place, according to R.W. Connell, some forms of masculinity carry more social and political weight than others. Connell refers to these as ‘hegemonic masculinities’.<sup>97</sup> This has been a useful concept in my analysis of psychiatric nursing in mental hospitals. It has allowed me to ask why some forms of masculinity or femininity appeared to be more compatible with the role than were others.

A social construction approach to gender and identity has implications for the study of the history of psychiatric nursing. First, it creates a space to discuss the history of psychiatric nursing in a manner that goes beyond the assumption that nursing is a woman’s occupation. It challenges a well-entrenched belief about the unitary nature of nursing and creates a possibility for considering multiple meanings of the occupation. Second, and perhaps more importantly, is the opportunity to go beyond merely retrieving the history of psychiatric nursing and male nurses from marginalisation and obscurity. Scott’s suggestion about feminist history could apply equally to writing

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<sup>93</sup> Denise Riley’s discussion of the category ‘women’ and other collective identities has shaped my thinking on this topic. Riley argued that collective identities are temporary (historicized) and contested: Denise Riley, *Am I that Name?* London, 1988, pp.1-17.

<sup>94</sup> *ibid.*, pp.1053-75; Joan Scott, ‘Gender: A Useful Category for Historical Analysis’, *The American Historical Review*, 91, 5, 1986.

<sup>95</sup> Joan Scott, *Gender and the Politics of History*, New York, 1988, p.10.

<sup>96</sup> Lynne Segal, *Slow Motion : Changing Masculinities, Changing Men*, London, 1990.

<sup>97</sup> R. W. Connell, *Masculinities*, St. Leonards, N.S.W., 1995.

history of these marginalised groups. '[History] then becomes not just an attempt to correct or supplement an incomplete record of the past but a way of critically understanding how history operates as a site of production of gender [or nursing] knowledge'.<sup>98</sup>

Several questions relating to power and gender are asked in this thesis. How was masculinity and femininity constructed in relation to the roles and work of psychiatric nurses and the space they occupied? In what way was psychiatric nursing understood as a male or female occupation? How did the changes to psychiatric treatments shift the discourses of 'mental attendance' and 'mental nursing'? In what way did the discourses of nursing as a 'respectable, feminine profession' interact or compete with the discourses of psychiatric nursing as a largely male, working-class occupation?<sup>99</sup>

My sources and methods reflect my aim to explore both the 'official' story and the everydayness of the nurses' working lives. I have made extensive use of archival materials, largely from the records of the Mental Health Division of the Department of Health. Head Office records have been complemented by selected archives of individual hospitals. Access to these records is restricted. I am grateful to the Ministry of Health and individual district health boards for allowing me to use the material. Other primary sources include annual reports of the Department of Health's Mental Health and Nursing Divisions, the *New Zealand Parliamentary Debates* and the *New Zealand Gazette*. Records of the Public Service Association and the New Zealand Nurses' Organisation have also provided a rich source of primary data. Journals published during the period become for this purpose additional sources of primary data. The main journals used were *Kai Tiaki: The New Zealand Nursing Journal*, *New Zealand Medical Journal* and the *Public Service Journal*. I also consulted daily newspapers as a source of public comment on events in psychiatric nursing and mental hospitals.

Oral history interviews are the other major source of primary data for this research. First used by social historians to gain access to the stories 'from below', particularly from marginalised groups such as the working class, women and ethnic minorities, oral histories have more recently been viewed as a process by which meaning is constructed.

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<sup>98</sup> Scott, *Gender and the Politics*, p.10

<sup>99</sup> Sargison claimed that nursing reformers in New Zealand shaped an ideal of the 'good nurse' as being a 'good woman', pure, gentle self-disciplined, self-sacrificing and unquestionably obedient to male authority'. Sargison, 'Essentially', p.iv.

Although oral history methods can be used to check the reliability of information such as dates and events, they have much greater use in helping the researcher understand the multiple meanings ascribed to certain events, institutions, or processes.<sup>100</sup> The history of psychiatry, perhaps more than many topics of historical inquiry, is one of contested narratives.<sup>101</sup> Catharine Coleborne has discussed this phenomenon in relation to an oral history project about Tokanui Hospital near Te Awamutu, New Zealand. She found that the hospital had very different meanings for individual interviewees. For some, it was a place where one could belong, a whanau (extended family). For others, it was a closed, by implication a repressive, community operating under a 'code of silence'.<sup>102</sup>

In this research, oral histories have proved to be important both as sources of information and in the construction of meaning. There is little written archival information available about some aspects of psychiatric nursing, for example, nurses' reasons for joining the workforce or their day-to-day work. Interviews fill some of these gaps. They have, as John Tosh explains, allowed 'the voice of ordinary people to be heard alongside the careful marshalling of social facts in the written record'.<sup>103</sup> More importantly, recourse to oral history interviews has enabled me to explore the meanings of institution based psychiatric nursing through the eyes of the nurses themselves.

For nurses' reflections on the earlier period of my study, I have largely relied on existing oral history interviews. Three collections of particular value held in the Alexander Turnbull Library are the New Zealand Nursing Education and Research Foundation Oral History Collection (NERF-OHP), the Psychiatric Nurses' Oral History Project (NERF-PNOHP), and the Sunnyside Hospital Oral History Project. Oral histories of people who nursed at Tokanui Hospital are held at the Te Awamutu Museum. These have been of particular interest in relation to the later period of my research and, in particular, in relation to nurses who identify as Maori.

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<sup>100</sup> Anna Green's provides a useful summary of the changes in oral history: Anna Green, 'Oral History and History,' in *Remembering: Writing Oral History*, Anna Green and Megan Hutching, eds, Auckland, 2004, pp.1-8.

<sup>101</sup> This concept is explored in relation to patients' narratives in: Kerry Davies, "Silent and Censured Travellers"? Patients' Narratives and Patients' Voices: Perspectives on the History of Mental Illness since 1948', *Social History of Medicine*, 14, 2, 2001, pp.267-92.

<sup>102</sup> Catharine Coleborne, "Like a family where you fight and roar": Inside the "Personal and Social" Worlds of Tokanui Hospital, New Zealand, through an Oral History Project', *Oral History in New Zealand*, 2004, pp.17-27.

<sup>103</sup> Tosh and Lang, p.314.



My own oral history interviews formed the basis of most of the remembered history. I undertook 39 interviews and one focus group. Thirty-seven of the interviewees were nurses, one other had been a union leader and the last had been medical superintendent of a large mental hospital. Two of the interviews had been conducted for a smaller project on the history of the 'Oakley Strike' prior to commencement of this research.<sup>104</sup> This topic has become part of the larger project. Ethics approval for interviewing was granted by the University of Auckland Human Subjects Ethics Committee (see Appendix A).

Selection of people to interview was based on several criteria. My aim was to interview 'key informants' as well as those who could provide reflections on their experiences as 'ordinary nurses'. Key informants were people who had played significant roles in psychiatric nursing administration, education, or industrial leadership. Most were nurses but one was a union leader and another was a medical superintendent. Some 'ordinary nurses' have become leaders in mental health, nursing, education, Maori Health or Pacific Island Health in the years since the period covered in this thesis. They have provided useful insights into this earlier period of psychiatric nursing history.

In finding nurses to interview, I used what I have termed, 'informed snowball sampling'. The psychiatric nursing community in New Zealand is not large and informal networks of nurses, particularly surrounding individual hospitals, remain strong. By using my own connections as a mental health nurse to contact nurses in each region, I was put in touch with retired and practising psychiatric nurses who were known to carry the memories of nursing in that area. They, in turn, helped me contact others. I attempted to achieve a spread across New Zealand, to interview people who had worked in each of the public mental hospitals and to include a broadly representative sample of men and women, Maori, Pakeha (New Zealanders of European ethnicity) and Pacific Island nurses. I am indebted to Erina Morrison-Ngatai who agreed to be a consultant on Maori issues. She advised me who to contact and paved the way for my interviews with many of the Maori participants.

Thirty-five of the nurses were registered psychiatric nurses (RPN), one a registered general nurse (RN) and one was a Samoan-trained registered nurse who had worked as a

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<sup>104</sup> The 1971 psychiatric nurses' strike is discussed in some detail in Chapter VII.

nurse-aide in a New Zealand psychiatric hospital.<sup>105</sup> Several RPNs also held general nursing qualifications. All interviewees except the general nurse had worked in public psychiatric hospitals. She had practised in a general hospital psychiatric unit in the early 1970s. All but one of the registered nurses had trained in New Zealand within the hospital based system of nursing education. My decision to focus almost entirely on registered psychiatric nurses is an act of definition. There were others who worked in public mental hospitals as ‘psychiatric assistants’, nurse aides, or community nurses (second level nurses with shortened training). Within a broad definition, they too are nurses. There were many others who worked for months or years as student nurses but left before completing their nursing training. By focusing my interviews on registered psychiatric nurses, I have, in a sense, subscribed to the nurses’ own defining professional discourse. It becomes evident in my thesis, however, that the boundaries between categories of workers in public mental hospitals were not always clear.

Of the psychiatric 35 nurses interviewed, there were 14 men and 21 women. At the time of their interviews, their ages ranged from 50 years to 91 years. Three commenced nursing in the 1930s, two in the 1940s, 13 in the 1950s, 11 in the 1960s and six in the 1970s (see Appendix E for brief biographical details). Among the nurses were those who had worked at all the public mental hospitals except one (Raventhorpe). Seven of the nurses identified as Maori and three as Pacific Island ethnicity. The remainder were Pakeha. One was originally from the Netherlands and two from England.

Potential interviewees were sent a Participant Information and a Consent Form (see Appendix B, C and D). In most cases, consent was returned by post, but in some cases interviewees chose to return it at the time of interview. It was explained to the participants that consent for archiving the interviews may be sought at a later date. Most of the interviews were conducted in the participants’ homes but several were held in their workplaces. One group interview was conducted with three nurses who had worked at Seaview Hospital in Hokitika. The purpose of the group interview was to explore some of the issues that had emerged in individual interviews. Interviews were audio-tape recorded and copies made to ensure the originals were not damaged during use. Written summaries were made for ease of analysis.

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<sup>105</sup> I have used the registration titles as they applied in the period I am studying. Under the Health Practitioners Competency Assurance Act, 2003, all registered nurses now come under the single title, ‘Registered Nurse’ but work within their designated scope of practice.

My analysis of the oral history interviews involved a process of immersion, questioning, contrasting, and comparing. This was a complex task. As Perry Blatz notes, the difficulties in oral history analysis arise from the need to make meaning of the ‘sheer complexity of human experience – its interrelatedness, inconsistency, and irrationality, and more importantly, our fallibility in attempting to understand it’.<sup>106</sup> Unlike written archival data, oral history involves a relationship between historian and informant. The interviewee’s subjective experience, emotional response, and quality of memory are as important to the process of analysis as is their recall of ‘empirical’ data. The relationship between researcher and interviewee frames the content and tone of the interview. My experience led me to conclude that analysis requires openness and as Blatz argues, ‘no small amount of humility’.<sup>107</sup>

As a mental health nurse, I was in some respects an ‘insider’ in relation to the psychiatric nurses I interviewed.<sup>108</sup> This status created a level of trust with the interviewees, especially because as psychiatric nurses they had often experienced the effect of stigma by association with mental illness; they had felt misunderstood by other nurses and by the general public. My lack of experience in the public mental hospitals meant that I was in other respects an ‘outsider’ who had to demonstrate trustworthiness as a researcher. Although I have an understanding of the language and concepts of psychiatric nursing, I had to remind myself that in relation to my interviewees’ lived experience of psychiatric nursing I was indeed, an ‘outsider’.

The interpretive process sometimes commenced even before the interview itself. When making dates, times, or places to meet potential participants, we often became engaged in conversation about particular issues and events. Some of these discussions were continued within the proceeding interview. During the interviews themselves, I noted not only the spoken words but also participants’ body language, their levels of engagement with particular topics, and their emotional responses when recalling and retelling particular experiences. As Anna Green explains, ‘the way we tell stories, and the language we use, is not always as straightforward as it might first appear. It is rarely

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<sup>106</sup> Perry Blatz, ‘Craftsmanship and Flexibility in Oral History: A Pluralistic Approach to Methodology and Theory’, *The Public Historian*, 12, 4, (Fall 1990), p.12.

<sup>107</sup> *ibid.*

<sup>108</sup> Being part of a community as an oral history interviewer is considered both a strength and a weakness: Alistair Thomson, ‘Fifty Years On: An International Perspective on Oral History’, *The Journal of American History*, September, 1998, pp.582-3.

a transparent or neutral medium'.<sup>109</sup> Often, participants waited until after the tape recorder was turned off to make their more negative responses or comments. Similarly, more personal comments were sometimes made casually over a cup of tea or when I was preparing to leave. Although the content of these conversations have not been included verbatim in the thesis, they often reinforced or expanded my understanding of certain issues and events. One retired male nurse for example who had spoken at length about his sense of unfairness in the mental hospital system, called out as I drove away from his home, 'Power to the workers!' This interviewee's exclamation lodged in my mind as a symbol of psychiatric nurses' constructed identity as unionised workers.

The interpretive process continued as I listened to the audiotapes and took notes. I visited and revisited the interview data and often re-listened to the interviews as new questions emerged from my analysis. Interview data was analysed alongside the archival data, providing an additional source of information. Initially, I sought evidence about pre-identified topics such as the psychiatric nurses' experience of commencing work, participation in education, or learning new practice roles. As I became more immersed in the details and events of the period, I discovered that the nurses' memories and reflections provided unexpected and invaluable insights into their collective culture and identity. The analytical process became cyclical. At times, the nurses' memories sent me back to the written sources to check out dates, official perceptions, or political and social contexts. At other times, information from the archives directed me back to the interviews to check out how events or practices appeared to the nurses. I re-contacted several participants by phone to ask for more information or check out their perceptions of particular issues or events.

In the process of going to-and-fro between the archival and interview data, I specifically sought to uncover what appeared to be inconsistencies or contradictions. This process allowed me to establish a level of 'authenticity' or validity in the data and gave me confidence in my conclusions on particular issues or interpretations of events.<sup>110</sup> By searching for the presence of internal and external inconsistencies and contradictions I was also able to gain insight into the subjective experience and the multiple constructed identities of being a psychiatric nurse, especially in relation to gender and class

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<sup>109</sup> Anna Green, "'Unpacking" the Stories,' in *Remembering: Writing Oral History*, Anna Green and Megan Hutching, eds, Auckland, 2004, p.11.

<sup>110</sup> Carol Greich, *Qualitative Research in Health: An Introduction*, St Leonards NSW, 1999, pp.148-9.

differences. As Elizabeth Kennedy argues, the learning gained from the subjective nature of oral history interviews rather than undermining the authenticity of the data, is complementary to the ‘empirical’ insights.<sup>111</sup>

Participants’ memories of certain events varied. Their memories of dates and details of events were not always consistent with written archival data. Rather than viewing the ‘unreliability’ of memory as a weakness, oral historians have over the past 25 years come to see the distortions of memory as a resource. Mistaken memory can provide vital cues to the meaning people attach to certain events.<sup>112</sup> During my process of analysis and interpretation, it became evident that there were times when the nurses’ memories were more important as an indication of subjective meaning rather than as a source of empirical data. One retired nurse for example when recalling her training days at Seacliff Hospital exclaimed, ‘it was a lovely life...the days were beautiful in those days – lovely and sunny.’<sup>113</sup> Her subjective experience of the weather was no doubt coloured by her happy memories of the hospital community and work as a psychiatric nurse.

Nurses have trusted me with their reflections at a time when psychiatric nursing practice of the 1960s and 1970s is being challenged within the New Zealand legal system. I am aware that this may have coloured the content and flavour of some of the interviews. For some participants, the decision to proceed with an interview was not done lightly. I have attempted to manage the participants’ information with care. The consent process provided for individuals to withdraw at any time up until the end of data collection. They also had the right to ask for parts of their interviews not to be used. Participants were able to choose whether or not they would be identified. Two people asked to remain anonymous. Finally, I sent each participant the excerpts of the thesis that include references to their interview data. They were again given the opportunity to have their names removed. They also had the chance to alter or delete material from their interviews.

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<sup>111</sup> Elizabeth Lapovsky Kennedy, ‘Telling Tales: Oral History and the Construction of pre-Stonewall Lesbian History’, Robert Perks & Alistair Thomson eds, *The Oral History Reader*, 2<sup>nd</sup> Edition, New York, 2006, p.281.

<sup>112</sup> Alistair Thomson, ‘Fifty Years On: An International Perspective on Oral History’, *The Journal of American History*, September, 1998, pp.584-8.

<sup>113</sup> Kath McLeod interview 1 September 2004.

My thesis cannot fully claim to be a 'history from below'. It is largely devoid of the patients' voice.<sup>114</sup> Patients' (consumers or clients) perspectives have only recently been sought by historians researching madness and mental health services.<sup>115</sup> My decision to omit written and oral primary data about or from individual patients was based on practical and ethical considerations. Firstly, it is a study of an occupational group, not of mental health services per se. Inclusion of patients' perspectives would have been beyond the scope of this study. Secondly, ethical considerations make access to patient information and interviews difficult. As Coleborne discovered in the process of calling for interviewees for the Tokanui Oral History Project, 'concern over the possibly deleterious effects of interviews with current mental health clients had the effect of excluding their participation...'<sup>116</sup> There is a risk, however, that by omitting the patient perspective, this thesis may perpetuate the silencing of 'those who travel in silence' through the mental health system.<sup>117</sup> In an attempt to avoid this, where possible, I have included reflections from published writing by people who were patients during the period of study.

The focus of this study is the people who provided care in public mental hospitals. It does not include nurses who worked in Ashburn Hall, in Dunedin, the one private mental hospital in New Zealand, nor have I explored in any detail the work of nurses in psychiatric wards attached to general hospitals. In Chapter VI, I have briefly discussed the development of psychiatric units at general hospitals, a trend that was occurring in the late 1960s and 1970s. I have not focused in detail on nursing in these units other than to allude to the changing trends and new opportunities for psychiatric nursing.

I have not attempted to tell the story of those nurses who specialised in caring for people with intellectual disability. Psychiatric nurses in public mental hospitals provided care for large numbers of people with intellectual disabilities. Beginning in the 1920s, the Department of Mental Hospitals gradually established separate institutions for these patients. From 1963, these institutions were renamed 'psychopaedic hospitals' and a separate training and nursing registration was established for psychopaedic

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<sup>114</sup> Roy Porter warned of potential for gross distortion by ignoring the patient's view in the history of medicine: Roy Porter, 'The Patient's View: Doing History from Below', *Theory and Society*, 14, 2, 1985, pp.175-98.

<sup>115</sup> See, for example: Davies, 'Silent and Censured Travellers'; Gittins, and, in the New Zealand context, Coleborne.

<sup>116</sup> Coleborne, p.20.

<sup>117</sup> Davies, 'Silent and Censured Travellers', p.271.

nurses.<sup>118</sup> Because these nurses were employed by the same organisation, however, their employment concerns overlapped with those of psychiatric nurses. My discussion on conditions of service and union issues relate to both groups of nurses. It is also difficult to differentiate the two types of nurses in Departmental statistics. Much of the statistical data in this study refers to the combined workforce of psychiatric and psychopaedic nurses.

The first half of this thesis (Chapters I-IV) relates to the period 1939 to 1959. During these two decades, institutional care of the mentally ill was entrenched within a centralised system of public mental hospitals. These four chapters investigate the changing, though sometimes unchanging, patterns of staffing, conditions, work and education during this period.

In Chapter I, I examine the physical and institutional environments in which mental nurses lived and worked in 1939 and in the following decade. A brief historical background contextualises these institutional settings. The physical and cultural distance between men and women is examined and two questions are raised; who were the mental nurses and attendants and why did they choose to enter the workforce?

Staffing problems are examined in Chapter II with particular reference to the effects of wartime and post-war employment patterns. Recruitment problems and employment strategies are discussed in relation to the public perception of mental hospital work. Issues of identity, gender, and stigma are explored.

During the 1940s and 1950s new physical therapies and treatment approaches were introduced in mental hospitals. Chapter III explores the relative impact these had on the role of psychiatric nurses compared with other factors. Particular attention is given to

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<sup>118</sup> For the history of intellectual disability services and policy, see: Sandy Bardsley, 'The Otekaieke Special School for Boys 1908-1950,' in *'Unfortunate Folk': Essays on Mental Health Treatment 1863 - 1992*, Barbara Brookes and Jane Thomson, eds, Dunedin, 2001, pp.123-36; Stephen Robertson, "'Production not Reproduction" The Problem of Mental Defect in New Zealand 1920-1935,' in *'Unfortunate Folk'. Essays on Mental Health Treatment 1863 -1992'*, Barbara Brookes and Jane Thomson, eds, Dunedin, 2001, pp.200-14; Philip Fleming, 'Eugenics in New Zealand 1900-1940', MA thesis, Massey University, 1981; Anne Hunt, *The Lost Years: From Levin Farm Mental Deficiency Colony to Kimberly Centre*, Levin, 2000; Mangere Hospital and Training School Jubilee Organising Team, *Mangere Hospital and Training School Twenty-five years, 1963-1988*, Auckland, 1988; B. Shepherd, *Fifty Years of Templeton Hospital and Training School 1929 - 1979*, Christchurch, 1979; Margaret Tennant, 'Disability in New Zealand: An Historical Survey', *New Zealand Journal of Disability Studies*, 2, 1996, pp.3-33.

investigating the effect of hospital conditions. Overcrowding, understaffing, and lack of resources all contributed to shaping the nature of nurses' work.

Chapter IV deals with the significant changes that occurred within psychiatric nursing education and registration in the two decades prior to 1960. These changes brought mental hospital nurses into closer contact with the broader nursing profession. In the process, significant cultural differences between the two groups were highlighted.

The second half of this thesis covers the period 1960 to 1972. During this time, substantial changes occurred in mental hospital services and in the nursing profession. Mental health policy shifted from care and containment to treatment and rehabilitation, and there were moves to bring mental hospitals into closer relationship with other health services. At the same time, there was a movement for reform in the nursing profession that was based on a belief in the unitary nature of nursing and in the need to include psychiatric skills in undergraduate nursing programmes. Changes in the mental hospital workforce were affected by both these movements.

Chapter V examines the cultural shifts that occurred within the psychiatric nursing workforce between 1960 and 1972. Staffing patterns changed and long-established structures, such as separation of the sexes broke down. Despite the changes and the contested identity of psychiatric nurses, they continued to occupy a place on the fringes of society.

The somewhat tortuous movement from custodial to 'therapeutic' nursing is addressed in Chapter VI. During the 1960s and early 1970s, the concept of 'therapeutic relationship' became a core principle of psychiatric nursing care in theory, if not in practice. Changes to practice are explored and, as in the earlier period, the influence of hospital conditions and economic factors are investigated.

Chapter VII addresses the conflicting agendas surrounding nursing education between 1960 and 1972. Calls for reform of basic general nursing education at times conflicted with the culture and identity of psychiatric nursing. Values associated with class and gender underpinned this conflict.

The final chapter (Chapter VIII) investigates psychiatric nurses' industrial unrest that escalated during the 1960s and culminating in strike action in 1971. Trade unionism



was central to the life and culture of psychiatric nurses throughout the 33 years covered in this thesis. This chapter highlights the working-class values that underpinned many of the nurses' collective actions and often brought them into conflict with the broader nursing profession.

This thesis contributes to a relatively new body of literature on psychiatric nursing as a gendered occupation.<sup>119</sup> In doing so, it adds a new perspective on the debates concerning the place of men in nursing. An underlying assumption is that men are central rather than peripheral in the story of psychiatric nursing. By focusing on the nurses as workers, rather than as burgeoning professionals, my thesis contributes an analysis not hampered by the assumption of psychiatric nursing as a subset of the nursing profession. In this respect, it builds on Lee-Anne Monk's study of attendants as workers in Victoria, Australia in the nineteenth century.<sup>120</sup> With its focus on the mid-twentieth century, this thesis contributes to a relatively unexplored period of psychiatric nursing history.

My thesis fills a gap in New Zealand nursing historiography. There is very little written about the history of psychiatric/mental health nursing. To date, the attendants or nurses have been included only as an aspect of institutional histories of mental hospitals and mental health services. There are also few historical works on mid- to late twentieth century nursing in New Zealand. Those that address general trends such as the transfer of nursing education have largely omitted psychiatric nursing perspectives. By accepting that nursing is not and cannot be 'a reality to be studied', I have been free to explore the socially constructed meanings attributed to the culture and identity of this occupational group of people variously called 'mental attendants', 'mental nurses', and 'psychiatric nurses'. This approach has not been applied previously to nursing history in New Zealand.

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<sup>119</sup> See for example: Boschma, *The Rise of Mental Nursing*; Boschma, Yonge, and Mychajlunow, 'Gender and Professional Identity'; Dooley; Monk.

<sup>120</sup> Monk.

# Chapter I

## Setting the Scene: background, context and culture 1876 -1940s

Prior to the 1900s, the public asylums where those in New Zealand society deemed to be insane were housed were primarily run by male and female attendants. By the period under review 1939 to 1972, changes had taken place that laid the foundations for transforming asylums into hospitals and attendants into nurses. These changes had been instigated by asylum administrators who were influenced by asylum reforms in the United Kingdom. Practical constraints, ideological influences, and lack of efficacious treatments, however, had prevented comprehensive implementation of reform. This chapter provides an historical background to New Zealand public mental hospital system. It also describes the institutional context in which the attendants and nurses lived and worked between 1939 and 1949. The collective culture and sub-cultures of the mental attendant/nurse workforce in that period is also explored.

### **Public mental hospitals – historical background**

Establishment of the Lunacy Department in 1876 marked the beginning of a centrally administered system of mental hospital care in New Zealand that lasted for almost a century. Made possible by the abolition of provincial governments, the change from provincial asylums to central government administration was driven by a desire to raise the standard of asylum conditions by introducing medical control and national standardisation. This signalled the end of lay administration of mental health. A medical officer was appointed as Inspector-General of Mental Hospitals and medical superintendents were put in control of individual asylums.<sup>1</sup>

The Lunacy Department took over the administration of eight provincial asylums, most of which were situated within the boundaries of cities or towns. Over the next few decades, two of the smallest asylums were closed, others were extended and two of the urban institutions were rebuilt outside the city limits. New asylums were also

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<sup>1</sup> Prior to 1876, most Provincial asylums were administered by lay superintendents. Medical officers had replaced most lay administrators by 1900. Seaview Hospital was the last to gain a medical superintendent in 1921: Matthew Philp, 'Scientific Pastors. The Professionalisation of Psychiatry in New Zealand 1877-1920,' in '*Unfortunate Folk': Essays on Mental Health Treatment 1863 -1992*, Barbara Brookes and Jane Thomson, eds, Dunedin, 2001, p.188; Brunton, *Sitivation 125*, pp.32-3.

established in rural settings. Location of asylums in rural areas represented a new policy founded on the dual objectives of retreat from exposure to negative public opinion and creation of an environment that could have both therapeutic and economic value.<sup>2</sup> Each asylum was surrounded by a farm which provided a workplace for patients and enabled the institution to be largely self-sufficient in terms of food supply.

Hospital administrators were doctors who had experience in British asylums. The system they established in New Zealand was very similar to the one they knew well.<sup>3</sup> The asylums provided a structured, largely closed environment. Patients and staff were physically and administratively separated into male and female 'sides' of the hospitals. Although medical superintendents espoused biomedical approaches, in the absence of any effective treatments they relied on environmental strategies for patient care. These included classification and separation of different types of patients, the creation of smaller communities (villas) within their institutions, and the establishment of structure in the patients' everyday lives. 'Our main resources, wrote Theodore Gray, the Director-General of Mental Hospitals from 1927 to 1947, 'are to be found in providing the elementary requirements, namely 'fresh air, sunshine, hydrotherapy in its broadest sense, suitable diet, exercise, recreation, rest, sleep...'<sup>4</sup>

At the beginning of the twentieth century, efforts were made to transform the Department's asylums into hospitals in order to create a more positive image of them in the public's mind.<sup>5</sup> Under the *Mental Defectives Act 1911*, language such as 'mental hospital', 'inmate' and 'nurse' officially replaced 'asylum', 'lunatic' and 'female attendant'. The Act also included a provision for voluntary admissions.<sup>6</sup> The Department's hope was that people with 'recoverable' mental illness would seek early treatment. Although voluntary admissions did gradually increase over the next two decades, they remained a small proportion of the total resident patient population.<sup>7</sup> The

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<sup>2</sup> Warwick Brunton, 'Out of the Shadows: Some Historical Underpinnings of Mental Health Policy', in *Past Judgement: Social Policy in New Zealand History*, Bronwyn Dalley and Margaret Tennant, eds, Dunedin, 2004, p.79.

<sup>3</sup> For a discussion of the influence of British psychiatry in the late nineteenth and early twentieth centuries, see: Philp.

<sup>4</sup> Director-General to Minister, 17 October 1929, HMH 8/1041, cited in: Brunton, 'A Choice of Difficulties', p.369.

<sup>5</sup> The asylums were called 'hospitals' from 1905.

<sup>6</sup> *New Zealand Parliamentary Debates* (NZPD), 1911, 154, p.187.

<sup>7</sup> Voluntary admissions rose from 23 p.a. in 1912 to 234 p.a. in 1939: *Appendices to the Journals of the House of Representatives* (AJHR), 1940, H-7, p.2. Voluntary boarders only comprised 4.2% of the resident patient population in 1939: AJHR, 1940, H-7, p.1.

major influences on hospital conditions were the growing number of patients, shortages of staff, and lack of resources. Between 1876 and 1939, the number of people resident in mental institutions rose from 736 to 7,797.<sup>8</sup> Building programmes could not keep up with the growth with the result that overcrowding was an ever-present problem.<sup>9</sup>

Creating a skilled, disciplined workforce was considered a vital step in institutional reform. Male and female attendants were the mainstay of the asylum/hospital workforce. Lists of rules were developed at individual asylums and in 1901 were collated into a national rulebook.<sup>10</sup> Influenced by developments in asylum-management in Britain, administrators moved towards a policy of transforming the attendant workforce into one that more closely resembled general hospital nursing, that is, female and trained. During the 1890s, general hospital trained nurses were appointed as matrons of two of the largest asylums and soon after, a policy was adopted of appointing female nurses in charge of some of the male wards.<sup>11</sup>

Training was gradually introduced for attendants. By the early 1890s, several medical superintendents had instituted staff training in their asylums.<sup>12</sup> Grace Neill, who was appointed as Assistant-Inspector in the Department of Hospitals, Asylums, and Charitable Institutions in 1895, was given responsibility for improving asylum training. She distributed copies of the Handbook for Instruction of Attendants on the Insane, a text produced by the Medico-Psychological Association of Great Britain and Ireland (MPA). Medical officers were instructed to base their training on the text and to hold examinations.<sup>13</sup> In 1904, in a system very similar to that provided in British asylums, the Department established a formalised, national training.<sup>14</sup> Attendants and nurses (as the women were now called) were entitled to register as mental nurses after three years' employment, attendance at lectures and successful completion of written, oral and practical examinations.<sup>15</sup> The first mental nurses registered in 1908.<sup>16</sup>

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<sup>8</sup> AJHR, 1939, H-7, pp.18-9.

<sup>9</sup> Brunton, 'A Choice of Difficulties', pp.237-40.

<sup>10</sup> *ibid.*, p.327.

<sup>11</sup> AJHR, 1892, H-4, p.2. *ibid.*, p.337.

<sup>12</sup> AJHR, 1891, H-2, p.3.

<sup>13</sup> Brunton, 'A Choice of Difficulties', p.335.

<sup>14</sup> AJHR, 1904, H-7, p.3.

<sup>15</sup> Although the term 'mental nurses' was officially applied to those who had registered, the men continued to be called attendants' even after success in examinations: AJHR, 1907, H-7, p.16.

<sup>16</sup> Seventy-nine men and women sat the exams at the end of 1907, 57 passed and gained registration as Mental Nurses: AJHR, 1908, H-7, p.6.

Mental attendants and nurses, although receiving training within the Department, were not given the opportunity to participate in developments within the wider nursing profession. They were not included in the provisions of state registration introduced for general nurses in 1901. Despite lobbying from Departmental administrators, trained, female mental nurses were also not given any concession towards general training and registration. Dr Frank Hay, the Inspector-General from 1907, believed that 'Every nurse passing through the general hospital will raise the status of the profession of mental nurses, and help to place it where it should be'.<sup>17</sup> His efforts to achieve recognition of the mental nursing qualification, however, were resisted by general nursing leaders who were concerned about the possible impact on their negotiations with Britain over reciprocity of state nursing registration.<sup>18</sup>

Medical administrators' hopes of creating a compliant, female nursing workforce were undermined by the presence of large numbers of working-class men and by their association with trade unionism. During the first decades of the Department's existence, male workers comprised approximately two thirds of the workforce.<sup>19</sup> Although the proportion of women increased after the turn of the century, men continued to be easier to recruit and to retain in the workforce. The presence of working-class men had a profound affect on the workforce culture. Trade union affiliation was one such affect. In 1913, mental hospital workers' links with the union movement were consolidated with the establishment of the Public Service Association (PSA). The union was formed a year after the *Public Service Act 1912* which had created a unified career structure and processes of appeal against dismissal for public servants. Although the PSA was not particularly militant, unionisation gave attendants and nurses the power to resist the ultimate authority of medical superintendents and set the workers apart from general nurses whose leaders were strongly anti-union.

Recruitment and retention of mental hospital attendants and nurses was an ongoing problem. Although numbers quadrupled between 1905 and 1939, staff turnover was high.<sup>20</sup> Shortages were particularly acute during the First World War.<sup>21</sup> The only time

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<sup>17</sup> AJHR, 1907, H-7, p.16.

<sup>18</sup> AJHR, 1909, H-22, p.9.

<sup>19</sup> Brunton, 'A Choice of Difficulties', p.306.

<sup>20</sup> Between 1876 and 1905, numbers of male and female attendants rose from 76 to 356: *ibid.* By 1939, there were 1,210 attendants and nurses: *New Zealand Public Service List, 1939.*

<sup>21</sup> AJHR, 1917, H-7, p.4.

the mental hospitals were fully-staffed was during the 1930s economic depression, but this luxury was short-lived.

### **Public mental hospitals 1939-1949**

In 1939, almost all mental nurses in New Zealand were employed in public mental hospitals.<sup>22</sup> A few nurses also worked at Ashburn Hall, New Zealand's only private mental hospital, located in Dunedin. Very small numbers of mental nurses were also employed alongside general nurses at Queen Mary Hospital (QMH) at Hanmer Springs. QMH, which had opened during World War One to treat returned servicemen suffering from shell-shock, was now administered by the Department of Health and treated patients suffering from a range of neurotic disorders and alcoholism.

Mental hospitals were administered centrally by the Department of Mental Hospitals. This was a different administrative arrangement to that of the general hospitals which were administered by local hospital boards. The Department was also distinct from the Department of Health that was responsible for all areas of health other than mental health. The Department of Mental Health administered eight institutions, each housing between approximately 450 to 1,400 patients.<sup>23</sup> Most public mental hospitals catered both for people with mental illness and people with intellectually disability, but there was a growing trend to separate the latter group into their own 'mental deficiency colonies'.<sup>24</sup>

By the 1930s, more than 80% the mental hospital staff members were attendants and nurses. In 1939, the Department employed 627 attendants and 583 nurses.<sup>25</sup> Other hospital employees included 26 medical officers, one dentist and 39 clerical workers. Another 176 people were employed for manual work such as farming, gardening, carpentry, cooking, laundry and cleaning (see Figure 2). The limited number of clinical

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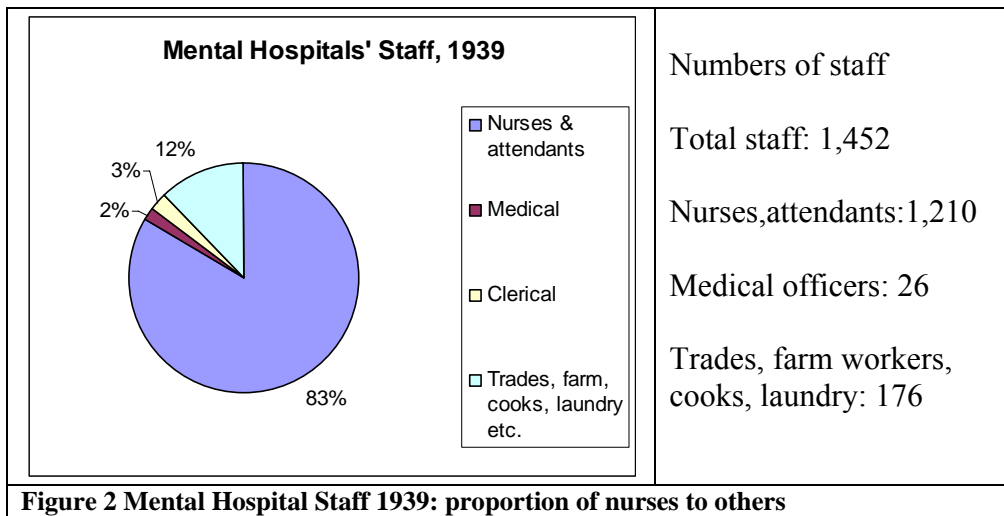
<sup>22</sup> The names for nurses in mental hospitals changed during the period studied. In 1939, the men were called 'mental attendants' and the women, 'mental nurses'.

<sup>23</sup> Four hospitals accommodated over 1,000 patients each: AJHR, 1940, H-7, pp.4-9.

<sup>24</sup> Terminology in the area of mental illness and mental disability changed frequently during the twentieth century usually because terms become associated with negative and stigmatising beliefs and attitudes. Where it is necessary for historical accuracy, I have used the terminology that was current at the period under discussion. In more general writing, I have chosen to use terminology that is currently accepted as non-discriminatory. I recognise that this language too, may be challenged within the next few years.

<sup>25</sup> New Zealand Public Service List, 1939.

and manual workers meant that hospitals relied heavily on the attendants and nurses; they provided all the nursing care and much of the domestic and outdoor work.



**Location**

Most of the Department’s hospitals were located in rural areas. The original asylums (now called hospitals), such as Auckland Mental Hospital, Sunnyside Hospital (in Christchurch) and Nelson Mental Hospital, had been built on the edges of urban centres, but the ‘second and third generation’ mental hospitals were situated in the countryside.<sup>26</sup> Seacliff Hospital and Porirua Hospital, for example, were approximately one hour by car or train from Dunedin and Wellington respectively. Other hospitals were more rurally sited: Tokanui Hospital was in rural Waikato close to the village of Kihikihi; Kingseat Hospital was 12 kilometres from the South Auckland town of Papakura; Ngawhatu Hospital was located in Stoke, five kilometres away from Nelson and its parent institution, Nelson Mental Hospital. Templeton Farm Colony was at a similar distance from Sunnyside, to which it was affiliated. Although Seaview Hospital was proximal to the township of Hokitika, it was isolated from the rest of the country by virtue of Hokitika’s remoteness (see p.xiii for map).

Isolation affected the culture of mental hospital communities in numerous ways. Patients easily became isolated from families and communities and the stigma of mental illness was exacerbated the public’s lack of exposure to life in mental hospitals. Attracting staff to isolated areas was difficult, and retention rates often depended on the

<sup>26</sup> Warwick Brunton has discussed a change in mental health policy around the end of the nineteenth century. Asylums built after this were located in rural areas away from the public eye, the location providing ample agricultural land for both economic and therapeutic purposes: Brunton, 'A Choice of Difficulties', pp.240-5.

hospital's ability to provide adequate accommodation, transport and recreational facilities. On the positive side, staff communities became close knit, with most workers living either on site or close by. Despite a general fear of mental illness among the public, there was often a close relationship between a mental hospital and its local town, especially in rural areas where the hospital became a significant source of employment. It was not uncommon for several members of one family to work at the local mental hospital.

Percy Atkinson, for example, was born in Hokitika where his father was Farm Manager at Seaview Hospital. As a young man, he worked at the general store further down the West Coast at Wataroa. Late in 1933, Atkinson realised he would soon be losing his job, so phoned his father to 'see if there was any hope of me getting a job up there'. He rode his pushbike back to Hokitika and was interviewed in the street by the new medical superintendent, Dr. H. M. Buchanan. Atkinson recalled that, 'He said to my father, "He's not very big, Jim", and the Old Man said, "Well, he just biked 72 miles this morning". That was enough reassurance for Buchanan who told Atkinson's father, "He can start on January the first".<sup>27</sup> Other members of Percy's family followed him at Seaview. His eldest daughter did part of her nursing training there and his other daughters worked at the hospital in their university holidays.<sup>28</sup> Many Hokitika families have had several members over two or three generations employed at Seaview.<sup>29</sup>

### ***Hospital estates***

Each mental hospital was self sufficient and situated on a large tract of land, which allowed space for buildings, gardens, and farms. Porirua Hospital's estate of 1,139 acres, for example, provided land for a farm, an orchard, large vegetable gardens, and a water reserve as well as a substantial area for hospital buildings. The farm included a herd of cows, sheep, a piggery and a poultry farm.<sup>30</sup> Farming was an essential part of the economic life of the hospitals, which were not only largely self-sufficient in food production but also sold excess produce to the public. Surplus goods were exchanged between the Department's hospitals, Seacliff, for example, supplied eggs and fish to

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<sup>27</sup> Percy Atkinson interview 28-9 August 2004.

<sup>28</sup> Percy Atkinson's son is also registered as a psychiatric nurse: *ibid*.

<sup>29</sup> For photo of the Groufsky sisters see Brunton, *Sitivation 125*, p.117.

<sup>30</sup> Williams, pp.125-39.



Sunnyside and Seaview Hospitals.<sup>31</sup> The mental hospitals' self-sufficiency was also evident in the range of buildings on the estates. Kitchens, bakeries, laundries, sewing rooms and boot-makers provided for the patients' basic needs. Most maintenance work was undertaken in engineering, carpentry, painting and upholstery workshops.<sup>32</sup> Completing the picture of self-sufficiency, each mental hospital had its own morgue and many had a cemetery.

The farms, workshops and workrooms not only served economic and practical functions, they were a central part of the treatment regime the patients. By 1939, the main therapeutic activity for many male patients was work on the farms, in gardens, and in workshops. Women worked in the sewing rooms, kitchens and laundries. Where the patients worked, the attendants and nurses supervised.

Older mental hospitals had grown up around the original, usually imposing, main buildings (see following photo). These were double or triple-storied structures with central administration surrounded by long corridors, kitchens, dining rooms and wards with large, open dormitories. Within the hospitals they were physically divided between the two 'sides' according to sex, the male side and the female side. This separation continued a policy that had its origins in the nineteenth-century asylums and was consistent with mental asylum/hospital design in many parts of the world.<sup>33</sup> Patients, and for the most part staff, were separated into male and female 'sides'. This division applied to wards, dormitories, dayrooms, dining rooms and courtyards. In the older style hospitals, male and female wards were usually placed at either end of the main block.

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<sup>31</sup> Kath McLeod interview 1 September 2004.

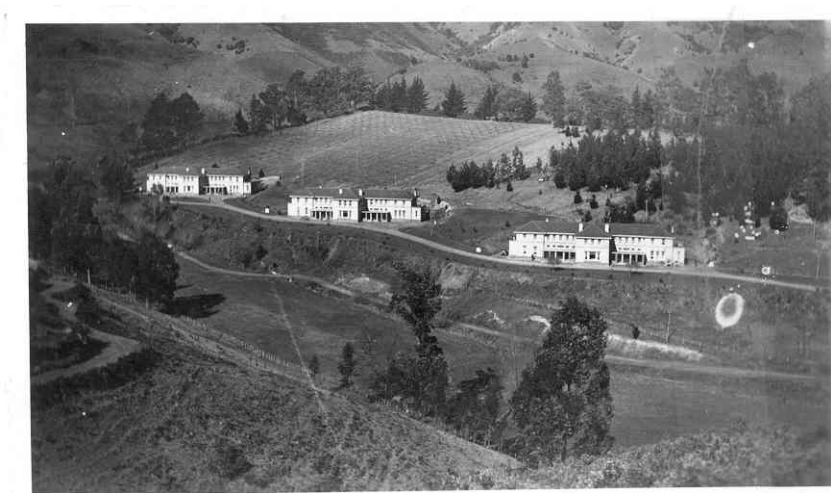
<sup>32</sup> See individual hospital reports, AJHR, 1939, H-7, pp.5-12.

<sup>33</sup> For discussion of English nineteenth-century asylum architecture, see Andrew T. Scull, *Social Order/Mental Disorder. Anglo-American Psychiatry in Historical Perspective*, London, 1989. For American asylum architecture, see Gerald Grob, *The Mad Among Us: A History of the Care of America's Mentally Ill*, New York, 1994. For an example of the effect of gender division in an English mental hospital, see Gittins, pp.98-126.



**Figure 3 Oakley Hospital main building circa 1960s**  
**Source: Personal collection**

In newer hospitals, the gender separation was sustained, or extended, in the villa design. From the early 1900s, the Department had designed all its new buildings on the ‘villa principle’ of stand-alone units housing no more than 50 patients each.<sup>34</sup> Men’s and women’s villas were usually positioned in different parts of the grounds.<sup>35</sup> The separation was most distinct at Ngawhatu, where the villas were placed in separate ‘male’ and ‘female’ valleys (see photo below). Nursing staff quarters were also segregated.



**Figure 4 Villas in Highland Valley, Ngawhatu Hospital, circa 1930.**  
**Source: Nelson-Marlborough District Health Board photograph collection.**

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<sup>34</sup> Tokanui Hospital, built in 1912, was the first institution built completely on villa lines.

<sup>35</sup> See, for example the plans of Seaview Hospital in 1928 and 1950: Brunton, *Sitivation 125*, pp.82-3.

Accommodation for single male attendants was in rooms attached to the wards or villas; some hospitals provided cottages for married attendants.<sup>36</sup> Hospitals also attempted to find space for male mess or recreation rooms.<sup>37</sup> Female nurses were, when possible, accommodated in nurses' homes, but not all mental hospitals had such facilities in 1939.<sup>38</sup> Some nurses' homes were not big enough to accommodate all female staff; the extra nurses, usually the most junior, slept in rooms attached to the women's wards. When Kath McLeod, for example, started nursing at Seacliff Hospital, she slept in an annexe off the reception ward. She recalled,

There were nine of us and we each had a room. Our lights were outside the room, and at half-past nine, when the Night Nurse came along to visit the other wards, she would turn off the lights – and that was it. Mind you, we turned them on again too!<sup>39</sup>

McLeod and the other nurses shared a bathroom that was used for newly admitted patients during the day. She remembered that 'There were three baths in the one room; three of us would go in together. We giggled and carried on – it was good fun!' The nurses at Seacliff stayed in those quarters until they commenced their first period of night duty, at which time, they moved into the nurses' home.<sup>40</sup>

Patient accommodation was very crowded and many older buildings were in need of repair or replacement. At Seacliff Hospital, for example, land slippage over many years had caused cracks in walls and other structural problems, and at Nelson Mental Hospital, the original wooden building was over 60 years old and well beyond its useful life.<sup>41</sup> Overcrowding had been exacerbated by the Government's financial restrictions during the economic depression of the early 1930s. Although the situation had improved a little by the late 1930s, Theodore Gray, the Director-General of the Department of Mental Hospitals, predicted that an extensive building programme would be needed to bring the hospitals up to international standards. Not only were new wards required, but

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<sup>36</sup> Medical officers were normally provided with housing, but this was less common for attendants. Nurses were not expected to need housing away from the hospital since it was assumed that they did not need to provide for their families.

<sup>37</sup> AJHR, 1938, H-7, p.8.

<sup>38</sup> In 1939, Seaview Hospital did not have a nurses' home: AJHR, 1939, H-7, p.4. That year, the home at Ngawhatu was completed and one at Kingseat was under construction. Additions were also made to the nurses home at Auckland Mental Hospital: AJHR, 1939, H-7, p.4 and AJHR, 1940, H-7, p.2.

<sup>39</sup> Kath McLeod interview 1 September 2004.

<sup>40</sup> *ibid.*

<sup>41</sup> AJHR, 1936, H-7, p.3.

also other facilities, such as store rooms, kitchens, staff accommodation and recreation halls.<sup>42</sup>

### ***Administration and staffing structure***

Despite rhetoric about the need for closer ties with general medicine, mental hospital administrators had jealously guarded their Department's autonomy. When Gray took charge in 1927, he assumed the title of 'Director-General' asserting that this role was on a par with that of the Director-General of Health.<sup>43</sup> Centralised administration created a considerable degree of uniformity in all areas of mental hospital life. Rules of conduct, salaries, patient policies and ordering of stores were all controlled centrally. The Department's rulebook, issued to all attendants and nurses, outlined expectations for behaviour including: courteous relationships with other staff and patients; details on procedures for both routine nursing care and emergencies; responsibilities to attend training; and proper behaviour within staff accommodation.<sup>44</sup> Circumstances not covered in the lists of rules were addressed by reference to the authority vested in the medical superintendents. The rulebook stipulated that the proper channel of communication for staff was through the medical superintendent, who could make rules to meet local circumstances. Staff members were reminded that 'implicit obedience must be given to all regulations set out in this handbook, as well as to the local rules of each hospital'.<sup>45</sup>

Medical superintendents carried considerable authority within their own hospitals. They were supported by a chief clerk, a head attendant and a matron, and made decisions on a surprising range of issues from farm supplies to overnight leave for nurses and attendants. Depending on the size of the hospital, there were also deputy head attendants and deputy matrons. The personnel structure mirrored the physical gender divisions (see Table 1). Although by 1939 some nurses were working on the male side of hospitals, the lines of reporting remained strictly gender-specific. The head attendant controlled the male side and the matron was in charge of the female side. Junior attendants reported through 'senior' and 'charge attendants' to the head attendant. Junior nurses reported through 'senior' and 'charge nurses' to the matron. Matrons interviewed

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<sup>42</sup> AJHR, 1937, H-7, pp.1-2.

<sup>43</sup> Derek Dow, *Safeguarding the Public Health: A History of the New Zealand Department of Health*, Wellington, 1995.

<sup>44</sup> Mental Hospitals Department, *Mental Hospitals: Rules for Staff*, Wellington, 1940, p.7.

<sup>45</sup> *ibid.*

female applicants, allocated nurses to wards, set standards for nursing care, controlled the nurses' home, and disciplined nurses who infringed the Department's rules. Head attendants had similar authority and responsibilities over the attendants.

Mental Hospital Staff Structure, 1939	
Medical superintendent - Senior assistant medical officer                      Chief clerk - Assistant medical officer	
Male Side	Female Side
Head attendant	Matron
Deputy head attendant/s	Assistant matron/s
	Tutor sister/s
Charge attendants (in charge of a ward)	Charge nurses (in charge of a ward)
Deputy charge attendants	Deputy charge nurses
Senior attendants	Senior nurses
Attendants (unqualified)	Nurses (unqualified)
Other hospital staff including: farm manager, farm workers, tradesmen, domestics, laundresses, cooks, and clerical staff.	

**Table 1 Mental hospital staffing structure, 1939.**

There were, however, some critical differences in the roles of head attendant and matron. These reflected the Department's beliefs about the proper place of men and women in a hospital environment. The matron, who was expected to hold qualifications in both general and psychiatric nursing, was responsible for the physical nursing aspects of the hospital. She was in charge of the dispensary and for nursing care in both the male and female infirmaries. Under the medical superintendent, the matron also took responsibility for the nurses' and attendants' training, particularly if there was no tutor sister. In contrast, the head attendant had a general responsibility for the hospital environment and the outdoor activities of both male patients and attendants. He managed the work gangs, ensured the boilers were stoked each night and provided male staff for chopping wood or digging graves. The hall porter and night watchman, amongst many others, were under his authority. Medical superintendents relied on their head attendant for the smooth running of the institutional plant, while the matron took

care of ‘womanly’ concerns such as care of the sick, teaching, food preparation and moral guidance for young nurses. The head attendant position was seen as vital to the smooth running of the hospital. In 1945, the Public Service Association (PSA) argued that the head attendant ‘is actually the right-hand man to the Superintendent and is responsible for keeping the administration of the hospital moving’.<sup>46</sup>

### ***Employment conditions***

Mental nurses and attendants were public servants; their conditions of employment were set by the Public Service Commission (PSC) in consultation with the Director-General of the Department of Mental Hospitals. Under the *Public Service Act 1912*, salary scales were established for employees in four broad divisions; ‘Administration’, ‘Professional’, ‘Clerical’ and ‘General’.<sup>47</sup> A classification list (also known as the New Zealand Public Service List) of each Division’s employees was published annually with everybody’s names, length of service and salary. Attendants and nurses were classified under the General Division, along with all other mental hospital staff except medical personnel who were in the Professional Division and clerical staff, who were in the Clerical Division.

Working hours had been the most significant industrial issue in the years just prior to the Second World War. Under the Labour government, which came into office in 1935, a forty hour/five day week had been introduced for most state employees. This standard had not seemed possible for mental hospital workers, since it would have required considerably more staff and accommodation. In response to pressure for reform however, in 1936 Gray had established a committee with PSA representation, to review working hours.<sup>48</sup> A new roster was approved, based on a 42-hour week with staff receiving time off or extra pay for longer hours.<sup>49</sup> The three-day cycle roster consisted of one long day of 13 hours, one short day of ten and a quarter hours, then one day off.<sup>50</sup>

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<sup>46</sup> Public Service Association Claim for Attendant Staff and Hall Porters, 14 May 1945, p.2, H, 1, 31097, ANZ, Wellington.

<sup>47</sup> Alan Henderson, *The Quest for Efficiency: the Origins of the State Services Commission*, Wellington, 1990, p.66.

<sup>48</sup> AJHR, 1936, H-7, p.4.

<sup>49</sup> Roth, p.94.

<sup>50</sup> Times for the short day are reported differently in various sources. All sources agree that the shifts started at 7am. One gives the finishing time as 5pm. See: KT, 36, 3, 1943, p.56. Slightly different total hours per shift are cited in: Brunton, 'A Choice of Difficulties', p.348. In the late 1950s, Isla Frew noted that the nurses worked 45 hours per week on the 3 day on/one day off roster: Isla Frew, 'Psychiatric

Night shifts started at 7.45pm and finished at 7am (see Appendix F). Nurses and attendants were entitled to one month's leave after every five months. To facilitate the change, the Public Service Commission had authorised 270 new nursing and attendant positions.<sup>51</sup> Shortages of female nurses, however, remained a problem, and the women continued to work long hours, though now they were paid for the overtime they worked.

Salaries for male attendants were considerably higher than those for nurses. This was consistent with contemporary cultural and political ideology, which assumed that men were the family breadwinners and that women's primary function was as wife and mother. The concept of a man's right to a 'fair and reasonable' wage to support his family had, for many years, underpinned decisions of the Arbitration Court, a state institution that provided compulsory arbitration between employers and workers. From 1936, the court was required to fix a 'family wage', sufficient for a man to support a wife and three children. This criterion continued to be used by the Court to set basic salaries until 1951.<sup>52</sup> In New Zealand and Australia, the 'family wage' became a central plank in both industrial relations and welfare policy.<sup>53</sup> The New Zealand Labour Government's social welfare legislation of the 1930s and 1940s was built around the premise of supporting the family structure with the father as wage-earner.

Although the arbitration system was responsible for instituting gender pay differentials, there was a general societal concurrence from both men and women for the concept of the male breadwinner. Before the Second World War, few women questioned their lower wages or temporary employment. Deborah Montgomerie has argued that even during the war, most women perceived their work as contributing to the war effort and therefore did not demand equal pay with men.<sup>54</sup>

Male attendants' salaries were set in relativity to prison warders. Attendants started at £245 per annum, less £16 for meals while on duty if living out. Their salary increased to £255 after one year. After three years and successful completion of the Senior

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Nursing: A study of Psychiatric Nursing at Seacliff Mental Hospital', Preventative Medicine dissertation, University of Otago, 1958, pp. 10-1.

<sup>51</sup> AJHR, 1937, H-7, p.3.

<sup>52</sup> Melanie Nolan, *Breadwinning: New Zealand Women and the State*, Christchurch, 2000, p.163.

<sup>53</sup> Donald Denoon, Philippa Mein Smith, and Marivic Wyndham, *A History of Australia, New Zealand and the Pacific*, Oxford, 2000, pp.237-40.

<sup>54</sup> Deborah Montgomerie, *The Women's War: New Zealand Women 1939-45*, Auckland, 2001, pp.78-80.

Examination, the rate went up to £265.<sup>55</sup> Junior attendants' salaries were a little higher than the outdoor workers in the mental hospitals, but lower than the tradesmen. The starting rates were equivalent to other non-skilled workers in the Public Service.<sup>56</sup> Other public servants on equivalent salaries included second-grade gardeners at Queen Elizabeth Hospital in Rotorua or a chauffeur in the Department of Internal Affairs in Wellington. Head attendants were paid at similar levels to chief gaol warders.<sup>57</sup> For a salary breakdown refer to Table 2.

Female staff	Salary	Male staff	Salary
Matron (Class A)	£360-405	Head attend (Class A)	£410-420
Matron (Class B)	£315-345	Head attend (Class B)	£390-400
Matron (Class C)	£285-300	Head attend (Class C)	£370-380
Tutor sister	£245-260	NA	-
Charge nurse	£200-220	Charge attendant	£295-310
Deputy charge ns	£180	NA	-
Senior nurse	£170	Senior attendant	£265-275
Nurse (3 <sup>rd</sup> year)	£150	Attendant (3 <sup>rd</sup> year)	-
Nurse (2 <sup>nd</sup> year)	£140	Attendant (2 <sup>nd</sup> year)	£255
Nurse (1 <sup>st</sup> year)	£130	Attendant (1 <sup>st</sup> year)	£245

**Table 2 Salaries of mental hospital nurses and attendants for year ending 31 March 1940. Source: Supplement to the New Zealand Gazette, 19 October 1939, p. 211.**

Although the nurses earned less than their male colleagues, their salaries, particularly at the less skilled levels, were considerably higher than nurses in general hospitals. In 1940, the starting salary for junior mental nurses was £130 per annum less £25 for board. This increased to £140 after one year, then £150 after two years. Pupil (student) nurses in general hospitals commenced at between £30-50 per annum. This rose to £65-95 per annum in the fourth year (refer to Table 3 for a comparison of mental and general hospital salaries).<sup>58</sup> The low salaries awarded to general nurses reflect assumptions their employers made about their status and motivation. It was assumed that women would consider it a privilege to have the opportunity to train as a nurse; the salary provided during their training years was considered to be a generous allowance provided over and

<sup>55</sup> New Zealand Public Service List, 31 October, 1939

<sup>56</sup> For example, postmen, cleaners and storemen in the Post and Telegraph Department were all paid £250p.a: New Zealand Gazette, 1939, vol. 2, pp.1,271-1,434.

<sup>57</sup> New Zealand Public Service List, 31 October, 1939,

<sup>58</sup> Vocational Guidance booklet, circa 1941, H-MHD-1, 8/116/0, ANZ, Wellington.



above the free accommodation and education.<sup>59</sup> No such privilege was assumed for junior mental nurses; they were rarely, if ever, referred to as ‘pupils’. The overriding driver of mental nurses’ salaries was the need to recruit female workers to a socially unacceptable occupation.

	Mental Hospital (1940)	General Hospitals (1941)
Matrons	£285 –£405	£200-500
Charge nurses (sisters)	£200 – £220	£120-200
Staff nurses	£170	£95 – 125
Pupil (4th year)	-	£65-95
Pupil (3rd year)	£150	£45 –85
Pupil (2 <sup>nd</sup> year)	£140	£35 –75
Pupil (1st year)	£130	£30 –50 pa

**Table 3 Comparison between salaries of mental and general hospital nurses, 1940-1.**

**Sources:** Supplement to the New Zealand Gazette, October 19, 1939, p. 211; H-MHD-1, 8/116/0, ANZ, Wellington.

Note: Rates for nurses in general hospitals represent a range published in a Vocational Guidance booklet in 1941.

### **Culture of attendants and nurses**

The collective culture/s of mental hospital attendants and nurses was shaped by numerous factors: individual’s socio-economic backgrounds; reasons for applying for work; the geographical isolation of the hospitals; and the Department’s structures, rules and expectations. The separation of men and women created two unique subcultures within the hospital community. Varied employment patterns between attendants and nurses and gendered expectations of behaviour created distinct communities on the male and female sides. Working-class values underpinned both sub-cultures. Trade unionism was particularly important, however, on the male side.

### ***Who were the attendants and nurses?***

Attendants and mental nurses were largely drawn from working-class backgrounds. Most people applied to work at mental hospitals for reasons of economic or social convenience rather than from a sense of duty or professional aspiration. There did appear to be some differences, however, in the motivations of men and women.<sup>60</sup> The men, for example, were attracted mainly by the salaries, job security and

<sup>59</sup> Salaries for general nurses were pegged down by a number of factors including hospital boards’ frugality and the attitude of nursing leaders to nursing as a vocation: Dunsford, p.181.

<sup>60</sup> Evidence derived from the oral history informants, and from responses to advertising campaigns of the 1940s and 1950s.

accommodation.<sup>61</sup> A sizable number of men had commenced work as attendants during the depression of the 1930s, for financial reasons. Donald Graham, for example, left a job on a farm to earn twice as much at Tokanui. His decision was based ‘purely on economics’; he was not interested in mental nursing. He reflected ‘Nobody would be, not with the conditions that existed in those times’.<sup>62</sup> Some men were recruited specifically for their sporting skills.<sup>63</sup> Most hospitals had football and cricket teams, some of which were very successful in local and regional tournaments.<sup>64</sup> James Nolan, who also commenced during the depression, had previously worked in various jobs including fruit-picking and in an upholstery factory. His keenness on outdoor work and sports led him to work at Sunnyside Hospital. James had played for the hospital rugby team before, so when the medical superintendent offered him a job, he was not sure if it was primarily for his potential contribution on the sports field or for his work as an attendant.<sup>65</sup> Many of the ‘depression recruits’ made a career out of mental nursing and had a significant influence on the attendant/male nursing workforce for many years. Figure 5 shows three male attendants in typical dress of the time.



**Figure 5 Seaview Attendants Bill Johnson, Bill Flemming, Jack Strange, circa 1940s.  
Source: Seaview Hospital collection, Hokitika Museum.**

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<sup>61</sup> All the men interviewed for my own research, who were employed during the 1940s & 50s, cited money and accommodation as the main motivators for applying to work at mental hospitals. This is also true of the men who were interviewed for the NERF-OHP and NERF-PNOHP collections.

<sup>62</sup> Donald Graham interviewed by Lois Wilson, 15 December 1983, OHInt-0014/061, NERF-OHP.

<sup>63</sup> The emphasis on sporting skills as criteria for recruitment of male nurses was common in British mental hospitals at the same period: Gittins, pp.173-7.

<sup>64</sup> See Wendy Hunter Williams for an account of the prominence of sports at Porirua Hospital: Williams, pp.141-52.

<sup>65</sup> James Joffre Beatty Nolan interviewed by Lois Wilson, 3 November 1983, OHInt-0014/124, NERF-OHP.

While money and accommodation were also important for the women, their motivations for starting mental nursing were somewhat more complex. This was not a mainstream career choice for young women. Those who chose mental nursing seemed to fall into three broad categories. Some lived close to mental hospitals and had family members in the industry; for them, it was a logical and convenient choice. A second group of women chose the occupation because it offered a reasonably good salary and/or accommodation. Rita McEwan, who later became a professional leader in psychiatric nursing, began her career because of economic necessity. In 1939, McEwan, who at that time had little money and was living with her brother in Christchurch, moved to Nelson in search of work. While waiting for the fruit-picking season, it was suggested that she seek temporary employment at the local mental hospital. She applied at Nelson Mental Hospital on Friday, and commenced work the next Monday morning. What started as a temporary job at a relatively good salary became a career that lasted over 40 years.<sup>66</sup> Other women talked of being curious about mental nursing; they made a deliberate choice to resist societal and family expectations about ‘proper’ work for women. When Betty Dracevich chose to apply to Avondale Hospital in 1949, she was rejecting the more obvious and more respectable choice of the local general hospital. Her father was horrified, but she went nevertheless.<sup>67</sup> Figure 6 illustrates nurses’ uniforms and the sense of camaraderie talked about by many informants in this study.



**Figure 6 Mental nurses, Seaview Hospital circa 1940s.  
Source: Seaview Hospital photograph collection, Hokitika Museum**

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<sup>66</sup> Rita McEwan interviewed by Judy Heffer, 30 September 1988, OHInt-0139/2, NERF-PNOHP.

<sup>67</sup> Betty Dracevich interview 30 August 2003.

### *Male and female sides: cultural differences*

Although staffing structures on the male and females sides were officially the same, as already intimated, there were significant differences in the culture and relationships. These differences although largely related to gender, were also influenced by age. There was, for example, considerable disparity between the average age and length of employment of the attendants and nurses. All employees started as junior attendants or junior nurses. Promotion to senior nurse or attendant depended on remaining in the job for three years and achievement in both the Junior and Senior Examinations. Promotion to the higher positions of charge or deputy-charge was largely based on seniority of applicants for vacancies. These were advertised nationally in the Public Service Gazette. Because of turnover of staff on the female sides, the women could gain promotion very quickly. Officially they had to wait six months after qualifying, but in reality, many nurses ‘acted up’ as charge nurses before that.<sup>68</sup> Men usually waited many years before achieving even a deputy-charge attendant position.<sup>69</sup>

Female nursing recruits tended to be young women, many of whom stayed for a very short time. The minimum age for women was 19 years but in some circumstances, 18-year old women were employed.<sup>70</sup> The nurses’ dates of birth were not recorded in the New Zealand Public Service List, but officials reported that a high proportion were under 22 years when they started.<sup>71</sup> Because of the turnover rate, only 34.6% of nurses were above Junior Grade (see Appendix P). This resulted in a workforce on the female side comprised of a large group of young women with little experience of working life, let alone mental hospital work. There were very few experienced nurses to carry the responsibilities of the day to day work. In 1939 there were only 8 female nurses in the Senior Grade in the whole country.<sup>72</sup> The ‘experience gap’ between charge nurses and junior nurses created an environment in which direction and supervision were the order of the day. Even though many of the charge nurses were not very old themselves, they must have seemed figures of imposing authority to the relatively young juniors.

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<sup>68</sup> The PSA claimed that women could achieve deputy charge nurse within five years of commencing work: Statement of Claims for Female Nursing Staff, 14 May 1945, H, 1, 31097, ANZ, Wellington.

<sup>69</sup> On average, men achieved promotion to deputy charge attendant in 12-15 years: PSA Claim for Attendant Staff and Hall Porters, 14 May 1945, H, 1, 31097, ANZ, Wellington

<sup>70</sup> Draft advertisements for staff, November, 1940, H-MHD-1, 8/116/0, ANZ, Wellington.

<sup>71</sup> Theodore Gray claimed that 70% of nurses prior to the Second World War were 21 years or under: H-MHD-1, 8/110/1, ANZ, Wellington.

<sup>72</sup> New Zealand Public Service List, 1939.

The female nurses' hierarchy was quite formal. In a system that mimicked many aspects of general hospital nursing, mental nurses were expected to show deference to their seniors. Betty Dracevich who started nursing at Avondale Hospital in 1948 recalled, 'You stood with your hands behind your back and you waited till they (sisters) even (acknowledged you) – you didn't even cough to say you were there.'<sup>73</sup> Sisters ate in separate dining rooms, which were out of bounds to other nurses, even those delivering a message.<sup>74</sup> Nurses in the main dining-room were served according to their rank. Dracevich, who was the only new recruit at Avondale Hospital for six months, recalled the experience of being a junior nurse. 'When you got to the dining room, you had to wait because you were the Junior. You didn't take your meal till it was your turn and you were last - I was always last!'<sup>75</sup>

Nurses' homes were controlled by home supervisors. At some hospitals, the home supervisor was a charge nurse, but at others, the position was occupied not by a nurse, but by a woman especially employed for the role.<sup>76</sup> The home supervisor was responsible for ensuring the nurses stayed healthy, attended to their duties and were protected from harm. They also monitored adherence to the nurses' home rules. The Department's rules specified certain restrictions, for example, 'Nurses may entertain lady visitors in the public rooms of the Nurses' Homes at the times and upon occasions approved by the Medical Superintendent'.<sup>77</sup> Even with local rules, there was a high degree of similarity across the hospitals; alcohol was banned in nurses homes, visitors other than family were kept to a minimum, nurses were required to sign out and hand in their keys when leaving the grounds, and bedtimes were fixed at between 10.30pm and 11pm.<sup>78</sup> Discipline at the nurses' homes was as much about public perception as it was about control of the women. Mental hospital administrators, like their general hospital

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<sup>73</sup> Betty Dracevich interview 30 August 2003.

<sup>74</sup> Kath McLeod recalls having to wait outside and pass the note to whoever came to the door: Kath McLeod interview 1 September 2004.

<sup>75</sup> Betty Dracevich interview 30 August 2003.

<sup>76</sup> In 1939, there were formal charge nurse positions for nurses' homes at Auckland and Seacliff Mental Hospitals. Other hospitals do not appear to have had a charge nurse permanently appointed to the role. By 1959, most of the home supervisor positions were part of the domestic staff: New Zealand Public Service List, 19 October 1939, Vol. 3,

<sup>77</sup> Psychiatric Hospitals Rules for Staff, draft copy 1939, H, 1/28739, ANZ, Wellington.

<sup>78</sup> Summary of rules at individual mental hospitals, 6 June 1939, H,1, 28739, ANZ, Wellington.

equivalents, were keen to demonstrate to parents that nurses' homes were safe places for their daughters.<sup>79</sup>

Kath McLeod described her experience on night duty at Seacliff Hospital Nurses Home:

My room was next to [the] big nurses' lounge.... You can just imagine a lot of girls having a lot of fun – playing the piano - it was hard to sleep. It was no use complaining. You had to be in bed by eight-thirty in the morning and you weren't allowed out until three-thirty in the afternoon.<sup>80</sup>

Although the rules were strict, nurses found ways to by-pass them. 'What we did', McLeod explained, was to 'go way up above the nurses' home into a paddock. We would take our bedding, and we would sleep there for the day... We sneaked - it wasn't allowed'.<sup>81</sup>

Male attendants were generally older than female nurses when they started work and stayed much longer in the service. Men were required to be at least 21 years of age before commencing work but very few commenced at the minimum age. The average age of men starting work in 1939 was 27 years.<sup>82</sup> The maturity and previous work experience of novice attendants arguably gave them a degree of confidence in relations with their seniors. Because of the slow rates of promotion on the male sides, a high proportion (60 percent in 1939) of the men were at senior attendant level or above; many were therefore very experienced in mental hospital work. Even at senior grade (the first level after qualification) more than half the men had worked in the Department for ten years or more (see Appendix O). This relatively flat structure, arguably allowed the men to work in a more collegial manner.

Relationships between staff on the male sides were superficially less hierarchical but order was maintained through systems of power based on seniority, military-like insistence on rules, and tight though informal networks. Head and charge attendants

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<sup>79</sup> Patricia French suggests that control of nurses' homes in general hospitals was part of an overall strategy of producing the 'ideal nurse' through training, control and surveillance: French, p.35. Dunsford also discusses the rigid regimes in general hospital nurses' homes, but indicates that this was tempered somewhat from the 1930s, particularly in relation to trained nurses, because of nursing shortages: Dunsford, p.177.

<sup>80</sup> Kath McLeod interview 1 September 2004.

<sup>81</sup> *ibid.*

<sup>82</sup> This is a rough estimate based on the dates of birth of men starting work over a twelve month period: New Zealand Public Service List, vol.3, 19 October, 1939.

wielded considerable authority because of their years of experience. Their seniority brought with it extensive institutional knowledge and well-established networks of relationships; they knew the ropes. On average, men did not achieve promotion to charge attendant for 20 years and head attendant for 25-30 years. By this time, they were well-known and respected (or feared) for their knowledge, skills and reputation as managers of staff and patients. Within the hospital community were the attendants' family members, long-time friends, sporting mates, union colleagues, and sometimes co-members of specific societies or churches. Authority was reinforced by such memberships. For many years at Seacliff, for example, it was commonly believed by staff that control of the hospital swapped between the Freemasons and the Roman Catholics, depending on who held significant positions, such as medical superintendent and head attendant, at the time.<sup>83</sup> This intertwining of relationships within the male sides of mental hospitals was not unique to New Zealand. Diana Gittins noted at Severalls Hospital in England, a 'network of invisible, and sometimes secret, yet interrelated allegiances – Trade Unions, Freemasonry, kinship...' that had far-reaching effects on the working lives of attendants.<sup>84</sup>

The men's accommodation was not as strictly controlled as the women's and appeared to function in a less hierarchical manner. Male staff dining rooms were, for example, somewhat less formal than on the female sides and there were no separate dining rooms for charge attendants. This did not mean that dining arrangements were devoid of rank, but the rules were less explicit. New attendants quickly discovered, however, if they had broken the unspoken rules.<sup>85</sup> The relative lack of hierarchy in the men's quarters can be explained partly by the fact that few men of higher rank were living on-site; men were allowed marry and to live away.<sup>86</sup> The men who lived on site were single and junior. Male accommodation more closely resembled single-men's quarters at work

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<sup>83</sup> Gordon and June Rapson interview 31 August 2004, Neville Griffin interviewed by Kay Carncross, 22 November 1988, OHInt-0139/3, New Zealand Nursing Education and Research Foundation Psychiatric Nurses Oral History Project (NERF-PNOHP), ATL, Wellington.

<sup>84</sup> Gittins, p.158.

<sup>85</sup> James Nolan described a hierarchical system at Sunnyside Hospital where, for example, the 'junior boy' waited until last to have morning tea: James Joffre Beatty Nolan interviewed by Lois Wilson, 3 November 1983, OHInt-0014/124, New Zealand Nursing Education and Research Foundation Oral History Project, (NERF-OHP), ATL, Wellington.

<sup>86</sup> The Department had allowed its male staff to marry since the staffing difficulties of the First World War.

projects, than nurses' homes. At most hospitals, these were adequate, but basic.<sup>87</sup> It was assumed that men could live more independently and more roughly than women, an assumption that was reflected in the choice of words describing the men's accommodation as 'quarters' rather than 'homes'. At Seacliff, staff nick-named the quarters, 'the Ranch'. Bedrooms at the Ranch were eight foot by eight foot; bathrooms had showers with no curtains and concrete hand basins with no pipes under sinks.<sup>88</sup>

The language and routines surrounding the attendants' conditions had some parallels with life in the military. Not only were the rooms called 'staff quarters' but the dining or lounge rooms were called 'mess rooms'. There was no equivalent of the home supervisor. Instead, a senior member of staff was allocated each day to supervise 'messing' arrangements, serving meals in the attendants' dining rooms.<sup>89</sup> The attendants' behaviour was monitored and controlled to some degree. Rooms were checked by a senior member of staff (usually a head attendant) during the day, and by the night charge attendant after hours. Attendants were required to remain in their quarters on the night of their rostered 'long day' so they could be available for emergencies in the wards. They were also expected to ask permission from the Medical Superintendent to stay out late on their short day or day off.<sup>90</sup> James Nolan recalled that the attendants were locked in on the 'sleep-in' night. This did not, however, stop him or his friends having fun. As he recalled, there were 'ways and means to get around it'; even if the windows couldn't be opened wide, the men 'could pass a few beers in!'<sup>91</sup>

Another factor influencing the cultures on the male and female sides was the contemporary expressions of masculinity and femininity in New Zealand society. The strict separation of sexes created two distinct communities within each hospital. The culture on the male sides appears to reflect what Jock Phillips has described as typical attributes of working-class male culture in mid-twentieth-century New Zealand. He has identified physical strength, mateship, drinking and gambling as lingering traditions of the exclusively male communities that predominated in New Zealand's colonial

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<sup>87</sup> Men's accommodation in the early 1950s at Porirua consisted of basic, single rooms attached to a ward. The attendants' dining room was next to the large male patients' dining room: Russell Flahive interview 1 June 2004.

<sup>88</sup> Neville Griffin interviewed by Kay Carncross, 22 November 1988, OHInt-0139/3, NERF-PNOHP.

<sup>89</sup> A deputy charge attendant was allocated to staff messing each day. In 1950, PSA delegates asked for a permanent position for each hospital, but this was not considered necessary: PSJ, 37, 1950, p.8.

<sup>90</sup> James Joffre Beatty Nolan, interviewed by Lois Wilson, 3 November 1983, OHInt-0014/124, NERF-OHP.

<sup>91</sup> *ibid.*



frontier. These markers of masculinity, he argues, survived despite attempts by the Protestant middle class to create male respectability.<sup>92</sup> Phillips claims that although a higher proportion of men were married in the 1930s than ever before in the history of colonial New Zealand, most men wed relatively late, and were therefore accustomed to a lifestyle free of feminine influence and domestic responsibilities. He suggests that men therefore attempted to 'preserve their male identity and keep alive an exclusive sense of male camaraderie at the workplace'.<sup>93</sup>

Mental hospitals provided a work environment that supported such ambition. Masculine attributes such as physical strength, farming skills and sporting prowess were valued by the employers; mateship was enhanced by the long-standing relationships and the need to pull together in the face of danger. Men could establish their own regimes out of the view of women. Although alcohol and gambling were not officially condoned, they were part and parcel of life for many men of the male sides.

Although mental nursing was not a stereotypical feminine occupation, the world the nurses created within the female sides of mental hospitals reflected, in many ways, dominant contemporary values concerning femininity. The women's wards and living areas tended to be tidier, prettier, and generally more 'feminine' than the men's areas. Hospital administrators commented from time to time on the benefits a woman's presence could bring to an all male space. When the Nelson Hospital nurses, for example, complained about having to walk almost a mile from the furthest villa to the nurse's home for meals, Gray suggested that they could eat in the closer, men's dining room. He hoped that this would result in a '... better and tidier table service'.<sup>94</sup>

Dominant ideology in pre World War Two New Zealand associated respectable femininity with women's attributes as wives or mothers. Women's work outside the home was generally limited to roles that supported these primary domestic roles.<sup>95</sup>

Mental hospitals were generally seen as unsuitable work places for respectable young women, who could be exposed to both physical and moral dangers. To ensure safe passage for young nurses, matrons, charge nurses and home supervisors strove to create

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<sup>92</sup> Jock Phillips, *A Man's Country? The Image of the Pakeha Male, A History*, Rev. edn, Auckland, N.Z., 1996, p.78.

<sup>93</sup> *ibid.*, p.243.

<sup>94</sup> 5 February 1941, H-MHD-1, 8/110/1, ANZ, Wellington.

<sup>95</sup> Caroline Daley, *Girls & Women, Men & Boys: Gender in Taradale, 1886-1930*, Auckland, 1999; Deborah Montgomerie, 'Personal Affair Between Me and Hitler? Public Attitudes to Women's Paid Work in New Zealand During World War Two', MA thesis, University of Auckland, 1986.

order and to insist on proper feminine behaviour. This could be achieved only through strict discipline and respect for the nursing hierarchy.

The respect accorded to matrons and charge nurses was in many ways similar to the traditions within general hospitals. Until the Second World War, nurses were not permitted to continue work after marriage. Consequently, the few who did make mental nursing a career spent their working and home lives on the hospital grounds. Certain privileges were afforded these senior nurses in acknowledgement of their station. Matron and sub-matrons had quarters separate from the other nurses (for which they paid a greater board). The Matron would usually have her own cottage or flat, while the sub-matrons shared accommodation. It was not unusual for a trusted 'worker-patient' to be allocated to do the Matron's housework and wait on her domestic needs. One tradition that probably originated in general nursing, was for Matron to receive an early morning cup of tea in bed, brought to her by the nurse in charge of the night shift.<sup>96</sup> Depending on the personality of the individual matron, this would be seen by the nurses as either an honour or a fearful burden. One matron at Auckland Mental Hospital, whose apartment was on the third floor, was known to regularly demand a fresh pot of tea because the nurse had been unable to deliver the original tea hot enough for her liking.

### ***Trade unionism***

As public servants, mental hospital employees were represented industrially by the Public Service Association (PSA). The union was divided into regional sections, of which each hospital was a subsection. It was within the subsection structure that mental hospital staff took up local problems with medical superintendents and forwarded remits to the annual conference. Although by the end of the 1930s, the PSA officers often referred to the 'Mental Hospital Group', there was no such formal section within the union. The Porirua Hospital subsection had been acting as a central committee for mental hospital staff from 1938.<sup>97</sup> One of the Porirua members, a senior attendant, George Armes, was coincidentally the Wellington Section representative on the PSA

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<sup>96</sup> Kath McLeod interview 1 September 2004.

<sup>97</sup> PSJ, 26, 9, 1939, p.564.

Executive, so was also able to speak for Mental Hospital Department employees.<sup>98</sup> In 1939, however, the Association recognised the special needs of mental hospital employees, hydro-electric workers and women, by amending its rules to authorise a representative of each of these groups on the Executive.<sup>99</sup>

During the 1940s, the PSA become more militant.<sup>100</sup> The changes were largely due to the leadership of Jack (J.P.) Lewin who was vice-President from 1945 to 1946 and President from 1946 to 1951. With a group of activists known as the Korero, Lewin shifted the attention of the union towards the needs of its General Division 'blue collar' members.<sup>101</sup> He not only led the PSA into a more militant phase, but he took a personal interest in the Mental Health Group and later represented it on the Executive.<sup>102</sup> In the post-war years, mental hospital attendants and nurses were some of the most radical members of the PSA.

The unionism of mental nurses and attendants distinguished them fundamentally from other kinds of New Zealand nurses. General nurses were discouraged by their professional leaders to have anything to do with trade unions. The New Zealand Registered Nurses Association (NZRNA) viewed trade unionism as a threat to the professional status and autonomy of nurses. During the late 1930s and 1940s, the NZRNA strongly resisted the Labour Government's attempts to persuade it to affiliate as a trade union. They also opposed improvements in conditions such as payment for overtime hours.<sup>103</sup> In 1941, the NZRNA president claimed that, 'Nursing is not just a job. Unions, however valuable, with their demands and possible strikes, have no place in nursing.'<sup>104</sup> This anti-union position was accepted without question by many general nurses. In 1943, for example, a group of student nurses asserted that, 'an industrial

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<sup>98</sup> PSJ, 26, 1, 1939, p.2. Armes continued representing mental hospital employees even after transferring to the Department of Internal Affairs in late 1940. He resigned as the mental hospitals' representative in November 1945: PSJ, 32, 11, 1945, p.519.

<sup>99</sup> PSJ, 26, 11, 1939, p.692.

<sup>100</sup> For discussion on shifting focus of the PSA during the mid-1940s, see: Roth, p.111. Also: Henderson, p.161.

<sup>101</sup> Hicks, Colin, 'Lewin, John Philip, 1915 -1990', *Dictionary of New Zealand Biography*, updated 16 December 2003, URL: <http://www.dnzb.govt.nz/>.

<sup>102</sup> Lewin's radical leadership left an indelible mark not only on the PSA but also specifically on the Mental Hospital Group. Russell Flahive who followed Lewin as MHG representative on the Executive attributed the power of the union to his influence: Russell Flahive interview 1 June 2004.

<sup>103</sup> Although the NZRNA made a decision in 1939 to register as a union, this had to be set aside because of legal difficulties and considerable opposition from its members: KT, 32, 2, 1939, p.73 & KT, 33, 1, 1940, p.1.

<sup>104</sup> KT, 34, 1, 1941, p.39.

union is probably a suitable type of organization for men and women engaged in the industrial or other commercial projects but entirely unsuitable for those who undertake the care of the sick'.<sup>105</sup>

The differences between general and mental nursing were not unique to New Zealand. Mental nurses in Britain were unionised far earlier than general nurses.<sup>106</sup> The National Asylum Workers Union (NAWU) was formed in 1910 and undertook its first official strike in 1918.<sup>107</sup> The union became particularly militant during the 1920s.<sup>108</sup> In the Netherlands, mental nurses participated in union activities in the early twentieth century, but became ambivalent about such involvement as the occupation became more professionally-orientated.<sup>109</sup> There is little evidence of unionisation amongst psychiatric nurses in the United States during this period.<sup>110</sup> In Canada, mental nurses in some provinces were heavily unionised while others were not.<sup>111</sup> The different international patterns appear to reflect interplay of gender and class. In areas where men remained in the workforce in large numbers, unionism was significant. In countries such as the United States and the Netherlands, where mental nursing was redefined as a female, middle-class occupation, there was much less evidence of trade union activity.

## Conclusion

The mental nurse and attendant culture of the 1940s was influenced by the physical, social, and administrative isolation of the institutions in which they worked. They were not only isolated geographically but also by the stigma of mental illness and by the administrative insularity of the Department of Mental Hospitals. Gender and class played a powerful role in shaping and expressing the identity and culture of this group of workers. Recruitment and retention patterns, and gendered expectations of behaviour, contributed to the significant cultural differences between the male and female sides. Overall the staff culture was dominated by male working-class values, including loyalty

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<sup>105</sup> KT, 36, 10, 1943, p.237.

<sup>106</sup> Christopher Hart, *Behind the Mask: Nurses, their Unions and Social Policy*, London, 1994.

<sup>107</sup> There was an earlier strike in Rainhill Asylum in 1914, but this was spontaneous, unofficial, and over within a few hours: Arton, p.245.

<sup>108</sup> Hart, p.138.

<sup>109</sup> Boschma, *The Rise of Mental Nursing*, pp.199-200.

<sup>110</sup> Olga Church gives very little attention to union activity, except when mentioning the superintendents' opposition to unionisation in 1920: Church, 'That Noble Reform', pp.134-5.

<sup>111</sup> Veryl Tipliski, 'Parting at the Crossroads: The Emergence of Education for Psychiatric Nursing in Three Canadian Provinces, 1909-1955', *Canadian Bulletin of Medical History*, 21, 2, 2004, pp. 253-79.

to the trade union. As New Zealand entered the Second World War in 1939, staffing issues became a critical problem in mental hospitals. Gendered perceptions of the work hampered efforts to recruit and retain sufficient numbers of women. Staffing problems coloured all other aspects of mental hospital life.

## **Chapter II**

### **Mental Nurse and Attendant Staffing 1939 to 1959**

‘A good sprinkling would find it a tolerable job, as they go’

The outbreak of World War Two in 1939 exacerbated a chronic problem of understaffing in mental hospitals. Despite vigorous recruitment campaigns, compulsory ‘manpowering’, and a post-war immigration campaign, critical shortages of staff, especially women, continued well into the 1950s. Although the staffing problems reflected a general shortage of young women in New Zealand’s labour market, recruitment problems into mental nursing was made worse by poor working conditions and the social stigma attached to mental illness. The impact of understaffing was far reaching. Female nurses in particular had to contend with increased workloads and long hours on duty. The men, not as drastically affected, experienced indirect benefit from the shortages. The staffing crisis, during and after the war, disrupted the implementation of a policy to replace male attendants with professionalised female nurses. There were simply not enough women.

#### ***Male nursing contested***

The Department of Mental Hospitals was generally in favour of employing women, rather than men for nursing duties. Although Theodore Gray valued the service of men in mental hospitals, and relied on them for administrative and labouring tasks, he did not consider they should be nurses. Men, he argued, should be kept ‘more for duties in specialized wards and villas for really difficult cases, for farm and garden gangs, for haircutting etc’.<sup>1</sup> One of Gray’s priorities during the 1930s had been to replace charge attendants with female nurses. By the late 1930s, women were in charge of most male wards in some hospitals, but in others, had charge of only one or two male wards, usually admission and infirmary.<sup>2</sup> Staffing establishments had been adjusted to reflect this policy. In 1937, a new staffing establishment for the Department set the number of charge nurses at 94 and deputy charge nurses at 151. This compared with 52 charge attendants and 79 deputy charge attendants.<sup>3</sup> Staffing establishments did not necessarily translate to numbers of staff, however. In 1939, while most of the charge nurse positions

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<sup>1</sup> Gray to medical superintendents, 16 October 1936, H-MHD-1, 8/125, ANZ, Wellington.

<sup>2</sup> Medical superintendents to Gray, 24 October 1936, H-MHD 1, 8/125, ANZ, Wellington.

<sup>3</sup> 11 October 1937, H-MHD-1, 8/125, ANZ, Wellington.

were filled, there was less than half the required number of deputy charge nurses (refer to Table 4 for details). Male charge and deputy charge attendant positions were all filled to the establishment levels. Staffing shortages during the 1940s disrupted Gray's plans to transform the mental hospital workforce into a feminine and respectable, middle class occupation.

Male	HA Class A	HA Class B	HA Class C	Ch. Attend	Dep-Ch. Attend.	Senior Attend.	Attend.	Total
Estab. (1937)	4	8	9	52	79	—	480	631
Actual (1939)	4	8	9	54	79	223	250	627
Female	Matron Class A	Matron Class B	Matron Class C	Charge Nurse	Dep-Ch. Nurse	Senior Nurse	Nurse	Total
Estab (1937)	4	9	17	94	151	—	501	776
Actual (1939)	4	9	16	90	67	8	381	583

**Table 4 Staffing numbers against staffing establishments, 1939.**

Sources: H-MHD-1, 8/125, ANZ, Wellington; NZPSL, 1939.

### Wartime staffing

As soon as New Zealand entered the war in September 1939, demands increased for women's labour in a wide range of occupations. General hospitals, where patient numbers had grown rapidly since free hospital care was introduced by the first Labour Government in 1938, were particularly affected.<sup>4</sup> Other social legislation had expanded social services which competed for professional women workers. By the late 1930s, the nursing shortages, that had been an intermittent problem for general hospital boards for many years, had become endemic.<sup>5</sup> War created an even greater demand for general nurses both at home and abroad. 'In an unpredictable future', wrote the editor of *Kai Tiaki*, 'one thing is certain - the urgent need for more and more nurses'.<sup>6</sup> She encouraged nurses to see that their work in New Zealand hospitals was just as important

<sup>4</sup> Cullens, p.21.

<sup>5</sup> AJHR, 1939, H-31, p.69.

<sup>6</sup> KT, 33, 3, 1940, p.65.

to the war effort as going overseas.<sup>7</sup> She later implored them to stay in nursing rather than be tempted to move into another field of work.<sup>8</sup> National recruitment of general nurses also became a priority for Mary Lambie, the Director of Nursing in the Department of Health, throughout the war years.<sup>9</sup>

Wartime conditions exacerbated the serious shortage of mental nurses. As war began to impact on the labour market, the pool of women willing to work in mental hospitals decreased substantially.<sup>10</sup> The Department of Mental Hospitals tried various ways to remedy the situation. Advertisements were placed in local newspapers and employment was extended to married women, especially to wives of attendants and servicemen. In a departure from pre-war policy, temporary employment was allowed. Nelson Mental Hospital, which usually staffed most of its wards with women, asked for permission to employ attendants in four of the male villas. This would have had a dual purpose of relieving the nursing shortage and also providing male labourers for a 'cleaning up gang' and assistance for the baker, butcher and lorry driver.<sup>11</sup> The Department responded to this, and other requests, by enlisting the support of the Government's manpower office to assist with advertising in newspapers and with women's organisations.<sup>12</sup> Individual hospitals also went to great lengths to recruit staff. Auckland Mental Hospital, for example, undertook a recruitment campaign in small towns in its catchment area. Advertisements were placed in newspapers, movie theatres and local auxiliaries. The Chief Clerk, I. Lilly, visited five centres from Kaitaia to Thames, to undertake interviews. The result was disappointing. A total of only eight interviews were undertaken and only five firm appointments were made.<sup>13</sup>

A recruitment officer on the East Coast responded to the Department's appeal for help by suggesting that Maori women could make suitable mental nurses. He claimed, 'I know of numbers of instances of Native girls who make excellent maids when trained'.<sup>14</sup> Despite the critical situation, the Department was unwilling to consider this

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<sup>7</sup>KT, 33, 5, 1940, p.133.

<sup>8</sup>KT, 34, 12, 1941, p.399.

<sup>9</sup> Dunsford, pp.158-60.

<sup>10</sup> AJHR, 1940, H-7, p.4.

<sup>11</sup> 26 November 1940, H-MHD-1, 8/116/0, ANZ, Wellington.

<sup>12</sup> Until 1942, the role of the manpower office was to direct men into work that would support the war effort. Women's contribution was until then, voluntary: 18 & 20 June 1941, H-MHD-1, 8/116/0, ANZ, Wellington.

<sup>13</sup> 28 July 1941, H-MHD-1, 8/116/0, ANZ, Wellington.

<sup>14</sup> E.Rhodes, Recruitment Liaison Officer, Gisborne, 28 July 1941, H-MHD-1, 8/116/0, ANZ, Wellington.



possibility. 'We have a few Maori nurses at some institutions', wrote the Chief Clerk, 'but our general experience is that they are not satisfactory'.<sup>15</sup> The Department, willing to bend its rules to employ married women and temporary workers, was less willing to employ Maori women. This appears to be consistent with the restrictions Maori women generally faced when seeking employment in the 1940s.<sup>16</sup>

Nursing shortages brought male PSA members into conflict with the Department and the Public Service Commission. In 1941, when female nurses at Nelson and Avondale (Auckland) Mental Hospitals complained about their long hours, the PSA requested that nurses be temporarily withdrawn from the men's wards and replaced by attendants.<sup>17</sup> Gray's response was adamant. He claimed that women were especially needed to nurse new patients who were often physically as well as mentally ill. These patients, he argued, were 'as much entitled to proper and adequate sick nursing as those in public hospitals'. He pointed out that there were only 41 women employed in men's wards and that there was also a shortage of male staff.<sup>18</sup> John Boyes, the Acting Public Service Commissioner, passed on Gray's recommendations to the PSA and suggested that, 'any temporary advantage gained [by withdrawing female nurses from male wards] would be offset by a lowered standard of work'.<sup>19</sup>

Boyes' letter caused an outcry in the PSA and among the male attendants, the latter taking umbrage at the assumption that they were incapable of caring for patients' physical, as well as mental, needs. They claimed that the men passed the Department's examinations in higher numbers and averaged longer service, and were therefore more experienced than the women. The policy was not only humiliating, they argued, but wrong.<sup>20</sup> Although Boyes quickly apologised and commended the existing male staff on their conscientious service over many years, he remained unmoved in his assertion that,

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<sup>15</sup> 11 August 1941, H-MHD-1, 8/116/0, ANZ, Wellington.

<sup>16</sup> Montgomerie suggests that racism was prevalent in the labour market during the war as it had been previously. Maori women were restricted to a narrow range of occupations at the bottom of the 'female employment pecking order': Montgomerie, *The Women's War*, p.68.

<sup>17</sup> Public Service Association Executive Committee Minutes, 3 June 1941, 82-046-016/3, p.17, ATL, Wellington.

<sup>18</sup> Gray to Public Service Commissioner 16 June 1941, H-MHD-1, 8/125, ANZ, Wellington.

<sup>19</sup> Public Service Association Executive Committee Minutes, 21 July 1941, 82-046-016/3, p.25, ATL, Wellington.

<sup>20</sup> PSJ, 28, 11, 1941, pp.654-5.

‘generally speaking, female nurses are more competent for attention to sick patients than are male nurses’.<sup>21</sup>

### ***Manpowering***

For the first few years of the war, the Government relied on women and men to come forward to fill places in industries depleted by the demands of war. When voluntary approaches did not work, the Government turned to compulsory means to recruit and retain both men and women. From January 1942, under the National Service Emergency Regulations (later to be transferred to the Industrial Manpower Emergency Regulations), certain industries were deemed to be ‘essential’ to the war effort. Mental hospitals, public and private hospitals and a range of food and other industries were so named. Under the Emergency Regulations, all civilians of working age were required to register with district manpower officers who would direct them to work in an essential industry. If already working in such an occupation, they could not leave without permission from the National Services Department.<sup>22</sup> Successive regulations were introduced so that people of different ages, sex or certain occupations were required to register at different times. Women between the ages of 20 and 30 years and men between 46 and 49, for example, were required to register first.<sup>23</sup> Women aged 18 and 19 years were included the following year. In 1944 it was extended to include women up to 40 years.<sup>24</sup> Both mental and general hospitals were considered priority industries for women directed by the manpower officers.

Essential industry status had different implications for mental nursing than for general nursing. General nursing leaders worried about the loss of control over their profession and their standards.<sup>25</sup> The New Zealand Registered Nurses Association (NZRNA) unsuccessfully attempted to have control moved from the Department of National Service to the Director-General of Health.<sup>26</sup> In contrast, those involved with mental nursing were more concerned about the possibility that manpowering would further

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<sup>21</sup> *ibid.*, p.639.

<sup>22</sup> AJHR, 1946, H-11A, p.30-1.

<sup>23</sup> Presumably men under the age of 46 were already registered because of the requirement to register for military duty. Every civilian was liable for direction to an industry of national importance, irrespective of age or sex. For description of regulations and process, see: AJHR, H-11A, pp.31-2.

<sup>24</sup> AJHR, 1946, H-11A, p.133.

<sup>25</sup> Nursing was the only occupation to oppose manpowering of its members: Montgomerie, *The Women's War*, pp.105-6.

<sup>26</sup> *KT*, 35, 4, 1942, p.101.

dissuade women from applying to work at mental hospitals.<sup>27</sup> The stigma of mental illness was such that many women were reluctant to take up the work if they did not have the freedom to leave.

It soon became apparent that shifting control of recruitment of mental nurses to the Department of National Services was ineffective and possibly counter productive. Interviews of women aged between 20 and 22 years commenced in July 1942. Most of the young women made it clear that they did not want to work in mental hospitals. Both manpower officers and appeal committees showed unwillingness to direct young women to mental hospitals; few interviewees were deemed suitable for the work.<sup>28</sup> Of the first 100 'girls', interviewed in Christchurch, only one was considered suitable.<sup>29</sup> The committees were also sympathetic to appeals from staff members who wanted to leave mental hospital work. It was not difficult to persuade them that what they were required to do was 'dangerous, arduous and unpleasant'.<sup>30</sup> It appeared to be reasonably easy to obtain a medical certificate to verify 'industrial fatigue' or 'emotional strain' caused by the work.

Mental nurses' descriptions of their working conditions to the committees sometimes found their way into the media. These disclosures increased public disapproval of compulsory direction to mental hospitals. One Dunedin correspondent claimed that most parents would be alarmed to think of their daughters being compelled to work in a mental hospital.<sup>31</sup> The Editor of the *Otago Daily Times* agreed. He suggested that mental nursing, 'requires a special mental approach..., special attributes of character, and a high physical condition'. He warned that, 'The results from the compulsory association of impressionable young women with the sick or insane could be individually most unfortunate...'<sup>32</sup>

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<sup>27</sup> Gray to Minister, 11 March 1942, H-MHD-1, 8/116/0, ANZ, Wellington.

<sup>28</sup> Some were rejected on the grounds of medical unsuitability, either because of physical illness or because of a history of mental illness in themselves or their close family. Medical reports on women interviewed in 1945 by the manpower officer in Hokitika included evidence that one woman's 'whole family (was) neurotic to a degree', another's 'two cousins (were) in mental hospitals as patients', and another had had past admissions in mental hospitals. One woman was rejected because of cardiac problems: 15 July 1945, CAWU, CH890/14f, ANZ, Christchurch.

<sup>29</sup> Department of National Service memo to Department of Mental Hospitals, 18 August 1942, H-MHD-1, 8/116/0, ANZ, Wellington.

<sup>30</sup> 13 November 1942, Gray to Nordmeyer, H-MHD-1, 8/116/0, ANZ, Wellington.

<sup>31</sup> *Otago Daily Times* (ODT), August 1942, copy in H-MHD-1, 8/116/0, ANZ, Wellington.

<sup>32</sup> ODT, 4 September 1942, p.4.

Attempts to champion the work of mental nurses often reinforced the negative aspects of their working conditions. A letter to the *New Zealand Herald* bemoaned the fact that, 'these gallant girls sometimes work eight days without a break and do more than double a 40 hour week, without any overtime rates of pay'.<sup>33</sup> The writer suggested that, 'If these conditions are not remedied, some of these nurses will themselves become patients for the human make-up was not built to withstand the physical and mental strain to which they are subjected.'<sup>34</sup> Such appeals confirmed parents' worst fears about the dangers of mental nursing.

Relationships between the manpower committees and the Department of Mental Hospitals were strained. After ten months of mental nursing being classified as an essential service, the Department was still 28% below establishment for female nurses and 14% below for male attendants.<sup>35</sup> Very few women had been successfully directed to mental nursing. Gray complained that gazettement as an essential industry had been a fruitless exercise, laying the blame squarely on the committee members, whom he accused of being ignorant of mental hospital conditions and carrying, '...all the prejudices and preconceived ideas of them gathered from sensational literature'.<sup>36</sup> Decisions on appeals and resignations should, he argued, be under the authority of the Public Service Commissioner who had a much better understanding of mental hospital conditions than the manpower officers. For their part, the manpower committees were critical of the Department's unrealistic expectation that compulsory direction could solve their long-term staffing problems.<sup>37</sup> They also questioned the wisdom of placing emphasis on salaries and conditions. Women might interpret generous working conditions as attempts to compensate for the difficult nature of the work. This could, they argued, confirm women's suspicions that mental hospitals were not suitable places to work.

The manpower committees continued to question the wisdom of sending young women to work in mental hospitals. While acknowledging the undermining influence of public prejudice, the committee claimed that compulsion could '...amount to mental cruelty in

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<sup>33</sup> *New Zealand Herald* (NZH), 16 September 1942, p.8.

<sup>34</sup> *ibid.*

<sup>35</sup> Gray to Minister of Health, 13 November, 1942, H-MHD-1, 8/116/ ANZ, Wellington.

<sup>36</sup> *ibid.*

<sup>37</sup> PSJ, 30, 6, 1943, pp.227-32.

the case of young girls on the threshold of life...'<sup>38</sup> They were not convinced that the women they were interviewing were the 'right type' for mental nursing. When in 1943 twenty young women appealed their direction to Porirua Hospital, the Wellington District Manpower Committee decided a change of policy was required. They announced that in the future, women would only be obliged to work for six months in mental hospitals. Feeling the need to explain its unusual decision, the committee indicated that the type of woman suitable for mental nursing was preferably, 'a volunteer inspired either by a liking for the work itself or a sense of Christian duty and, failing that, a directed person of such an age as to possess mental stability and, in addition, possessing the qualities of kindness, patience, tact, cheerfulness and above all, good health and physique'.<sup>39</sup> Instead of this paragon of virtue and resilience, the committee was dealing with 'young city girls' with no nursing experience and a 'confessed horror' about working in a mental hospital. Even the PSA, who were critical of the manpower committees' failure to direct women to mental nursing, conceded that, 'Mental Hospital work would not suit all temperaments, but a good sprinkling would find it a tolerable job, as they go...'<sup>40</sup>

Disagreements continued over the right approach to the staffing problem. Gray criticised a decision of the manpower office not to direct any women below 25 years to mental nursing, pointing to the fact that 70% of pre-war nurses were 21 years or under.<sup>41</sup> Medical superintendents complained about their inability to properly discipline their own staff. If the manpower officers refused to dismiss an unruly nurse or attendant, the superintendents had little recourse. The PSA became increasingly critical of the lack of progress by both the manpower office and the Department. Staff concerns by the end of the war, spread well beyond the issue of nursing shortages to a general dissatisfaction of mental hospital administration.<sup>42</sup> Their various suggestions, such as payment of a bonus for all female staff, the appointment of a special recruitment officer for each hospital, and general improvement of salaries, were dismissed by Gray as unnecessary. He accused the PSA of artificially producing discontent among female

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<sup>38</sup> PSJ, 30, 6, 1943, p. 228.

<sup>39</sup> *ibid.*

<sup>40</sup> *ibid.*, p.230.

<sup>41</sup> Gray to Nordmeyer, 28 February 1944, H-MHD-1, 8/110/1, ANZ, Wellington.

<sup>42</sup> PSJ, 31, 3, 1944, pp.109-11.

staff.<sup>43</sup> Staffing levels had not improved. By December 1945, the Department was 253 nurses and 85 attendants short of the authorized establishment.<sup>44</sup>

Manpowering had exposed a public concern about the suitability of mental nursing for women. Mental nursing was incompatible with the contemporary beliefs of ‘respectable womanhood’. Montgomerie has argued that manpowering did not radically challenge the place women occupied in the workforce. Prior to the war, employment of women was closely aligned to the imperative of domesticity. A very narrow range of acceptable professions for women included teaching and nursing.<sup>45</sup> General nursing, in particular, was compatible with contemporary views on femininity and domesticity. Women could participate in the workforce, but still retain feminine virtues of nurturing, self-sacrifice and obedience.<sup>46</sup> Nursing leaders in New Zealand had emphasised the Nightingale imperative that a good nurse was a good woman.<sup>47</sup> Mental nursing, however, did not fit this image. The work was perceived as dangerous, dirty and isolating.<sup>48</sup> It potentially exposed women to the worst aspects of human behaviour. The manpower committees, reliant on public support for their work, were loath to pressure women into occupations that could be detrimental to their primary responsibility as wives and mothers. Like the public they represented, they were concerned about the need to protect vulnerable young woman from the world of madness: ‘These young women are the future mothers of our nation and irredeemable harm may be done through compelling them to work where they are physically and temperamentally unsuited’, wrote one member of the public.<sup>49</sup> Despite the work of Gray and others to change the image of mental nursing, it remained in the public mind as something suitable only for a ‘certain type of woman’. She must be tough, old enough to be no longer in need of protection, physically and

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<sup>43</sup> Gray to Nordmeyer, 28 February 1944, H-MHD-1, 8/110/1, ANZ, Wellington.

<sup>44</sup> AJHR, 1946, H-7, p.3.

<sup>45</sup> Montgomerie, 'Personal Affair', pp.26-8.

<sup>46</sup> For a discussion on the public image of general nurses, see: Sargison, ‘Essentially’.

<sup>47</sup> Jan Rodgers argues that the Nightingale ethos of forbearance, obedience and endurance shaped the development of nursing education in New Zealand. Nurses were to parallel the idealized vision of women, as mother and helpmeet: Rodgers, 'A Good Nurse', pp.62-3. Sandra Wallace emphasises the development of the general nursing professional as one dominated by the assumption that this was women’s work and that nurses should possess the supposed feminine qualities of endurance, patience and obedience, Wallace. Deborah Dunsford suggests that although general nursing in the 1940s was changing into more of an occupation than a vocation, the traditions of devotion and service remained lynchpins to the appeal of nursing for many young women: Dunsford, pp.172-3.

<sup>48</sup> In some respects this view was not too far from the reality for young women who took up mental nursing, see: Kennedy, pp.52-61.

<sup>49</sup> NZH, 2 September 1942, p.2.

mentally strong, while still possessing the ability to be cheerful, tactful and kind. Such a woman did not fit the contemporary values of femininity.

### *Men's experience of war*

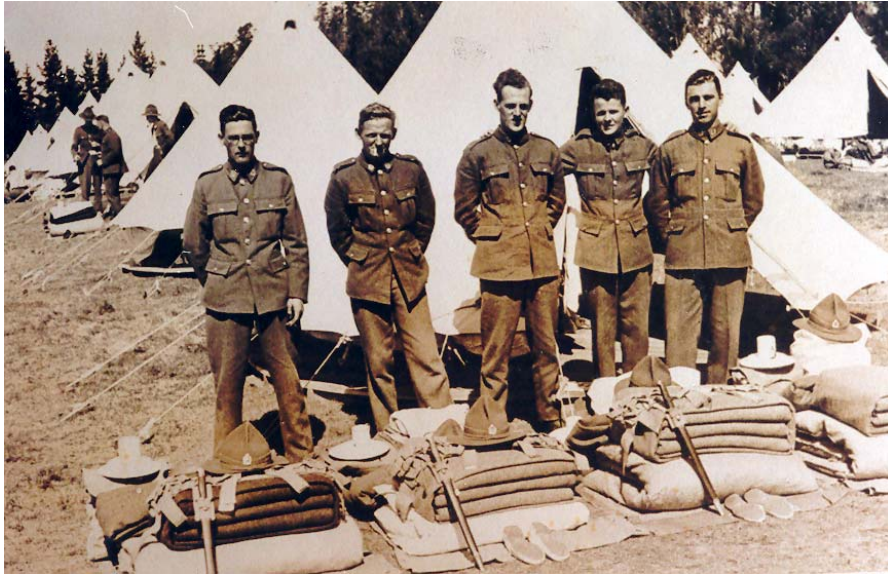
The male attendants' experiences during the war were different from those of the female nurses. Male staffing in mental hospitals was less affected by the war than female staffing. Attendant numbers remained reasonably good, but the Department had trouble retaining experienced men. The attendants' main concerns included freedom to participate in the war, protection of their positions while they were away, and a fair distribution of labour for those left behind. Initially, the Department was agreeable to releasing men for military service and replace them with temporary workers. Some men were only too happy to have a break from the hospital. One attendant described their haste, '...we tended to throw our keys on the table and go ... We weren't being very brave. We were breaking our necks to get away, and when we were over there, we were breaking our necks to get back'.<sup>50</sup> By December 1940, over 100 men from the mental hospital service had gone overseas, but rather than being perceived as a loss, their departure was celebrated.<sup>51</sup> The fortunes and misfortunes of the mental hospital workers who went into military service were followed closely by the hospital communities. The photograph below, for example, shows a group of Seaview attendants at Burnham Military Camp near Christchurch. A chatty report on the Porirua Sub-Section in the *Public Service Journal* reported that a large number of their married men had left for military camp. 'Jack, who is a little frail these days, is simply frothing to join Peter, Jim and the boys somewhere in the Land of the Pharaohs and the spicy [?] Nile'.<sup>52</sup>

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<sup>50</sup> Donald Graham interviewed by Lois Wilson, 15 December 1983, OHIny-0014/061, NERF-OHP, (OHColl-0014), ATL, Wellington.

<sup>51</sup> AJHR, 1941, H-7, p.2.

<sup>52</sup> PSJ, 27, 12, 1940, p.793.



**Figure 7 Kit Inspection: Seaview Hospital attendants at Burnham Camp, 1940, Bart Dowell, Jim Ellis, Duncan Ross, Bert Grenfell. Source: Seaview Hospital photograph collection, Hokitika Museum.**

After the introduction of conscription in mid 1940, the hospitals experienced difficulty in maintaining a sufficiently experienced attendant workforce. Head office directed medical superintendents to appeal against male attendants enrolling in overseas service.<sup>53</sup> Attendants complained that such decisions were being made in their absence. The PSA managed to obtain an agreement that the men would be advised of time and place of manpower committee meetings so they could attend.<sup>54</sup> As staffing became more difficult, Gray took every opportunity to fill vacancies. Aware that men were being rehabilitated from war, he reminded those responsible that there were vacancies at all the mental hospitals for attendants and that ‘any reasonably fit and otherwise suitable’ returned serviceman would be welcome to apply.<sup>55</sup> Some hospitals experienced more serious shortages of male staff than others, Tokanui being particularly short staffed on the male side.

One of the effects of war was a greater pressure to make staff ‘sleep-in’ overnight. It had been the Department’s practice to require staff to take turns at sleeping on the wards on their nights off and to be on call if needed. They were not paid unless called. In some hospitals, there was a tradition that ‘sleeping-in’ was only required of the more junior staff. It was not popular with the attendants, and before the war, some hospitals had managed to discontinue the practice. During the war, the issue became a bone of

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<sup>53</sup> Brunton, *Sitivation* 125, p.46.

<sup>54</sup> PSA Executive Committee, 1 July 1942, 82-046-016/3, ATL, Wellington.

<sup>55</sup> Gray to Director of Rehabilitation, November 1943, H-MHD-1, 27/4, Box 78, ANZ, Wellington.



contention because, with men away, there were fewer to take the shifts. At first the PSA lobbied on behalf of Sunnyside Hospital staff for responsibility for 'sleeping-in' to be spread across all staff, including deputy-charge attendants. They also demanded payment for the shifts. The Public Service Commissioner was unwilling to consider either option. He argued that it was part of their conditions of employment.<sup>56</sup> Later, with growing staffing shortages, 'sleeping-in' was re-introduced at both Porirua and Tokanui Hospitals. Porirua attendants objected strongly and managed to have the practice abolished at their hospital in mid-1944. Tokanui Hospital, however, continued to require its attendants to sleep-in. The staff questioned the legality of the requirement, and threatened to refuse to do the shifts. The PSA, meanwhile, lobbied for payments of 3/- for each time a female nurse was required to sleep away from her permanent sleeping quarters. Presumably, with the serious nursing shortage, it was not considered possible to abolish the practice on the female sides.<sup>57</sup> The response from the Public Service Commissioner demonstrated the Department's desperate shortage of both accommodation and staff. He claimed that, 'No nurse is regarded as having permanent sleeping quarters. She sleeps where the Department can most conveniently accommodate her.'<sup>58</sup>

### **Post-war: desperate measures for desperate times**

Shortages of female workers in all industries worsened in the immediate post-war years.<sup>59</sup> At the time, this was attributed to the low birth rate during the depression and high marriage rate after the war.<sup>60</sup> Historians, while agreeing with the importance of these factors, have provided a more complex analysis. The immediate post-war period is viewed as a time when the ideology of domesticity was paramount. Women's primary contribution was assumed to be the restoration of peacetime society and lay in their willingness to support returning soldiers and rebuild families; women therefore left the

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<sup>56</sup> PSA Executive Committee, 5 October 1942, 82-046-016/3, ATL, Wellington.

<sup>57</sup> It was common practice for the female nurses to sleep-in the night after their 'long-day'. In some cases they were also required to 'sleep-in' the night before. One of the reasons the Department resisted abolishing the practice was because there was not enough space in the nurses' homes to accommodate all nurses: H-MHD-1, 8/110/1, ANZ, Wellington.

<sup>58</sup> PSJ, 31, 12, 1944, p.511.

<sup>59</sup> Between December 1943 and December 1945, the female workforce had declined by 20% and continued to decline during 1946: Montgomerie, *The Women's War*, p.171.

<sup>60</sup> KT, 39, 8, 1946, pp.203-4; Cullens, pp.26 & 43.

workforce in large numbers.<sup>61</sup> Mental hospitals were but one of the country's industries that became desperately short of women workers. Their problems were accentuated, however, by the hospital conditions, the stigma of mental illness, and the limited options available to administrators. General hospitals closed wards in response to nursing shortages, but this was not an option for the mental hospitals, because of the nature of their patients. Intensive recruitment campaigns were launched for all types of nurses.<sup>62</sup>

***Commission on staffing: attendants and nurses have their say***

A commission of inquiry into staffing at mental hospitals was established in early 1946. The three person commission, which included a representative of the Public Service Commission (PSC), the Department of Mental Hospitals and the PSA, toured all the hospitals to hear submissions from staff.<sup>63</sup> Its comprehensive report documented over 600 staff suggestions. Many of these, such as improved salaries, heating in nurses' homes, payment of overtime rates, installation of telephones and provision of recreational facilities, focused on their own comfort. Other suggestions, such as better clothing and shoes and improved meals, focused on patient welfare. Requests for improved mechanisms for control of infectious diseases were, no doubt, both patient-centred and self-serving. Staff asked for separate facilities to nurse tuberculosis patients, sterilisation equipment, rubber gloves to handle soiled linen, and designated vehicles to take dirty linen to the laundry (some hospitals were using the same vehicles for transporting food and dirty laundry).<sup>64</sup> Other demands reflected a concern for professional issues. There were requests for improved training resources, such as preliminary courses for nurses and attendants before entering wards, supplies of books and clinical equipment and opportunities for postgraduate (post-qualification) education.

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<sup>61</sup> Deborah Montgomerie, 'Sweethearts, Soldiers, Happy Families: Gender and the Second World War,' in *The Gendered Kiwi*, Caroline Daley and Deborah Montgomerie, eds, Auckland, 1999, pp.163-90. Melanie Nolan argues that the government's social policy, while supporting women to stay at home, also encouraged married women into the workforce. Although the overall number of working women dropped, the percentage of married women in the workforce began to climb: Nolan, *Breadwinning*, p.200.

<sup>62</sup> Address by Mary Lambie, 'Recruitment and Training for Nurses in New Zealand', *KT*, 41, 3, 1948, pp.89-90.

<sup>63</sup> The Committee members included George Bolt, the Assistant Public Service Commissioner, John Russell, Deputy Director-General of the Department of Mental Hospitals and Jack Hunn, the President of the PSA, Report of Staffing of Mental Hospitals, H-MHD-1, 8/109/2, ANZ, Wellington.

<sup>64</sup> *ibid.*

The commission was generally supportive of the employees' concerns. Its recommendations focused not only on recruitment, but on a broad range of improvements that could aid retention. Adequate housing and transport were, in particular, seen to be essential to attract and retain staff in rural settings. Some of the problems continued to be a source of irritation over the next decade, but one of the union's central demands was satisfied. Before the report was published, the Public Service Commission announced a new pay scale for mental hospital staff.

***Frustration: Nurses and attendants take industrial action***

Frustrations over staffing and conditions led to industrial action by nurses and attendants. While awaiting the release of the Commission's findings, Seacliff nurses refused to work more than five days without a day off, while Porirua nurses, who had already been working eight days on and one day off, refused to increase their working days to eleven. They felt that they had pulled their weight during the war and now should not be asked to do even more. The action caused tension between nurses and the hospital administrators. Two Porirua nurses who tried to persuade another nurse not to accept a 'call-back' duty were charged with 'conduct unfitting of employees of the Public Service'.<sup>65</sup> Jack Turnbull, the PSA General Secretary, however, represented them at the hearing and the charges were dismissed.<sup>66</sup>

Several months later, nurses and attendants at all mental hospitals threatened industrial action over the issue of overtime payments. The Commission into Staffing had recommended that overtime rates should be paid for hours worked above 40 per week. There was a difference of opinion, however, over when the payments should start. The PSC decided to commence payments from 1 October 1946.<sup>67</sup> The PSA's Mental Health Group claimed they should have been back-dated to 1 April 1946. In a move that had significant implications for patient care, nurses and attendants decided to refuse all call-back duties and to take their rostered day-off every three days. The PSA Executive, while supporting the decision, was aware of the potential for disapproval from its other members. They explained that the mental hospital staff had not come to this position

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<sup>65</sup> PSJ, 33, 9, 1946, p.398.

<sup>66</sup> Roth, p.118.

<sup>67</sup> The Department of Mental Hospitals calculated that it would cost an extra £16,000 to back-date the overtime payments to April 1946. It would also involve many hours of work to calculate payments for the 1,200 staff involved: Director-General memo to PSC, 14 November 1946, H-MHD, 1, 8/80/1, Vol. 1, ANZ, Wellington.

light-heartedly, 'but with a full sense of responsibility and with the assurance that members throughout New Zealand will stand firmly behind them'.<sup>68</sup>

For nine days from 26 February 1947, nurses and attendants refused to work call-back duties. The nurses and attendants' rhetoric reflected a combination of union solidarity and professional concern. Although asserting that patients must be inconvenienced for them to achieve their occupational gains, they offered, if necessary to work without pay if patients required their attention.<sup>69</sup> During the industrial action problems did occur but were dealt idiosyncratically by staff committees in each hospital.<sup>70</sup> Staff decided to resume normal duties after the Prime Minister, Peter Fraser, became involved. Bypassing the PSC, Fraser referred the dispute to the Solicitor-General and the PSA reluctantly agreed to abide by his decision.<sup>71</sup> The Solicitor-General found in favour of the PSC; overtime was not backdated to April 1946.<sup>72</sup>

Mental hospital employees were at the vanguard of a PSA protest in the late 1940s.<sup>73</sup> Under the *Factories Act 1946*, the government had committed to extending penal and overtime rates for all state servants. The PSC however was reluctant to implement the legislation without changes to rosters. The Mental Health Group was the first to enter negotiations over the issue. They demanded the right to retain their rosters and bi-annual leave entitlement but the PSC refused to pay the new overtime and penal rates and instead offered a 15 percent commuted allowance. In doing so, the PSC was attempting to align mental nurses with general hospital nurses who were subject to a ten percent overtime limit. The PSA objected strongly to their members' conditions being 'held down to the level of the worst paid employees in the country'.<sup>74</sup> Negotiations ended in a stalemate, but mental hospital nurses were commended by their union for again being 'in the front line' of public service protest.<sup>75</sup>

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<sup>68</sup> PSJ, 34, 2, 1947, pp.46-7 & p.49.

<sup>69</sup> PSJ, 34, 2, 1947, p.47.

<sup>70</sup> PSJ, 34, 3, 1947, p.89.

<sup>71</sup> This was just one of several incidents when the PSA had bypassed the Public Service Commissioner by taking issues directly to the Prime Minister. The actions reflected the strained relations between the Public Service Commissioner and the PSA: Roth, p.120. PSJ, 34, 3, 1947, p.89

<sup>72</sup> PSJ, 34, 4, 1947, p.127.

<sup>73</sup> There were 1,290 members of the Mental Health Group in 1949. This represents approximately 75% of mental hospital staff: PSJ, 36, 1949, p.37.

<sup>74</sup> PSJ, 35, 7, 1948, p.7.

<sup>75</sup> PSJ, 35, 6, 1948, p.5.

The issue of overtime rates continued unresolved for some years. Mental hospital staff members were ambivalent about the issue. They demanded an eight-hour day and 40-hour week with overtime payments, but were concerned that this might be achieved at the cost of their bi-annual leave. They received support from an unlikely quarter. The Government Services Tribunal, established in 1949, made an early decision to recognize the bi-annual leave as compensation for occupational strain.<sup>76</sup> This recognition became a bargaining tool for the Mental Health Group.<sup>77</sup> A compromise agreement was reached in 1954 when the Tribunal made a determination for salaries and conditions that included a provision for nursing staff (men and women) to choose either to receive overtime payments or to take time-off in lieu as bi-annual leave.<sup>78</sup> Most people chose to take the extended leave. The right to two months leave per year remained a valued part of mental nurses' conditions of service for many years.

### ***Immigration: the solution to staffing problem?***

The Department of Mental Hospitals attempted a range of strategies to address the post-war staffing crisis. Head office sent pamphlets to Vocational Guidance, advertised in daily newspapers and displayed posters at money order offices throughout the country. When these strategies failed to attract more than a few applications, the Department sought approval to recruit overseas.<sup>79</sup>

As the war years were coming to a close, the Government came under considerable pressure to open up immigration in order to increase New Zealand's population and ease a critical labour shortage. The country had an estimated shortfall of 32,605 male workers and 24,470 female workers.<sup>80</sup> A parliamentary committee on population, established in December 1945, was due to report its findings.<sup>81</sup> In the meantime the newly-formed National Employment Service (NES) transferred two senior officers to

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<sup>76</sup> The Government Services Tribunal was established by legislation passed in December 1948. Its role was to determine pay and conditions for public servants: Henderson, pp.195-6.

<sup>77</sup> May 1951, Circular memo from R. Kearney, Secretary, Mental Health Group, 82-046-030/6, ATL, Wellington.

<sup>78</sup> Those who chose overtime payments still received 28 consecutive days leave per annum or 35 days for those with over ten years' service: PSJ, 41, 10, 1954, p.14.

<sup>79</sup> General hospitals were also suggesting overseas recruitment. In 1946, Taumaranui Hospital Board, for example, asked the Hospital Board's Association to request the Department of Health to recruit 1,000 nurses and domestics from England, NZH, 14 May 1946, p.6.

<sup>80</sup> Megan Hutching, *Long Journey for Sevenpence: An Oral History of Assisted Immigration to New Zealand from the United Kingdom, 1947-1975*, Wellington, 1999, p.40.

<sup>81</sup> The Dominion Population Committee reported its findings in September 1946. It gave cautious support for planned immigration, *ibid.*, p.44.

London to deal with immigration queries, and commenced planning for a programme of assisted immigration.<sup>82</sup> Although the Government had not made an announcement on immigration, the crisis in mental hospitals forced it into pre-emptive action. Cabinet agreed to recruit 200 women from Britain to work as trainee nurses in mental hospitals.

Mental nurses became the forerunners of a more general assisted immigration scheme that started in 1947. The NES, which had overall responsibility for the nurses' scheme, established protocols which it later used with other immigrants. Between 1946 and 1975 approximately 77,000 moved to New Zealand under the wider scheme, most coming from the United Kingdom and the Netherlands. Immigrants received free passage in return for two years contracted work.<sup>83</sup>

In the case of the mental nurses, the Department of Mental Hospitals worked closely with the NES and the New Zealand High Commission in London to coordinate their recruitment and transfer. Dr Ronald Lewis, the Department's Director of Clinical Services, on sabbatical in London, was commissioned to interview and select the prospective nurses.<sup>84</sup> Other aspects of the recruitment campaign were put in the hands of the New Zealand High Commission, which advertised for single or widowed women between the ages of 20 and 35. Applicants provided birth certificates and names of referees, and submitted themselves for medical examinations and chest x-rays.<sup>85</sup> Although no experience was required, many of the applicants had undertaken some nursing training and some were qualified general or mental nurses. This caused a measure of anxiety for the High Commission, which did not want to be seen to be poaching nurses from Britain since they too were experiencing serious shortages. A decision was made that only untrained women would be selected, except in special cases.<sup>86</sup>

Hundreds of women responded to the advertisements. Those selected signed a two-year contract and agreed to undertake training as psychiatric nurses. They were given free passage and were paid four-weeks' salary (£90) while on board ship. Lewis tried to

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<sup>82</sup> The National Employment Service commenced operations in April 1946. It amalgamated with the Labour Department to become the Department of Labour and Employment in April 1947, *ibid.*, p.45.

<sup>83</sup> In the actual scheme, immigrants paid £10 towards their passage, and thus became known as 'Ten-pound Poms', *ibid.*, p.9.

<sup>84</sup> AJHR, 1947, H-7, p.2.

<sup>85</sup> Report from New Zealand High Commission, London, 31 July 1946, H-MHD, 1, 8/116/8, ANZ, Wellington.

<sup>86</sup> Memo to Department of External Affairs, 9 September 1946, H-MHD-1, 8/116/8, ANZ, Wellington.

select well-educated women, but decided that the ‘hard-working type’ with less academic ability would also prove their worth.<sup>87</sup> Because of the type of woman applying, a decision was made to appoint 25 cooks as well as the 200 nurses.<sup>88</sup> To assist his New Zealand colleagues with placement and supervision, Lewis established a grading system for the prospective nurses. Grade I was ‘superior type’, likely to pass state registration. Grade II was a ‘good average for pre-shortage days’ who Lewis predicted could pass the state examination with a reasonable effort. Grade III was unlikely to pass but could give useful service ‘under the present conditions’.<sup>89</sup> Lewis’ reference to state examinations reflects the current belief that psychiatric registration, established in 1945, would improve the standard of mental nursing.

Gray instructed the medical superintendents to welcome the British women with appropriate social activities. This was taken seriously by existing nurses, who were only too pleased to greet those who would relieve them of some of their work. Seacliff Hospital nurses went to great lengths to welcome the new immigrants. ‘Bright, flower-bedecked rooms, smiling welcomes and appetizing breakfast did much to dispel the cold grey dawn heralding the arrival of the twelve “Home” nurses to Seacliff Mental hospital recently’, reported the PSA journal.<sup>90</sup> Not only had the Seacliff nurses ‘delved deeply into their treasured stores’ to put on a welcoming breakfast, but they also took pains to ensure that the new recruits would not have to undertake arduous work in their first few weeks. Kath McLeod who was in charge of the nurses’ home at that time, recalls doing the cleaning herself rather than asking the English girls to do it.<sup>91</sup>

For some mental hospital tutor-sisters, this immigration scheme was an opportunity to implement their ideas on nursing education. Rita McEwan, a tutor-sister at Ngawhatu Hospital, lobbied the Director-General for permission to offer a preliminary school for the new recruits. She submitted a curriculum for circulation to other hospitals.<sup>92</sup> McEwan’s friend, Muriel Dandy, who held the tutor-sister position at Tokanui, was also keen to offer a preliminary school.<sup>93</sup> Although Gray criticized their proposed curriculum

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<sup>87</sup> 20 August 1946, Lewis telegram, H-MHD-1, 8/116/8, ANZ, Wellington.

<sup>88</sup> 25 September 1946, H-MHD, 1, 8/116/8, ANZ, Wellington.

<sup>89</sup> List of nurses sailing on the Rangatikei, December 1946, H-MHD-1, 8/116/8, Part 1, ANZ, Wellington.

<sup>90</sup> PSJ, 34, 2, 1947, p.54.

<sup>91</sup> Interview with Kath McLeod, 1 September, 2004.

<sup>92</sup> Rita McEwan to Gray, 12 August 1946, H-MHD-1, 8/116/8, ANZ, Wellington.

<sup>93</sup> Muriel Dandy to Gray, 16 September 1946, H-MHD-1, 8/116/8, ANZ, Wellington.

as 'overcrowded', his support for their initiatives appeared to have influenced the decision about where to send the first immigrant nurses.<sup>94</sup> The first group of 26 women arrived on the Rangitata in mid-October 1946. Twelve were sent to Tokanui, eleven to Ngawhatu and three, at their request, went to Porirua.<sup>95</sup> Over the next eight months, five more groups of women arrived and were allocated to mental hospitals across the country.

Finding willing recruits had been no problem, but assisting them to make the transition to New Zealand mental hospital conditions proved more difficult. Immigration officials, concerned that some might renege on their two-year contracts, decided to confiscate the women's passports; a decision the new nurses resisted strongly.<sup>96</sup> Despite the efforts of all concerned, the very problems that had plagued the Department for years were highlighted by this campaign. Within a few weeks, one nurse had walked out of Nelson Mental Hospital and four nurses were threatening to do the same at Tokanui. The women, whose average age was 25 years, were ill-prepared for the isolation, hard work and conditions. Many were from cities and found it difficult to adjust to country life. The main complaint at Tokanui, for example, was that there was nowhere to go in their off-duty time. Buses were irregular and there was little social life in the locality. Several enterprising trainees, however, found their own solution and hitch-hiked to Auckland on their days off.<sup>97</sup> Other trainees complained about the nature of the work. They were repulsed by the sights, sounds and smells of the hospital and patients.<sup>98</sup> A common complaint from those with any experience or training in mental nursing was that they were required to start again as juniors and undertake a considerable amount of cleaning and cooking. Nurses with experience were also less willing to adapt to New Zealand mental hospitals' treatment and protocols. Tensions arose between such nurses and their New Zealand colleagues.<sup>99</sup> Two new immigrants at Kingseat complained that their

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Variations of the preliminary schools were offered at the other hospitals. Sister Todd offered a two-week, less intensive programme at Porirua: 14, November 1946, H-MHD-1, 8/116/8, ANZ, Wellington.

<sup>94</sup> Gray to Public Service Commissioner, 15 October 1946, H-MHD-1, 8/116/8, ANZ, Wellington.

<sup>95</sup> Gray to Lewis, 25 October 1946, H-MHD-1, 8/116/8, ANZ, Wellington.

<sup>96</sup> Some nurses absolutely refused to hand over their passports: Hutching, pp.46-7. Others complained to the PSA: PSJ, 34, 2, 1947, p.54.

<sup>97</sup> Medical Superintendent, Tokanui to Gray, 14 November 1946, H-MHD-1, 8/116/8, ANZ, Wellington.

<sup>98</sup> Women arriving at Sunnyside were shocked seeing the patients and hospital for the first time: 23 December 1946, 1, 8/116/8, ANZ, Wellington. Three trainees at Tokanui complained that the sights and smells made them feel sick, frightened and unable to eat or sleep: 4 December 1946, 1, 8/116/8, ANZ, Wellington.

<sup>99</sup> Immigrant nurses at Porirua complained of tensions between themselves and the New Zealanders: 16 June 1947, 1, 8/116/8, ANZ, Wellington.



nursing skills were not being used; doctors carried out all the nursing tasks such as tube feeding and giving injections, leaving them with the cooking and cleaning. Within two weeks of starting work, they had resigned and gone to the newspapers with their complaints.<sup>100</sup>

Rather than address the conditions in mental hospitals, the Department decided to alter its recruitment processes. Recruits were asked to sign a form before leaving Britain indicating that they understood that their work would include unpleasant duties including cleaning and cooking. Nurses with any prior experience signed a second form agreeing to forgo any seniority. The Director of Employment suggested that in the future, they should not employ women with previous nursing experience. He claimed to be, 'very strongly of the opinion that future selection should be confined to girls of a suitable type who are inexperienced in nursing of any kind, who are willing to settle down to hard work and are not going to raise objection to domestic work, including cooking'.<sup>101</sup> This policy was endorsed by the Department. Dr John Russell, the Acting Director-General, wrote to three trained nurses explaining why their applications had been turned down, while untrained women were being offered positions. 'Naturally' he explained 'our own trained staffs do not like their methods being criticized any more than you would under similar circumstances'.<sup>102</sup>

The hope that this immigration campaign would provide a solution to the mental hospitals' staffing problems was short-lived. The lack of adjustment to the work and conditions was such, that of the 278 women recruited, 110 resigned before their contract was finished and most others left soon afterwards.<sup>103</sup> As a result, the female nursing staff vacancies were only briefly reduced to 241 in April 1947, but crept back to over 300 in September 1948.

The Department's head office administrators were grappling with their own problems. In 1947, the new Minister of Health, Mabel Howard, decided to amalgamate the Department of Mental Hospitals with the Department of Health. She had taken an opportunity afforded by two significant staff changes that year. Theodore Gray retired

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<sup>100</sup> C. Symon and B. Higgins to Gray, 20 January 1947, Dr G.Tothill, Medical Superintendent Kingseat Hospital to Gray, 30 January and 18 February 1947, H-MHD-1, 8/116/8, ANZ, Wellington.

<sup>101</sup> 18 February 1947, H-MHD-1, 8/116/8, ANZ, Wellington.

<sup>102</sup> 1 May 1947, H-MHD-1, 8/116/8, ANZ, Wellington.

<sup>103</sup> H-MHN-1, 8/116/0, ANZ, Wellington.

after 20 years in charge of Mental Hospitals and Michael Watt retired after 16 years as Director General of Health. The amalgamation was unpopular with officers of the Department of Mental Hospitals. Russell, who had been Gray's deputy for almost 20 years, stepped into the position of Director of the new Division of Mental Hygiene. He was never comfortable with the new arrangements and stayed in the position for only three years.<sup>104</sup> Although there is little evidence that the amalgamation directly affected nurses and attendants in the short term, it was seen by some to be a retrograde step. Rather than viewing it as an opportunity for countering stigma, some nurses and attendants perceived it as a process for undermining their service's independence and unique identity. By 1950 the administration of mental hospitals was finally functioning as an integrated section of the Department of Health, even though the new Director of Mental Hygiene, Dr Ronald Lewis, remained unconvinced about the merits of the new system. He was concerned that specialised medical control would be undermined and the patients' welfare affected.<sup>105</sup>

#### **'Some girls think the work is dirty': 1950s Staffing:**

Staffing levels remained at critical levels until well into the 1950s, the lowest point being 1951, when the mental hospitals were running with just over half their female nursing establishment (433 nurses of an establishment of 808).<sup>106</sup> Despite rigorous recruitment, the levels did not begin to improve until 1956, when changing demographic trends increased the number of young women available for employment. Even then, staffing did not keep pace with the growing patient population or the Division's estimates of how many nurses were required.

Obstacles to recruitment and retention of young women were considerable. Psychiatric nursing remained an unusual choice for young women; families were generally not keen on the occupation. Those who did start often found the work and hours very difficult. Many left in their first year. The few who stayed often did so out of sheer determination. Once through the first few months, however, many became 'hooked' by psychiatric nursing. In particular, they valued relationships with their patients, the sense of satisfaction when someone recovered and the camaraderie among staff.

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<sup>104</sup> Dow, pp.156-7.

<sup>105</sup> AJHR, 1951, H-31, p.16.

<sup>106</sup> AJHR, 1952, H-31, p.25.

### ***Recruitment campaigns***

During the 1950s the Division of Mental Hygiene undertook a series of increasingly sophisticated, though not always successful, campaigns to recruit female psychiatric nurses. The campaigns reflected the Division's attempts to re-package psychiatric nursing as an occupation suitable for respectable, educated young women. In 1951 Jack Marshall, the new Minister of Health in the National Government that superseded Labour in the 1949 elections, announced his government's commitment to attracting 'young women and men with character and kind hearts' to work in the mental hospitals.<sup>107</sup> The announcement brought a small flurry of attention from national newspapers, the *New Zealand Observer* noting that funding for mental hospital patients was less than half that allocated to patients in general hospitals.<sup>108</sup> The *New Zealand Truth* chose to expose hospital conditions, claiming the situation was so desperate that, in some cases, patients had to cook and clean for themselves.<sup>109</sup> With Cabinet's approval of £3,000, the Division launched a recruitment campaign in the final months of 1951 that included newspaper and radio advertisements, leaflets and posters, in the style of recent advertising campaigns for general nurses. Advertisements focused on opportunities for fulfilling work, recreation and generous holidays to attract young single women, aged 18 years and over. Readers were encouraged to seek further information by returning tear-off coupons from newspapers and magazines. Married women were accepted, but hospitals remained cautious about their ability to fit the work around family commitments.<sup>110</sup>

The Division was aware that one of the greatest obstacles to recruitment was the public perception of mental hospitals. Lewis believed that if 'girls can be persuaded to see the actual conditions, the chances of us obtaining them as recruits is increased'.<sup>111</sup> To this end, some hospitals supplemented the national campaign with more personal, local initiatives. At Tokanui, for example, the hospital administrators arranged prompt follow-up of inquiries. The medical superintendent, Dr Geoffrey Blake-Palmer reported 'encouraging results' when immediate action was taken to arrange for the 'girls' to visit

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<sup>107</sup> October 1951, H-MHD-1, 8/116/12, Vol.1, ANZ, Wellington.

<sup>108</sup> *New Zealand Observer*, 10 October 1951

<sup>109</sup> *New Zealand Truth*, 24 October 1951, p.11.

<sup>110</sup> Dr Geoffrey Blake-Palmer, Medical –Superintendent, Seacliff Hospital suggested that the chief need was for younger women, but older and married women could be of use if they had few 'home ties', 24 June, 1954, DAHI, D266, 354e, 6/25/0, ANZ, Dunedin.

<sup>111</sup> Memo from R.G.T. Lewis, 26 November 1951, H H-MHD-1, 8/116/12, Vol.1, ANZ, Wellington.

the hospital.<sup>112</sup> At Seacliff, the social worker, Miss M.I. Tully, undertook a comprehensive recruitment tour of small towns in the Otago region. Her personal approach came at some cost; she drove 423 miles, travelled on flooded roads and, at one point, her car had to be towed out of the mud. Her report on this rural adventure included a suggestion that some of the advertising material was ‘rather over-glamorized, causing a feeling of inferiority to country wenches’.<sup>113</sup>

Although a large number of women and girls returned coupons in this first advertising campaign, many of the respondents were school children who were merely curious, rather than serious inquirers. The results were not as good as had been hoped. Only 86 appointments were made during the campaign, and because of high rates of attrition, the actual numbers of female nurses increased by only 44.<sup>114</sup>

After another national recruitment campaign in early 1953, the numbers of female staff improved, but results were uneven across the country.<sup>115</sup> Sunnyside Hospital reported that inquiries were up, with a ‘better type of applicant’. Seacliff Hospital also noted some improvement, particularly in the numbers of applications from students at university and teachers’ college for work in the summer vacation. Other hospitals reported little if any improvement. At Tokanui, a high proportion of applicants were too young and others appeared to the Medical Superintendent to be ‘frankly in it for the money’. He suggested that what was needed to attract ‘more suitable types, was publicity of the mental hospitals and their functions’.<sup>116</sup> His views echoed the Division’s concern about the public image of mental hospitals; it seemed that fear and ignorance were inhibiting the recruitment of young women.

Further campaigns in 1953 were planned so that they would not clash with the Royal visit. Two advertisements were alternated in newspapers between September and November 1953. Leaflets were distributed nationally and hospitals were expected to do their bit by organising window displays in local towns. The Division also hoped to

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<sup>112</sup> 20 February, 1952, H H-MHD-1, 8/116/12, Vol.1, ANZ, Wellington.

<sup>113</sup> 6 June 1952, DAHI, D266, 354e, 6/25/0, ANZ, Dunedin.

<sup>114</sup> Despite the campaign’s focus on women, it did appear to have increased the number of male applicants: Report by J.W. Waldron, Staff Training and Welfare Officer, 1 July 1952, H H-MHD-1, 8/116/12, Vol.1, ANZ, Wellington.

<sup>115</sup> Female nursing numbers rose from 433 in December 1951 to 579 in April 1953: Lewis report to medical superintendents, 13 May 1953, H-MHD-1, 8/116/12, Vol. 2, ANZ, Wellington.

<sup>116</sup> October – November, 1953, H-MHD-1, 8/116/12, Vol. 2, ANZ, Wellington.

commission a promotional film, but this never eventuated.<sup>117</sup> Although male staffing numbers had improved, it was apparent that this last promotion had lost the effectiveness of the previous campaigns in attracting female staff.<sup>118</sup> The number of coupons received by the Division had reduced with each successive campaign and the recruitment committee was left wondering if this was because the novelty had worn off or whether there were merely fewer young women in the available employment pool.<sup>119</sup> The committee decided to discontinue national advertisements and to rely instead on propaganda articles, radio talks, a recruitment booklet, and modest local hospital advertising.<sup>120</sup> It seems in retrospect that this may not have been a good decision; the female vacancies climbed again to over 300 for the first time in three years.<sup>121</sup>

### ***Maori recruitment***

One group specifically targeted by the Division was young Maori women. Post-war government policy supported urban migration of Maori workers to help fill gaps in manufacturing and service industries. Mental hospitals were one 'industry' that made use of this trend. Megan Woods argues that the urban migration of Maori women was a deliberately orchestrated governmental policy to hasten racial integration. Nursing, like teaching and domestic work, was viewed as a suitable occupation that would train Maori women in the domestic skills necessary for their future roles as 'mothers of the race'.<sup>122</sup> Woods has suggested that Maori were encouraged to enter the nursing profession at lower levels as nursing aids or as psychiatric nurses.<sup>123</sup> Advertisements, repeated many times during 1956-7 in *Te Ao Hou*, promoted nursing as a 'natural occupation' into which Maori women could enter by way of nurse aiding (see Figure 8).<sup>124</sup> Other advertisements focused specifically on psychiatric nursing.<sup>125</sup> Although targeting Maori, the advertisements consistently used Pakeha images.

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<sup>117</sup> Plans for a film were deferred: 21 August 1953, H-MHD-1, 8/116/12, Vol. 2, ANZ, Wellington.

<sup>118</sup> J.W. Waldron, memo to Director, 9 October 1953, H-MHD-1, 8/116/12, Vol. 2, ANZ, Wellington.

<sup>119</sup> In 1953 the number of 18 year olds in the population was lowest at 11,700: Lewis memo, 1 December 1953, H-MHD-1, 8/116/12, Vol. 2, ANZ, Wellington.

<sup>120</sup> Lewis memo, 23 November 1953, H-MHD-1, 8/116/12, Vol. 2, ANZ, Wellington.

<sup>121</sup> AJHR, H-31, 1955, p.25.

<sup>122</sup> Megan Woods, 'Dissolving the Frontiers: Single Maori Women's Migrations, 1942-1969,' in *Shifting Centres. Women and Migration in New Zealand History*, Lyndon Fraser and Katie Pickles, eds, Dunedin, 2002, p.124.

<sup>123</sup> *ibid.*

<sup>124</sup> For example, *Te Ao Hou, The New World*, No. 18, 5, 2, May 1957 and No. 21, 6, 1, December 1957, inside front covers.

<sup>125</sup> *Te Ao Hou*, 24, October 1958, p.58.

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**Figure 8 Advertising for Maori nurses, 1957-8.**  
 Source: *Te Ao Hou, The New World*, 18, 5, 2, 1957, inside front cover.

The number of Maori women in general nursing increased by approximately 50 percent between 1952 and 1955.<sup>126</sup> In psychiatric nursing, the increase was much greater, though this is difficult to quantify, since the Division did not regularly record staff ethnicity. The patterns of Maori employment in mental hospitals varied considerably. Tokanui Hospital, in the Waikato, was situated in a rural Maori community and was an obvious employment choice for local women.<sup>127</sup> Figures reported in the early 1960s, suggest that numbers of female Maori nurses increased substantially at Tokanui during the 1950s. This was also the case at Kingseat Hospital, which was located in the northern part of the Waikato.<sup>128</sup> Urban mental hospitals in the North Island also attracted large numbers of Maori women, though many stayed for only a short time. Oakley and Porirua Hospitals became 'staging posts' for some Maori women moving to the city. Nurses who trained in these hospitals in the late 1950s recall large numbers of young Maori women who had recently moved from the country.<sup>129</sup> In 1963, Maori constituted more than a quarter of female nurses at Porirua Hospital and approximately

<sup>126</sup> The recorded number of Maori in general nursing increased from 97 in 1952 to 148 in 1955, AJHR, 1955, H-31, p.52.

<sup>127</sup> For example, Esther Graham joined her sister at Tokanui in 1937: Esther Kirianu Graham interviewed by Lois Wilson, 15 March 1984, OHInt-0014/062, NERF-OHP, ATL, Wellington.

<sup>128</sup> In 1963, almost half the female nurses at Kingseat and more than a third at Tokanui were recorded as being Maori, H, 1, 30779, 30/35/51, ANZ, Wellington.

<sup>129</sup> Margaret Bazley interview 29 January 2004.

one fifth at Oakley (Avondale) Hospital.<sup>130</sup> Sisters W. and K. Beattie who moved from rural Wairoa to work at Porirua Hospital were featured in *Te Ao Hou* in 1958.



**Figure 9 Nurses W. and K. Beattie from Wairoa at Porirua Hospital.**  
Source: *Te Ao Hou, The New World*, 6, 4, 1958, .58.

### *Assisted Immigration*

Local advertising was supplemented by overseas recruitment. Both psychiatric and general nursing were targeted occupations under the Government's assisted immigration scheme. From 1946 to 1958, the Nursing Division maintained a representative in London to assist with nursing inquiries. Despite this, it did not prove to be a great source of new recruits for psychiatric nursing. In 1953, at its height, the programme introduced 122 registered nurses, 19 pupil general nurses and nine mental hospital nurses (see Appendix H).<sup>131</sup> It is not clear how many of the registered nurses worked in mental hospitals, but the numbers were probably very small.<sup>132</sup>

It appears that the assisted immigrants of the 1950s were no more prepared for the conditions in New Zealand mental hospitals than the original group who had arrived immediately post-war. One nurse, who immigrated in 1950, was not told where she

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<sup>130</sup> H, 1, 30779, 30/35/51, ANZ, Wellington.

<sup>131</sup> AJHR, 1954, H-11.

<sup>132</sup> It is likely that only two registered nurses joined the mental hospital workforce on the Assisted Immigration scheme in 1953. There is the discrepancy between the figures reported by the Nursing Division, which may have only been citing the general hospital figures: AJHR, 1954, H-31, p.57 and those reported by the Department of Labour and Employment: AJHR, 1954, H-11.

would be working until her ship arrived in Wellington Harbour. She was ill-prepared for conditions at Porirua Hospital, ‘We had no idea, no idea at all’, she recalled. There was no orientation and the hospital was so short-staffed that she was required to work 15 days without a break. ‘When we arrived, I tell you, I’d have swum home if I could’.<sup>133</sup>

The mid-1950s, when female staffing levels were again particularly low, the Division considered a range of solutions, some more practical than others. A survey of staff resignations revealed that the rate of female staff turnover was increasing; the annual turnover was 66% in 1953.<sup>134</sup> J.W. Waldron, Staff Training Officer for the Division, suggested that good management principles needed to be applied and reasons for staff resignations should be addressed. National posters and advertisements were reintroduced for early 1955 and then dumped again later in the year because of a poor response. One idea, seemingly born out of desperation, was to follow the example of the Otago Hospital, who gave their patients a notice as they were discharged, explaining the nursing shortage and asking them to help recruit nurses. Lewis doubted ‘the wisdom of encouraging our discharged patients to act as recruiting agents’.<sup>135</sup> He was somewhat more responsive to the idea of recruiting from amongst the ‘two boatloads of German girls’ who one medical superintendent had heard were immigrating to New Zealand. There is no evidence, however, of specific targeting of these women.<sup>136</sup>

### ***Public promotion of mental hospitals***

The most favoured recruitment strategy throughout the 1950s was public education about mental hospitals. The Division and government both believed that stigma and ignorance were significant factors in preventing young women from seeking work in them. In 1952 Marshall reported to Cabinet that, ‘many prejudices and misconceptions unfortunately still exist and these must be steadily broken down if Mental Hospitals are to secure the right type of young women’.<sup>137</sup> To this end, the Ministry of Health commissioned a journalist to write a series of articles for daily newspapers and weekly magazines, which focused on the advances of modern psychiatric treatments, the changing appearance of mental hospitals and the popularity of psychiatric nursing as a

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<sup>133</sup> Williams, p.209.

<sup>134</sup> Waldron to Lewis, 21 October 1954, H-MHD-1, 8/116/12, Vol. 2, ANZ, Wellington

<sup>135</sup> Lewis to Blake-Palmer, Medical-Superintendent, Seacliff Hospital, 3 May 1955, H-MHD-1, 8/116/12, Vol. 2, ANZ, Wellington.

<sup>136</sup> Correspondence between the medical-superintendent, Tokanui and Lewis, 5 & 10 April 1956, H-MHD-1, 8/116/12, Vol. 2, ANZ, Wellington.

<sup>137</sup> 19 August 1952, H-MHD, 1, 8/116/12, Vol.1, ANZ, Wellington.



career. The central message was that treatment and cure was now possible and hospitals were no longer places to be feared.<sup>138</sup> *The New Zealand Herald*, for example, published a series of articles entitled 'Our Mental Hospitals' including one extolling the physical attributes of Avondale Hospital that '... once looked like a prison (but) today is one of the finest mental hospitals in the country'. The article went so far as to claim that the newly painted and curtained wards now resembled the Grand Palace Hotel.<sup>139</sup>

Advertising campaigns in the later years of the decade continued to use the public relations tactic, but took a regional approach rather than national. The Government's Publicity Department assisted individual hospitals with their own recruitment drives. A journalist would visit the hospital to gather information and meet staff, his job being to write articles for local newspapers, negotiate for window displays and show cards in local shops, and co-ordinate radio interviews and advertisements. For the first time, nurses were actively involved in promoting their profession. Nurses read scripted sound bites for radio advertising. Snippets such as, 'I followed several other callings before I took the opportunity to train as a psychiatric nurse and I've found this job the most satisfying of all' were interspersed with facts from an announcer about the training and conditions.<sup>140</sup> Articles in local newspapers provided readers with information about the latest advances in psychiatry, promotional material about the benefits of psychiatric nursing as a career, and appeals for assistance with the desperate shortage of staff.

Journalists trod a fine line as they attempted to paint a glowing picture of psychiatric hospitals while also exposing the need for female staff. A collection of articles published by the *Auckland Star* in February 1957 provides a good example of this dilemma. Headlines announced, 'New Drugs Beating Psychiatric Troubles', and 'Nurses lounge is bright, cheerful'. But young women attracted by these announcements may have been put off by other headlines on the same page announcing, 'Kingseat wants a lot more nurses, needs them badly' and another statement that, 'Some girls think the work is dirty'.<sup>141</sup>

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<sup>138</sup> 8 June 1952 Lewis memo re information articles, H-MHD-1, 8/116/12/1 Vol. 1, ANZ, Wellington.

<sup>139</sup> NZH, 6 September 1954, p.10.

<sup>140</sup> Proposed advertisements for Seacliff Hospital, 13 June 1956, H-MHD-1, 8/116/12, Vol. 2, ANZ, Wellington.

<sup>141</sup> *Auckland Star* (AS), 18 February 1957, p.7.

The style and content of advertisement for psychiatric nurses changed between the 1940s and the 1950s. Advertising for both psychiatric and general nursing became much more creative and sophisticated, but there were subtle changes in terms of content and focus. Victoria Cullens, in her study of post-war nursing shortages, suggests that in the earlier years the advertisements were composed of simplistic appeals for an ongoing supply of young women in hospitals and nursing training schools, while by the mid 1950s there was much more emphasis on the professional, responsible nature of nursing work and career opportunities.<sup>142</sup> A similar, but somewhat different change occurred in advertisements for psychiatric nursing. Advertisements in the 1940s focused on pay and conditions, such as holidays and accommodation; they did little to address the public view of mental nursing as a suitable occupation for young women. The work needed to be done; concrete rewards were offered rather than appeals to a higher calling. A shift occurred in the post-war period. Like the general nursing advertisements, those for psychiatric nurses began to appeal to a sense of vocation and career. What was different, however, was a focus on reassuring young women and their families that psychiatric nursing was a respectable, ‘ordinary’ occupation (see examples in Figure 10 below).

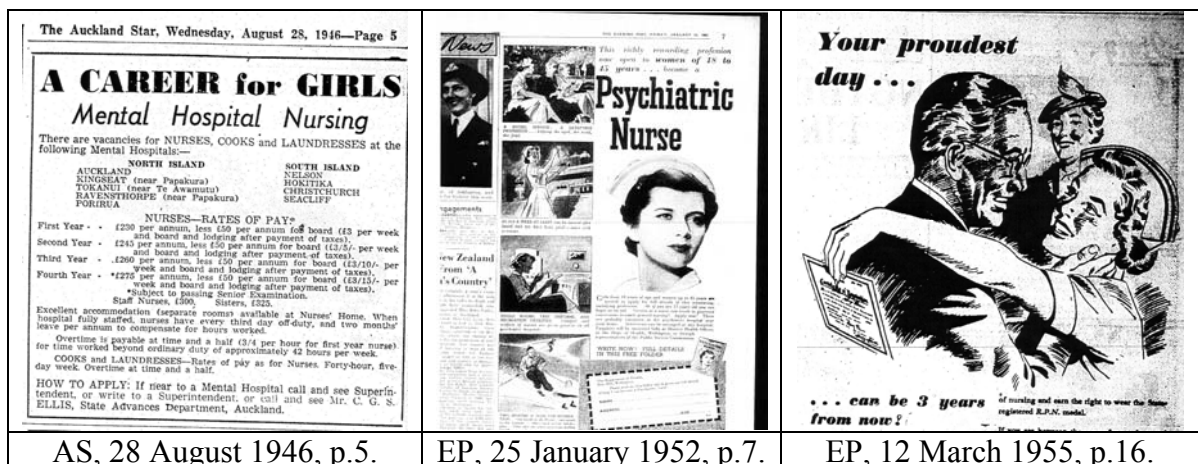


Figure 10 Advertisements for mental hospital nurses, 1946, 1952, 1955.

### Who responded?

Four nurses who commenced work in the 1950s provide insight into the direct effects of the recruitment campaigns. Their stories also demonstrate the determination required for women to resist family or societal expectations by taking up psychiatric nursing. Margaret Bazley (known as Margaret Hope until her marriage in 1965) was raised in Waihi, where there were few career options for female school leavers. She became

<sup>142</sup> Cullens, p.58.

fascinated by psychiatric nursing after being shown a brochure by a vocational guidance officer at school. The usual choices for women of teaching or general nursing did not appeal, but she felt that psychiatric nursing would allow her to build on her interests in psychology and English. Her family and friends were not keen for her to take up psychiatric nursing, but eighteen months before starting, an aunt took her to visit Avondale (previously known as Auckland Mental) Hospital. They were both horrified by what they saw: patients sitting in rows of armchairs in the corridors, surrounded by flies; dormitories packed full; and an admission ward with people sitting like zombies. Bazley recalls, 'I found it quite terrifying, but I just had to know more about it'. She started working at Avondale Hospital in February 1956. The work was extremely difficult and the environment was, in many ways, very harsh. Bazley was determined not to give up, however. She remembers that 'the only reason I didn't go home was that I would have had to have admitted to everyone in my [home town] that they were right'.<sup>143</sup>

Three years later another equally determined woman started work as a psychiatric nurse. Audrey was in her late twenties when she read a recruitment article about psychiatric nursing. She was working on a farm at the time, so was interested to read that farm people made excellent psychiatric nurses. She was not well qualified educationally and saw this as an opportunity for a career, '...something I wouldn't mind doing, something useful as well'. Her mother was horrified, but Audrey was independent and not about to change her mind. At Avondale Hospital, the assistant matron tried to persuade Audrey to start as a nurse aide because she was older than most applicants and might not be able to cope with the study. Audrey, however, was adamant that she wanted a career. She recalled, 'I said, "I'm not really interested in that", and I picked up my bag ... She said, "Sit down, sit down!" I thereupon became a student nurse'.<sup>144</sup>

Although negative media about conditions in psychiatric hospitals may have deterred some women, curiosity and a desire to help prompted others. Joy Collins read a sensational article about conditions at Porirua Hospital in the Truth newspaper. Among other things it claimed that patients at Porirua Hospital were being forced to drink their own urine. Joy was intrigued. She couldn't quite believe that things could be that bad

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<sup>143</sup> Margaret Bazley interview 29 January 2004.

<sup>144</sup> Audrey (pseudonym) interview 9 December 2003.

and was motivated to experience the hospital first-hand. She inquired about psychiatric nursing, was accepted without an interview and commenced at Porirua in 1958.<sup>145</sup>

Other women saw nothing unusual about applying for psychiatric nursing; it was part of a world they knew. At 18 years, Velda Kelly resigned from her job at the bank in Mosgeil and announced to her family that she was going nursing. They were surprised by her choice of psychiatric rather than general nursing, but did not oppose her decision. Kelly believes her attitude to psychiatric nursing had probably been influenced by the frequent visits of a close family friend who was a nurse/attendant at Seacliff. When she left home to start nursing at Seacliff in 1955, Kelly's father predicted that she would be back within six months. Indeed, she did find the transition difficult, not because of the patients or the work, but because of the strangeness of living away from home. She was determined to prove her father wrong, and in the meantime, she 'became hooked' on psychiatric nursing. For Jamesina Hippolite, a Maori woman who started work at Porirua Hospital in 1957, nursing was in the family. Two of her sisters were already on staff at the hospital, another was a general nurse. Hippolites' father encouraged her into nursing, rather than taking the easier option of work in a factory. Psychiatric nursing provided an opportunity for good pay and a qualification.<sup>146</sup>

These women all completed their training and became Registered Psychiatric Nurses. Many, many other young women did not stay the distance of the three-year training. The turnover was very high, particularly in the first year. Most nurses did not stay long enough to benefit from the training or become more than 'just another pair of hands'. Although the Division's goal was to recruit girls with solid secondary education, and preferably with school certificate, this was often not possible. The psychiatric nursing workforce in the 1950s was predominantly young, poorly educated, and inexperienced. For many young women the relatively good salaries, cheap accommodation and long holidays were not sufficient compensation for the hard work, long hours and stigma of association with mental illness

### ***Some improvement, but shortages continue***

Overall, female staffing levels in psychiatric hospitals did improve in the late 1950s. As expected, shortages of employment for young women generally eased from 1956, when

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<sup>145</sup> Joy Collins interview 27 January 2004.

<sup>146</sup> Jamesina Kett interview 2 June 2004.

the proportion of 18 to 25 year olds in the population started to increase.<sup>147</sup> General immigration also contributed to the improvement. During the 1950s, the names of 97 women and men with overseas qualifications were added to the New Zealand Register of Psychiatric Nurses (see Appendix J).<sup>148</sup> The Division continued to report shortages of over 200 nurses across the country but as official establishments were raised, absolute numbers of nurses increased significantly.<sup>149</sup> By 1958 there were signs of hope. One hospital was fully staffed, the standard of female applicant had improved, and the hospitals were, for the first time, in a position to attempt to establish preliminary schools. These would provide four to eight weeks of classroom teaching at the beginning of the nurses' training course. Although the staffing improvement may have been largely attributable to changing demographics, it does appear that the advertising campaigns had raised public awareness of psychiatric hospitals. As one medical superintendent said, 'any enlightenment of the public with consequent breaking down of parental prejudice against daughters doing this work will eventually be of advantage'.<sup>150</sup> Mental hospital administrators and politicians, however, faced an uphill battle to convince the public that psychiatric nursing was not only a career, but a suitable occupation for young women. Despite their concerted efforts to paint a picture of mental hospitals as places of recovery and normality, stories to the contrary slipped into the media from time to time. Patient overcrowding, possibilities of violence and nurses' long, hard hours of work belied the message that this was an 'ordinary female profession'.

### ***Male staffing 1950s***

Shortages of male staff existed but were much less critical than on the female sides.<sup>151</sup> Staff turnover was much lower and it was not as difficult to recruit men to the work. The main attractions seemed to be accommodation, reasonable pay and the absence of

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<sup>147</sup> General nursing staffing had eased somewhat by 1955: Cullens, p.i.

<sup>148</sup> Of the 97, 74 were registered with the General Nursing Council of Great Britain, 14 held Australian registration, 7 were registered in the Netherlands, and 2 were from other countries: Register of Psychiatric Nurses, 1945-1966: ABYO, 7889, W5148, 30, ANZ, Wellington.

<sup>149</sup> Another indication of success in attracting young women was that the average age of first year psychiatric nurses fell from 24.4 years in 1949 to 21.5 years in 1959 (calculated from date of birth of nurses in their first year of work: New Zealand Public Service List, 1949 and 1959-60, ATL, Wellington).

<sup>150</sup> J. U. Williams, Medical Superintendent, Nelson Mental Hospital memo to Lewis, 20 May 1958, H-MHD-1, 8/116/12, Vol. 2, ANZ, Wellington.

<sup>151</sup> Between 1951 and 1952, the shortage of men reduced from 171 to 131: 1 July 1952, H-MHD-1, 8/116/12, ANZ, Wellington. By the end of 1953, vacancies had again reduced to 82 in an establishment of 891: AJHR, 1954, H-31, p.25. In 1957, there were 88 male vacancies in an establishment of 1,000: AJHR, 1958, H-31, p.40.

hard physical work. The 1950s advertising campaigns, although targeted at women, raised the profile of mental hospitals and resulted in increased numbers of male applicants. By 1953, six hospitals were fully staffed on the male sides. Kathy Truman has suggested that economic stringency dominated recruitment policy throughout the 1950s. Until 1953, and arguably for some years afterwards, the priority for the Division was to recruit and retain numbers of staff, rather than being concerned with specific skills and educational standards; Head Office was concerned only with a 'head count'.<sup>152</sup> Although this is probably an accurate reflection of the usual recruitment practice, there were signs of concern about standards. J. Waldron posed the possibility of raising the standard of male appointments by centralising the selection process.<sup>153</sup> Most medical superintendents expressed support for the concept, but were reluctant to give up local control over selection. Those in rural areas particularly felt that they were best placed to check out the suitability of local recruits.<sup>154</sup> Others remained unconvinced that educational achievement was a necessary attribute for a male attendant. The medical superintendents' uncertainty arguably reflected continuing ambivalence about the attendants' roles. Mental hospitals were communities which required considerable maintenance of the physical plant as well as supervision of long term patients, both worker and otherwise. Employment stability was also valued. It was in their interests to continue employing men for their physical strength, ability with various trades and sporting skill. For superintendents, particularly in rural communities, a mature local family man who could put his hand to anything, would appear to be of more use than a well educated young man.

### **Male psychiatric attendants: 'just ordinary people'?**

In the 1950s, the role of male attendant/nurse in a psychiatric hospital appeared to be an acceptable occupation for working-class men. Many male recruits although not well educated, held some kind of trade qualification. The men usually sought work in mental hospitals because of the stable employment and relatively good conditions. For some, it was also an opportunity to work with people and gain a qualification. Most had been working for many years, some in several different occupations. Many applicants in the immediate post-war years had experience in the armed forces. In rural areas, applicants

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<sup>152</sup> Truman, p.124.

<sup>153</sup> 9 October 1953, 1, 8/116/12, Vol. 1, ANZ, Wellington.

<sup>154</sup> November 1953, MHD-1, 8/116/12, Vol. 1, ANZ, Wellington.

were often local men with some understanding of mental hospital work, but in urban areas, applicants were more likely to be transitional workers with little prior knowledge of the field. Russell Flahive's experience was not untypical. He had left school early during the war and worked in various jobs as a teenager before joining the air force in 1946. He travelled and worked in Australia for a number of years and then returned to Invercargill. His choice of career happened almost by chance. In 1951, a friend encouraged Flahive to accompany him to Wellington. They were both well qualified and jobs were plentiful, but they needed accommodation. Although they weren't eager to work at a mental hospital, Porirua provided what they needed. His friend returned to Invercargill six months later, but Flahive was hooked. He stayed for 38 years and became a national leader in the Public Service Association's Mental Hospital Group.<sup>155</sup>

During the 1950s, a high proportion of new attendants were immigrants from Britain and the Netherlands. When Flahive started work at Porirua, for example, he was the only New Zealander living at the male staff quarters, the others being either British or Dutch.<sup>156</sup> Some men were qualified psychiatric nurses when they immigrated, but most arrived with no former experience.<sup>157</sup> Adrian Moerenhout trained as a maintenance engineer in the Netherlands before immigrating to New Zealand in 1951. He worked in various jobs including bricklaying, milk delivery, and carpet-laying. Moerenhout found that he had an affinity with people rather than things. It was a customer on his milk round, an ex-psychiatric patient, who suggested that he might make a good psychiatric nurse and encouraged him to 'give it a go'. Moerenhout reflected that psychiatric nursing was attractive to new immigrants who were trying to establish themselves financially. The pay was good and penal rates increased it by approximately one third. He was 32 years old when he started work at Oakley Mental Hospital in 1959.<sup>158</sup>

Rural mental hospitals often attracted local men who had tried other occupations and were looking for a change. Francis Gugich was born in 1932 in Hokitika and brought up in the area. When he left school, after a four-year woodwork course at Greymouth Technical High School, he was not able to get work in his field and took a job as a

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<sup>155</sup> Russell Flahive interview 1 June 2004.

<sup>156</sup> *ibid.*

<sup>157</sup> During the 1950s, overseas nurses gaining psychiatric registration in New Zealand included 71 from Britain, 15 from Australia, seven from Holland and one from Canada: Register of Psychiatric Nurses, 1945-1966, ABYO, 7889, W5148, 30, ANZ, Wellington.

<sup>158</sup> Adrian Moerenhout interview 11 April 2004.

stacker on a gold mining dredge. The work was dangerous, so although Gugich stayed for three years, he took the opportunity when it arose to move into something less risky and went to work for Post and Telegraph on the telephone lines. This seemed to have long-term career prospects, but after three years, with signs that it was closing down, Gugich went to work at Westland Breweries as a cooper (barrel-maker) and also learned to drive trucks. When the brewery was relocated from Hokitika to Greymouth, Gugich was forced to look for a new job. He had not considered psychiatric nursing, but in discussion with the Hokitika night watchman, was persuaded to try working at Seaview Hospital. He started work in 1958 as an attendant, then after the first two years, began training as a psychiatric nurse. Gugich stayed on the staff for 33 years.<sup>159</sup>

The men's decision to work at a psychiatric hospital did not appear to have elicited a negative reaction from family or friends; it was an acceptable occupation for 'ordinary men'.<sup>160</sup> This pattern was very similar to that in Britain, where, for example, a significant number of ex-servicemen joined the staff of mental hospitals after the war.<sup>161</sup> In New Zealand, mental hospital work was similarly attractive to ex-servicemen. Jock Phillips has suggested that the culture of 'mateship', including tight friendship bonds, alcohol and the rough rigour, that dominated New Zealand men's experience during the war created difficulties for men reintegrating into 'normal society'.<sup>162</sup> Arguably, mental hospitals provided working environments that assisted with this transition. The male-only working community, hierarchical structure, sporting activities and emphasis on physical, outdoor work allowed men to ease back into working life in a culture not too dissimilar to army life.

Work as a mental hospital attendant/nurse did not generally challenge dominant notions of masculinity. The stereotypical 'Kiwi bloke' was an outdoors man, a good sportsman, comfortable in an exclusively male work community and ready to put his hand to anything. These attributes fitted well with the working environment on the men's side of the mental hospitals in the 1940s and 1950s.

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<sup>159</sup> Francis Gugich interview 29 August 2004.

<sup>160</sup> A comment made by Adrian Moerenhout about the men who staffed Avondale (Oakley) Mental Hospital when he began psychiatric nursing in 1959: Adrian Moerenhout interview 11 April 2004.

<sup>161</sup> Brown, Nolan, and Crawford, 'Men in Nursing', p.10.

<sup>162</sup> Phillips, pp.211-4.



## **Gender differences: a reflection of institutional realities?**

Joan Evans has suggests that prevailing definitions of masculinity have historically acted as a 'powerful barrier' to men entering the nursing profession. She argues that it is only in times of acute nursing shortages or war that men have been able to 'cross over' into nursing. She also claims that since the Nightingale reforms of the nineteenth century, men have been relegated to psychiatric nursing as part of a process of formal segregation of women and men within the occupation.<sup>163</sup> This analysis does not, however, provide sufficient explanation of the gender issues within mental nursing. In New Zealand, men who joined the mental hospital workforce before 1960 were not 'relegated' to a speciality of nursing. Most did not see themselves as nurses.<sup>164</sup>

It is my contention that mental attendance/nursing, particularly for men, was generally perceived as something different to nursing. It is more useful to understand the gender differences in the mental hospital workforce before 1960 as a product of the workers' relationship with the institutions, rather than as a subset of nursing. The identity of the nurses and attendants was closely related to the public image and culture of the institutions in which they worked. In Lee-Ann Monk's exploration of the occupational identity of attendants in Victorian asylums in the nineteenth century, she asserts that, '...the purpose and nature of the asylum gave meaning to the asylum work and the occupational identity of workers'.<sup>165</sup> Monk signalled that the attendant role and identity was changing at the end of the century as 'asylums' gave way to 'hospitals'.<sup>166</sup> In New Zealand, fifty years later, this expectation had only partially been fulfilled. Despite the introduction of somatic therapies, voluntary admissions and registration of psychiatric nurses, in many ways the mental hospitals continued to function as self-contained asylums. This work associated with this type of institution was perceived to be more suitable to men than to women.

## **Conclusion**

Staffing patterns in mental hospitals during the 1940s and 1950s provide an insight into the contemporary perceptions of mental/psychiatric nursing. Throughout the two

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<sup>163</sup> Evans, pp.321-8.

<sup>164</sup> For example, Russell Flahive interview 1 June 2004.

<sup>165</sup> Monk, p.248.

<sup>166</sup> *ibid.*, p.251.

decades, recruitment and retention of men was much easier than that of women. Although demographic changes, marriage patterns and a rise in the ideology of domesticity account for some of the differences, other factors are important. Psychiatric attendant/nursing was an acceptable occupation for ordinary, working-class men but mental/psychiatric nursing was not commonly perceived as a desirable occupation for women. During these two decades, significant changes occurred in the treatments available to mental hospital patients. Medical therapies, in particular, called for nurses to acquire a different range of skills. The next chapter explores to what extent these changes altered the work and practice of mental nurses and attendants.

## **Chapter III**

### **Work and Practice of Nurses and Attendants 1939-1959**

‘The nurses did everything, except where patients would help, and how we ever got on without the patients I really don’t know’.<sup>1</sup>

Between 1939 and 1959, the work of mental hospital nurses and attendants was largely constrained by the asylum-type conditions in which they worked. The quality and character of patient care was shaped by factors such as overcrowding, severe understaffing, and a predominance of patients with chronic illnesses. Demands to supply much of the domestic and outdoor labour of the self-sufficient institutions also constrained the work of the nurses and attendants. Changes did, however, occur during these two decades. Most significantly, the introduction of somatic treatments, hospital reforms and the diversification of the workforce created an expectation that male and female nurses would develop new therapeutic roles. Fulfillment of this expectation was delayed however by the overwhelming demands for basic (physical) patient care and physical labour.

#### **Hospital conditions: therapeutic ideal versus practical reality**

By 1939, despite at least thirty years of medical rhetoric within psychiatry, mental hospitals more closely resembled nineteenth-century asylums than they did twentieth-century general hospitals. Hopes for a therapeutic breakthrough had been almost entirely unfulfilled. Apart from malarial treatment for a few patients suffering from GPI (general paralysis of the insane), psychiatrists had little to offer patients in the way of treatments.<sup>2</sup> Psychological approaches had gained some credibility following their use with shell-shocked soldiers returning from World War One but they remained marginal within mental hospital practice. Psychiatrists were highly sceptical about the efficacy of psychotherapy particularly for the seriously mentally ill.<sup>3</sup> ‘Moral management’, in everything but name, remained the mainstay of mental hospital care. Work was the

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<sup>1</sup> A nurse cited in Williams, p.182.

<sup>2</sup> Prolonged baths were also still used from time to time to calm agitated patients: Reginald Medicott, 'Psychiatric Treatment', *KT*, 38, 2, 1945, pp.29-32.

<sup>3</sup> Shayleen Ann Thompson, "'The Keepers of Happiness". *European Psychiatry and the Insane in New Zealand, 1911 to 1950*', MA thesis, University of Auckland, 1992, pp.60-1.

main therapy for many patients. It was also an economic necessity in the largely self-sufficient hospitals.

Considerable importance was placed on the therapeutic value of the hospital milieu. Since 1912, the villa system had been central to the Department of Mental Hospitals' attempts to achieve home-like environments. Newer hospitals such as Tokanui, Ngawhatu, and Kingseat were built on villa lines. These allowed for behavioural and diagnostic classification of patients, greater freedom of movement and potentially more individual attention and treatment..<sup>4</sup> Upgrading the physical amenities and improving the standard of clothing, food, and recreational facilities were considered as important to patients' well-being as administering treatments.<sup>5</sup> The role of nurses and attendants was considered vital to the maintenance of a therapeutic environment. Structured routines, recreational activities, and relationships between staff and patients were considered essential elements for the patients' well-being and recovery.

Warwick Brunton has pointed to a paradox between the idealism of mental hospital administrators and the reality of conditions. Administrators' aims to provide comfortable, home-like conditions were often unable to be realised because of resource constraints, overcrowding, and understaffing.<sup>6</sup> Older hospitals, for example, were saddled with large, asylum-type buildings. Basic provisions were in short supply and patients were often confined in large, locked wards with few home comforts. Nursing care within these constraints remained largely custodial.

### ***Overcrowding and substandard Buildings***

Between 1939 and 1959 the patient population of mental hospitals grew by two and a half thousand, or more than one third (see Appendix G).<sup>7</sup> The growth was associated with the continuing use of mental hospitals as repositories for people who were deemed to be too troublesome or too expensive for other social services. In a pattern that was very similar to that in other western countries, mental hospitals filled with elderly,

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<sup>4</sup> Lake Alice Hospital built in 1950 was also built on villa lines but with smaller units of 11-30 beds: Brunton, 'Out of the Shadows,' p.83.

<sup>5</sup> AJHR, 1952, H-31, p.25.

<sup>6</sup> Brunton, 'Out of the Shadows,' pp.75-90.

<sup>7</sup> Average occupancy rose from 7,426 in 1939 to 9,964 in 1959: AJHR, 1939, H-7, p.17 and 1960, H-31, p.162.

chronically unwell and severely disabled patients.<sup>8</sup> Although administrators of the Department of Mental Hospitals complained about their institutions being used as dumping grounds they maintained a policy of accepting all compulsory and voluntary referrals. The *Mental Deficiency Act* required mental hospitals to accept people under a committal order. General hospitals were able to refuse admissions when they were too full or understaffed.

The growth of mental hospital populations was not accompanied by an equivalent increase in accommodation. The result was serious overcrowding. Shortages of labour and building materials during and after the war inhibited building projects. Mental hospitals experienced particular difficulties because they entered the war years with serious accommodation deficiencies. Lack of financial commitment on the part of the government added to the problem. Brunton has described successive governments' expenditure on mental health as 'modest' in comparison to other areas of health spending, a fact that he attributes to stigma and a lack of public advocacy for the mentally ill.<sup>9</sup> Although budgetary increases were made during the 1950s, these were insufficient to meet the resource needs of the expanding mental hospitals.

The effect of overcrowding on nursing care was profound. There was little indoor space for social activities since day rooms often had to be converted to dormitories. Patients had minimal privacy, and bed space was so restricted that in some cases nurses had to move beds in order to care for physically dependant patients. Crowding also affected patients' behaviour. Conditions in the refractory wards were particularly difficult, as many as 60 patients spent hours at a time in crowded day rooms. With little space, and only two or three staff in attendance, it was no surprise that fights between patients were a frequent occurrence.

Overcrowding and disrepair were more serious at some hospitals than others. Seacliff, Auckland, and Porirua Mental Hospitals had particular difficulties. At Seacliff, unstable land had caused cracks in walls and problems with water mains and sewerage pipes.

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<sup>8</sup> David J. Rothman, 'The Enduring Asylum,' in *Mental Health Care and Policy*, Phil Brown, ed., Boston, 1985, pp.56-66. Kathleen Jones, *Asylums and After: A Revised History of the Mental Health Services, From the Early 18th Century to the 1990s*, London, 1993, pp.145-9, 61.

<sup>9</sup> Brunton, 'Out of the Shadows,' p.78.

Parts of the main building were unusable.<sup>10</sup> Auckland Mental Hospital's buildings were old and some had been in need of repair well before the war. At Porirua, the effects of overcrowding were exacerbated by the parlous state of some of the buildings. Plans to relieve congestion by building a new hospital at Marton, had to be put on hold during the war.<sup>11</sup>

In 1942, Porirua's situation became critical when an earthquake seriously damaged the main building. The Department was compelled to evacuate over 500 patients at short notice. Half were sent to the Chateau and Wairakei Hotels in the central North Island and the others were absorbed into existing mental hospital facilities. Two further natural disasters prompted the Department to shift these patients once again. In 1946 volcanic ash contaminated the Chateau's water supply, and bush fires threatened the safety of Wairakei. This time the patients were moved to Raventhorpe, a military convalescent hospital that had just become available south of Auckland.<sup>12</sup> Although this hospital was not considered suitable to be used as a hospital in the long term, it did continue to be used for chronically unwell patients for many years. Nurses, who were evacuated to the Chateau and Wairakei, although having to contend with isolation, enjoyed the luxurious surroundings and a more relaxed atmosphere.<sup>13</sup> The nurses photographed at the Chateau just before moving to Raventhorpe appear to have benefited from their stay (Figure 11).



**Figure 11** Porirua nurses and others at the Chateau, December 1945.  
**Source:** Wendy Hunter Williams, *Out of Mind out of Sight. The Story of Porirua*, Wellington, 1987, p.188.

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<sup>10</sup> A new women's day room opened in 1947, allowed women patients to be moved from an unstable and potentially unsafe building. The men's side continued to be of concern, as gaps widened in walls: AJHR, 1949, H-7, pp.13-4.

<sup>11</sup> The Department purchased 541 acres of land for a proposed new hospital between Bulls and Marton in 1937: AJHR, 1938, H-7, p.3.

<sup>12</sup> AJHR, 1946, H-7, p.2.

<sup>13</sup> Williams, pp.189-92.

Another disaster had less impact on accommodation but was nonetheless extremely disturbing. In December 1942, fire destroyed a female ward at Seacliff and took the lives of 37 patients. The fire occurred at night when the ward was un-staffed and the doors and shutters were locked. The only two patients to survive were in unlocked rooms. A subsequent inquiry absolved the nurses from responsibility, but condemned the conditions under which they worked.<sup>14</sup> The building was badly designed and there was no automatic fire alarm. Shortages of staff meant that patients had to be supervised by a nurse who visited hourly from an adjacent ward. Recognising the difficulties for nurses and attendants, the report concluded that ‘...all members of staff labour under great disadvantages and will continue to do so until the institution is remodelled’.<sup>15</sup>

By the end of the war, overcrowding and spartan living environments had become a way of life for both the patients and those caring for them. There were 752 more patients than there were beds across the Department’s hospitals.<sup>16</sup> Some wards designed for 80 patients took as many as 130.<sup>17</sup> Beds were crammed close together and extra sleeping spaces were created by putting shakedown (mattresses) on the floor of dormitories or day rooms. An attendant who started work at Porirua in the early 1950s reflected:

When I worked in Ward 7 to get between the beds one had to turn sideways. The beds would be about eight inches apart. As well as that they had shakedown which consisted of a mattress filled with straw and placed on the floor under the hospital bed. So if the ward had 40 beds your report may read “40 beds and 10 shakedown”. The hospital was so overcrowded at that time that that was the only place they had for some patients to sleep. If a patient came and said, “My bed is wet”, it could well be from the patient above.<sup>18</sup>

Overcrowding became worse during the 1950s. For most of the decade there were over 1,000 more patients than allocated beds.<sup>19</sup> The situation was at its most critical in 1956 when there was a shortage of 1,238 beds.<sup>20</sup> Plans for expansion of existing facilities and the construction of new hospitals were slow to eventuate. Preliminary work started on

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<sup>14</sup> *Report of Commission upon Fire at Seacliff*, AJHR, 1943, H-7A, pp.1-6.

<sup>15</sup> *Report of Commission upon Fire at Seacliff*, AJHR, 1943, H-7A, p.5.

<sup>16</sup> This did not include 265 patients in temporary accommodation at the Chateau and Wairakei, AJHR, 1945, H-7, p.2.

<sup>17</sup> *Porirua Ladies*, produced by Southwest for National Radio, broadcast 9 November 2003.

<sup>18</sup> Williams, p.205.

<sup>19</sup> ‘Bed’ refers to the space allocated for patients, rather than literally meaning ‘beds’.

<sup>20</sup> AJHR, 1957, H-31, p. 37.

Lake Alice Hospital in 1945, but the first 83 patients did not move in until 1951. Likewise, building on Cherry Farm, a hospital planned to replace Seacliff, started in 1946 but the first ward did not open until 1953. Even then, it did not relieve the congestion, since the new hospital was merely replacing old or damaged buildings.<sup>21</sup> Although the funding for capital works increased steadily during the 1950s, the construction backlog was such that overcrowding did not start to diminish until near the end of the decade.<sup>22</sup> Because of overcrowding, the chapel at Oakley which had been converted to a dormitory in 1875 following a fire, continued to be used as a men's dormitory until 1961 (see Figure 12). It was re-opened for use as a chapel in 1962.<sup>23</sup>



**Figure 12 Oakley Hospital Chapel circa 1960.**  
Source: Personal collection.

### *Lack of resources*

Little was done during the war to maintain the function and appearance of the wards or to deal with fundamental needs for patients' comfort and dignity. Items such as patients' clothing, bed linen, and staff uniforms were in short supply. The variety of food was also limited. Wartime restrictions were accentuated by Gray's conservative approach to spending and reform. Despite criticism in Parliament about the food provided for mental hospital patients, for example, he claimed that improvements could be made within the

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<sup>21</sup> AJHR, 1953, H-31, p.23.

<sup>22</sup> Funding for capital works increased from £259,289 in 1951-2 to £850,000 in 1957-8: AJHR, 1954, H-31, p.27 and AJHR, 1958, H-31, p.44. Overcrowding remained over 1,000 beds until 1958: AJHR, 1958, H-31, p.44.

<sup>23</sup> Oakley Hospital Medical Superintendent's annual reports, 1957-62, 1962, YCAA, 1081, ANZ, Auckland.



existing budget.<sup>24</sup> Gray's fiscal caution and institutionalized attitude also made him unwilling to improve working conditions for his staff.<sup>25</sup>

Food restrictions and a shortage of cooks meant that the quality of meals often left a lot to be desired.<sup>26</sup> For many patients, the usual menu consisted of thick buttered bread, sometimes with jam or honey, for breakfast, a cooked meal at lunchtime and 'sops' in the early evening. Sops consisted of bread cut up into small pieces with hot milk poured over. Patients were given no food between meals.<sup>27</sup> Despite the shortages, it seems that hospital farms created a buffer in terms of food supply. Kath McLeod recalled the wartime menu at Seacliff Hospital as basic but sufficient. There were, for example, no scones or cakes except for fruit cake on Sundays.<sup>28</sup>

Complaints were made from time to time by the public and in Parliament.<sup>29</sup> In 1946, Arthur Sainsbury, a Justice of the Peace and ex-editor of NZ Daily Newspapers, published a booklet entitled, *Misery Mansion – Grim Tales of New Zealand Asylums*.<sup>30</sup> The booklet accused the government of neglect of mental hospitals and the staff of abuse. Sainsbury, who was president of the Mental Hospitals Reform Association of Auckland, also presented a petition to Parliament requesting immediate provision of small recovery homes as an alternative to hospitalisation.<sup>31</sup> The government adamantly denied Sainsbury's accusations, citing letters from grateful patients and impressed official visitors. Although largely discredited, *Misery Mansion* brought mental hospital conditions to public notice and caused the government embarrassment.<sup>32</sup>

Some improvements were made after the war, largely at the instigation of Mabel Howard, who became Minister of Health in 1947. Howard took a personal interest in creating a more homely environment for mental patients.<sup>33</sup> A small weekly allowance was approved for most patients and more liberal rations and fresh fruit were introduced into the patients' diet. Clothing became more varied, underwear was supplied to female

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<sup>24</sup> NZPD, 1944, 266, p.220.

<sup>25</sup> Brunton, 'A Choice of Difficulties', p.348.

<sup>26</sup> See description of food at Porirua in 1950s: Williams, p.212.

<sup>27</sup> Irene Smith interviewed by W.M. Lyon, 8 March 1983, OHInt-0014/185, NERF-OHP.

<sup>28</sup> Kath McLeod interview 1 September 2004. Another interviewee claimed that there was no problem with food supplies at her hospital during the war: Un-named interviewee (KP1).

<sup>29</sup> For example, see NZPD, 1945, 270, p.408.

<sup>30</sup> Arthur Sainsbury, *Misery Mansion: Grim tales of New Zealand Asylums*, Auckland, 1946.

<sup>31</sup> NZPD, 1946, 273, pp.637-46.

<sup>32</sup> NZPD, 1946, 273, pp.512; 1946, 274, pp.637-46.

<sup>33</sup> NZPD, 1947, 277, p.422.

patients who were considered 'able to appreciate it', and a decision was made to provide sanitary pads for menstruating women.<sup>34</sup> Hospitals attempted to brighten-up old wards by re-painting walls and fitting blinds or curtains. At Seaview, for example, white bedspreads were replaced by coloured quilts and large dining room tables and benches were replaced by small tables and individual chairs.<sup>35</sup> Gradually, the old iron hospital beds were replaced by standard wooden beds and upholstered armchairs replaced wooden 'colonial' chairs in patients' lounges.<sup>36</sup> Progress was slow, however, since materials were in short supply.<sup>37</sup> Hospitals continued to be short of basic provisions such as sheets, blankets and clothing throughout the 1950s.

Managing shortages was a daily challenge for nurses and attendants. The deficiencies were at times made worse by the attitudes of administrators. Some hospital secretaries took their budgeting responsibilities to extremes. Margaret Bazley recalled the ongoing battle she had with a hospital secretary over the supply of toilet paper and sanitary pads on the women's refractory ward. She recalls that when he came into the ward one day and stood, 'surveying his empire', she asked him, 'Did he know that there is not enough toilet paper for the patients; that we only got enough for the staff toilet?' The secretary replied that the hospital 'had more than enough; that he had calculated the number of sheets (of paper) each ward needed. He and his wife only used one piece each a day.' Another day, the secretary told Bazley that 'he didn't think it necessary to provide sanitary pads; there was enough old linen and plenty of nurses who could make them'.<sup>38</sup>

'Condemn Days', were a long-held tradition in the mental hospital system (see Figure 13). Once a month, charge nurses and charge attendants engaged in a battle of wills with hospital administrators to obtain replacements for their wards' damaged or lost property. The matrons or head attendants visited each ward with the 'condemning officer' (usually the storeman or secretary) to assess what was needed. Only items that were produced as evidence of damage beyond repair would be replaced. Charge nurses and attendants were creative. Many constructed their own branding irons so they could stamp their ward's name on fragments of linen, clothes or towels.<sup>39</sup> Others shared

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<sup>34</sup> AJHR, 1948, H-7, p.3; James Ogilvie (Peter) Mackie, 'Reminiscences of a Retired Bureaucrat', MS-papers, 7119, ATL, Wellington.

<sup>35</sup> Brunton, *Sitivation 125*, p.53. Also: AJHR, 1949, H-7, p.12.

<sup>36</sup> Mackie, 'Reminiscences'.

<sup>37</sup> AJHR, 1948, H-7, p.3.

<sup>38</sup> Margaret Bazley interview 29 January 2004.

<sup>39</sup> Mackie, *Reminiscences*.

pieces of broken china among the wards. Hospital administrators often conspired in the charade. At Auckland Mental Hospital, for example, Bazley recalled the assistant matron and ward sister engaging in small talk as the group of assessors very slowly moved through each ward. This gave the junior nurses time to ‘run like mad round the other way to get all the bits [of china] to the next ward to be laid out’.<sup>40</sup>



**Figure 13 Condemn Day, Braemar Hospital, circa 1930s.**  
Source: Nelson Marlborough District Health Board archives

### *Increasing chronicity of patient population*

Not only were hospitals overcrowded, with poor resources, but the numbers of patients with chronic conditions were increasing. A large number had conditions such as senility, intellectual disability or neurological impairment. This was a vexing issue for hospital administrators who complained about the limits on their ability to provide therapeutic programmes. The presence of large numbers of chronically unwell patients belied their claims that modern psychiatry was producing results. The Division took pride in the rising number of voluntary admissions (from approximately a quarter to a half of all admissions during the late 1940s and 1950s).<sup>41</sup> A relatively high discharge rate for voluntary admissions was taken as a sign that modern psychiatric treatments were effective.<sup>42</sup> Any positive impact of these changes on the nurses’ and attendants’ working lives, however, remained minimal since the number of voluntary patients

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<sup>40</sup> Margaret Bazley interview 29 January 2004.

<sup>41</sup> AJHR, 1946, H-7, p.1, 1960, H-31, p.77.

<sup>42</sup> AJHR, 1946, H-7, pp.1-2.

remained a small percentage of the total mental hospital population. In 1959, more than 90 percent of mental hospital patients were still under legal orders.<sup>43</sup>

The number of people in mental hospitals aged over 60 years rose from 21 percent in 1939 to 28 percent in 1949.<sup>44</sup> By the mid-1950s, 30 percent of all compulsory admissions were of people over 60 years.<sup>45</sup> Although Ronald Lewis, the Director of Mental Hygiene, believed that psychiatric hospitals were the best place for people with severe dementia, he considered that the numbers of senile patients were ‘a tax on the available hospital accommodation and ‘an added strain on nursing staff’.<sup>46</sup> He and other psychiatrists were frustrated by the community’s misuse of legal certification to place elderly people in psychiatric hospitals.<sup>47</sup> They felt that other organisations should be taking responsibility for the elderly.<sup>48</sup>

The Division’s policy to support mentally disabled people to live ‘amongst their own’ in large, purpose built communities was not always possible to implement.<sup>49</sup> Numbers of admissions of intellectually disabled children and adults grew rapidly. A growing number were young children, some as young as six months.<sup>50</sup> ‘Mental deficiency colonies’ at Levin (opened 1945), Templeton, and Nelson quickly filled to capacity.<sup>51</sup> A new facility planned for the Auckland region did not eventuate during the 1950s.<sup>52</sup> By the early 1950s, the Division admitted to difficulty responding to the ‘constant demand’ from families for admissions.<sup>53</sup> Those who could not be accommodated in the specialised institutions were admitted to mainstream mental hospitals. Transferral between hospitals was one way the Division managed overcrowding. Intellectually

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<sup>43</sup> Average percentage of voluntary boarders increased from 4.2% in 1939, to 4.7% in 1949 and 7.6% in 1959: AJHR, 1939, H-7; AJHR, 1949, H-7; AJHR, 1959, H-31.

<sup>44</sup> AJHR, 1939, H-7, p.12, 1950, H-31, p.29.

<sup>45</sup> AJHR, 1956, H-31, p.31.

<sup>46</sup> AJHR, 1950, H-7, p.23.

<sup>47</sup> AJHR, 1956, H-31, p.31.

<sup>48</sup> Gilbert M. Tohill, Medical Superintendent, Auckland Mental Hospital, Annual Report, 13 April 1954, YCAA, 1081/22c, ANZ, Auckland.

<sup>49</sup> AJHR, 1956, H-31, p.32.

<sup>50</sup> In 1947, there were 83 children under five years of age resident at Templeton, Nelson and Levin: AJHR, 1948, H-7, p.3.

<sup>51</sup> The term, ‘intellectual handicap’ began to replace ‘mental deficiency’ in the 1950s.

<sup>52</sup> St John’s Home, a facility for intellectual disability, was opened in 1963. It was a precursor of Mangere Hospital and Training School, opened in 1966.

<sup>53</sup> AJHR, 1953, H-31, p.22.

disabled patients were often the first to be shifted. Large numbers of children were transferred to Tokanui and Seaview Hospitals during the 1950s.<sup>54</sup>

Other chronic illnesses represented in the mental hospital patient population were epilepsy, schizophrenia, and manic depression. Some people with these conditions were able to function relatively well and were occupied with either supervised or unsupervised 'trusted' work. Others suffered from the long term effects of unremitting psychiatric symptoms and years of institutional life. People who nursed in mental hospitals during the 1940s and 1950s have remarked on the serious level of psychiatric illness and disability they encountered in their work; patients suffering from frank delusions or hallucinations; others who were mute or catatonic for months or years on end; people with serious depression that lasted for years and manic states that had to be allowed to run their course. Nurses have reflected that this was a time when they had to learn skills of observation, engagement and de-escalation. One nurse commented, 'You did not have the chemotherapy that you've got today. You actually knew what a deluded person was all about. You actually saw what a hallucinated person was all about...that's something you don't forget'.<sup>55</sup> Although not everyone resident in mental hospitals had a serious or debilitating illness, it was the chronically unwell who required most nursing attention. Junior nurses and attendants, in particular, spent long stretches of time working on the geriatric, disturbed (refractory), or 'mental deficiency' wards.

Conditions in some wards were extremely difficult. Staff dealt with large groups of patients who were doubly incontinent, severely disabled and sometimes sexually disinhibited. For many nurses and attendants, the smell of urine, faeces and disinfectant was the worst part of their job. One nurse reflected, 'I could stomach the work but the smells were awful. It was bad, but you got used to it.' She recalled some of the worst aspects of the job: cleaning up patients who had spread faeces over themselves or the walls or 'having to wrap a patient in a sheet so you didn't get "shit" on yourself while you took them to bathroom'.<sup>56</sup> Those who stayed in the job found ways to deal with the

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<sup>54</sup> Kenneth R. Stallworthy, 'The Intellectually Defective in the Mental Hospital', NZMJ, 58, 1959, p.571; Brunton, *Sitivation 125*, p.49.

<sup>55</sup> Neville Griffin interviewed by Kay Carncross 22 November 1988, OHInt-0139/3, NERF-PNOHP, ATL.

<sup>56</sup> Un-named (KP1) 23 September 2003.

unpleasantness. This same nurse reflected, ‘I always thought, “They are somebody’s daughter or mother, even if covered in tutae [faeces].”<sup>57</sup>

### ***Economic demands for manual labour***

Mental hospitals during the 1940s and 1950s remained substantially self-sufficient. The Division actively farmed 6,000 of the 10,500 acres of land it occupied.<sup>58</sup> Hospitals produced most of their own food and generated income from selling produce that was excess to their needs. Services such as laundry, bakery, kitchens and shoe repairs were also on site. Hospital maintenance and farm work was labour intensive since the Department was slow to invest in mechanisation. There were cows to milk (usually by hand), sheep to hand-shear, pigs to feed and poultry to maintain. In 1948, a horse and dray was still regularly employed for farm work at Porirua.<sup>59</sup> Attendants at Sunnyside learned to work with Clydesdale horses to deliver the coal and collect the rubbish.<sup>60</sup> Patients and staff polished floors by pushing a large block of wood wrapped in an old blanket back and forward across the floor.

Nurses, attendants and patients provided most of the labour for both indoor and outdoor work. Staffing establishments, particularly in the earlier years, provided relatively few auxiliary roles such as cleaners, cooks, farm labourers, and gardeners. In 1939, there were only 176 people employed in farming, gardening, cleaning and other maintenance roles compared with 1,210 nurses and attendants (see Appendix O).<sup>61</sup> Labour shortages during the war and postwar years limited the Department’s ability to create or fill such positions. Although the use of supervised patient labour was clearly an economic advantage for the hospitals, it also represented a continuing belief in the general principles of nineteenth-century moral therapy; the therapeutic value of a structured environment, daily routine, and work. Organising and supervising patients in occupational and recreational activities were considered a central part of the mental nurses’ and attendants’ role.<sup>62</sup> Some manual tasks, however, such as stoking boilers,

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<sup>57</sup> Un-named (KP1) 23 September 2003.

<sup>58</sup> The Division occupied 10,500 acres of which 6,000 was actively farmed: AJHR, 1955, H-31, p.26.

<sup>59</sup> Truman, p.86.

<sup>60</sup> James Nolan interviewed by Lois Wilson, 3 November 1983, OHInt-0014/124, NERF-PNOHP,ATL.

<sup>61</sup> New Zealand Public Service List, 19 October, 1939, vol.3, pp.2856-78.

<sup>62</sup> KT, 37, 10, 1944, pp.223-4

cleaning wards and helping in the kitchens were undertaken by nurses and attendants whether or not there were patients to supervise.

## **Work and practice**

### *Gender differences in work*

Attendants' and nurses' work differed substantially. Although they both provided care for patients, attendants for the men and nurses for the women, their other work was quite different. It was in the area of hospital maintenance that the differences were most pronounced. Men largely worked outside doing tasks that were strongly associated with male gender roles while women's work was mostly inside on domestic duties.

Most attendants worked a combination of ward duties and manual, usually outdoor, work. Their daily tasks were recorded in the 'Patient and Staff Workbook'. Each man was listed alphabetically and allocated a ward, a task, and the number of patients for whom he was responsible. Attendants began their day at 7am in the wards helping patients get up, dressed and fed before having their own breakfast. Most then took patients out on working parties. These could include gardening, fencing, roading, painting, bread room duties, cleaning, or bagging coal. Some took less able patients out in a 'walking party'. In the weekends, attendants could be allocated to cricket or church duties.<sup>63</sup>

A few attendants stayed in the wards to supervise patients in the day rooms and airing courts (fenced areas around wards) or to care for those who were bed ridden. Outdoor attendants returned to their wards at lunchtime to assist with patients' lunches and toileting, had their own lunch and then took their men back out to work. At the end of the day, they returned to assist with dinner. Those on a 'short day' finished at 5pm. The others had a dinner break before returning to the ward to get patients ready for bed. Their day finished at 8pm (see Appendix F).

Mental hospitals ran on a skeleton staff overnight. Attendants were allocated to wards in which patients required frequent checking, toileting and bed-changes; other wards were merely visited. Night attendants' responsibilities included checking the patients,

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<sup>63</sup> For example, see: Tokanui Hospital Staff and Patient Workbook 1939, YCBG, 5935/1, ANZ, Auckland.

maintaining the boilers, lighting fires for the morning and delivering the bread and milk. At least one attendant was appointed to fire patrol. Charge night attendants had overall responsibility for the hospital's physical plant. Francis Gugich described the 'strange' combination of nursing and other duties required of the male staff on night shift at Seaview Hospital in the 1950s.

You went round your own area first, ...then around the rest of the building. You cleaned out the fires, set them up for morning, checked the patients, made sure they were all there and all still alive.... You got the water boiling and gas fires going for the morning. Then went to the main kitchen .... You made the porridge, set up the gas ovens, so they would be nice and hot for the staff coming on in the morning. The other job was to keep the [coal] fires going for heating for the wards... Then you came back and had to do your own ward – did your wet-rounds, toilet those who required toileting, change all the beds that required changing. Then you started off again at about five o'clock in the morning, and you had to be back in your own villa by seven o'clock to actually do your own people, write up anything that went on in your own villa, and any unusual occurrence in the other villas.<sup>64</sup>

The attendants' occupational identity was, in many ways, shaped by the tasks they performed. The title 'attendant' remained in common and official usage throughout the 1950s, despite the fact that the men trained and qualified as registered psychiatric nurses.<sup>65</sup> Russell Flahive, who started work in 1951, explained that the men mostly saw themselves as attendants, because nurses were assumed to be female, 'there were no such things as male nurses in those days...the males had a different role... the men maintained the hospital in a physical sense'.<sup>66</sup>

Changes occurred during the 1940s and 1950s as the 'nursing' aspects of the attendants' role increased and their agricultural work decreased. Farm mechanisation and a drop in the number of available 'worker-patients' reduced the need for attendants to supervise farm work. Attendants also became less available for outdoor work as they were increasingly called on to assist with somatic treatments (discussed later in this

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<sup>64</sup> Francis Gugich interview 29 August 2004.

<sup>65</sup> In the Public Service Classification List of 1959, male employees were listed under a category called, 'Male Nursing Staff', but their designations were 'head attendant', 'charge attendant', 'senior attendant' and 'attendant': New Zealand Public Service List, 1959-60, pp.171-97, ATL, Wellington. Men were commonly referred to as 'attendants' in internal correspondence. For example, see: Kenneth Stallworthy to the Director, 20 February 1959, YCBG, 5929, 16b, 6/10/2, 388, ANZ, Auckland.

<sup>66</sup> Russell Flahive interview 1 June, 2004.



chapter).<sup>67</sup> Numbers of farm and garden workers employed by the Department increased fourfold across these two decades.<sup>68</sup> Not all attendants were happy with the changing role. PSA delegates debated the possibility of dividing the attendants' role so that men could choose whether to join the outdoor 'artisan' staff or become nurses and work indoors.<sup>69</sup> Although the proposal was rejected by the Mental Health Group, it reflected the developing tensions concerning the role and identity of male psychiatric nurses/attendants. A few qualified attendants did move into farming or gardening, though most appear to have done so during the 1940s when there was less differentiation between the roles.<sup>70</sup> By 1959, attendants' involvement in farm work had reduced but they still undertook manual work. They were assigned duties as varied as driving, cleaning grease traps, kitchen assistance, or running the dispensary.<sup>71</sup> Approximately one third on any day still supervised work gangs.<sup>72</sup>

Female nurses' work was rather different. They were allocated a ward each day, but not a working party. They usually worked indoors. Most nurses spent their days in the wards but some juniors were consigned to kitchen, laundry or 'bedding shed' duties. Kath McLeod recalled that at Seacliff,

We all had to take our turn to work in the laundry, and all took our turn to work in the kitchen. ... you started in the kitchen at half past six in the morning and you skimmed the cream off the milk to make the fresh scones for the matron and head attendant.<sup>73</sup>

Until the 1950s, both nurses and attendants took their turns to fill mattresses with straw for incontinent patients. This was a favourite occupation at Seacliff Hospital in the

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<sup>67</sup> In 1949, Porirua Hospital, for example, partially released its attendants from farm duties: Truman, p.83.

<sup>68</sup> Twenty-eight men were employed in garden or farm work in 1939, New Zealand Public Service List, Wellington, 19 October, 1939, vol.3, pp.2856-78. This rose to 115 by 1959: New Zealand Public Service List, 1959-60, ATL, Wellington.

<sup>69</sup> PSA Mental Health Group Conference, 3, 4 July 1957, 82-046-031/5, ATL, Wellington.

<sup>70</sup> In 1949, eight artisan employees held the Senior Mental Nursing qualification and two were RPNs: New Zealand Public Service List, 1949. In 1959, three farm or garden managers were RPNs, one other held the Senior Mental Nursing qualification. Another RPN was employed as a painter: New Zealand Public Service List, 1959.

<sup>71</sup> Tokanui Staff and Patients' Workbook, 1958/9, YCBG, 5935/6a, ANZ, Auckland.

<sup>72</sup> The head attendant at Tokanui estimated that he required 26 'inside staff' and 16 'outside staff' each day: Kenneth Stallworthy to Director, 20 February 1959, YCBG, 5929, 16b, 6/10/2, 388, ANZ, Auckland.

<sup>73</sup> Kath McLeod interview 1 September 2004.

winter since the 'bedding shed' which was heated to keep the straw dry, was the warmest place in the hospital.<sup>74</sup>

A junior nurse's work included a considerable amount of cleaning and polishing. Eileen Jones spoke of her experience at Sunnyside, 'When you were a junior, you didn't do a lot of nursing ... I always say I could work for the Council because I had practical experience [sweeping yards]'.<sup>75</sup> Tidiness and cleanliness was given high priority. As in general nursing, these things were seen as evidence of a well-run ward on both the female and male side.<sup>76</sup> Matrons and head attendants, who visited the wards several times a day, expected them to be immaculate. At one hospital, for example, all beds on the geriatric ward had to be made and floors cleaned and mopped before the Matron's visit at mid-morning.<sup>77</sup> Mitred corners, smooth bedspreads, and wheels all turned in the same direction were essential attributes of a well-made bed. It was not unusual for a charge nurse or charge attendant to pull off the bedclothes and insist on a junior making up all the beds again if they were not up to standard.

Floor polishing is one task that many nurses remember with amusement. The extensive wooden floors required daily waxing and polishing. Joy Collins recalled, 'we used to have these huge blocks of wood covered with a blanket [pushers]- in those days I had an 18 inch waist because you had to push it and push it to buff the floor'.<sup>78</sup> In the late 1950s, the Division introduced electric polishers and vacuum cleaners. These provided relief for nurses and patients. As James Mackie, a Department official, reflected, 'No longer did the poor old long stay chronic patient have to meander round the waxed wooden floor with a piece of condemned woollen blanket under each foot to polish it'.<sup>79</sup> Polishers saved some of the strenuous work but they were difficult to handle. Audrey quite enjoyed the new polishers but remembers that, 'it was so heavy, you were never sure whether you were pushing it or it was pushing you'.<sup>80</sup>

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<sup>74</sup> Kath McLeod interview 1 September 2004.

<sup>75</sup> Margaret 'Eileen' Jones interviewed by Margaret Harraway, 3-4 February 2000, Sunnyside Hospital Oral History Project, ATL.

<sup>76</sup> June Rapson, who moved from general to psychiatric nursing, experienced general as more strict on tidiness and cleaning: June Rapson, interview 31 August 2004.

<sup>77</sup> Audrey (pseudonym) interview 9 December 2003.

<sup>78</sup> Joy Collins interview 27 January 2004.

<sup>79</sup> Mackie, *Reminiscences*.

<sup>80</sup> Audrey (pseudonym) interview 9 December 2003.

Nurses supervised patients and worked alongside them doing domestic tasks. Although regular work was thought to be beneficial, it was the routine that was considered important, rather than the opportunity for interpersonal interaction. There was a lot of work to be done within a short time and nurses were not encouraged to spend time talking with patients.<sup>81</sup> Women, such as Collins, who nursed during this period, however, reflect on the relationships they were able to achieve with patients despite the constraints of prevailing attitudes and regulations.

I believe in those days, we got a lot closer to our patients because we worked with them, you talked to them, you knew what was going on with them... If I was scrubbing the corridor, I would get a group of them and we would all scrub the corridor. And to buff it off, .... we would make a game of the work with some of the younger patients; we would make a blanket, and sit them on it and run up and down the corridor to buff it. We combined work with fun for them... You actually got really alongside of them – you didn't become friends... – you weren't allowed to. It was very formal.<sup>82</sup>

By the end of the 1950s, the burden of domestic work still lay with the junior nurses. There had been small increases in the number of auxiliary staff such as cooks, seamstresses, and laundry workers, but most of these were employed to meet the needs of expanding services. There had been no increase in the number of cleaners (see Appendix O).<sup>83</sup> Unlike the decision to relieve attendants of farm work, there had been no effort to relieve the nurses or attendants of domestic work. Cooking, cleaning and polishing were still considered an integral part of a nurses' role. This was more accentuated, but not dissimilar to the situation in general nursing. Student nurses in general hospitals spent a considerable part of their working days on domestic duties. The practice, however, was beginning to be challenged by professional nursing leaders who believed that nurses should be free to focus on nursing care.<sup>84</sup>

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<sup>81</sup> Frew, pp. 17-8.

<sup>82</sup> Joy Collins interview 27 January 2004.

<sup>83</sup> Between 1939 and 1959, the number of cooks increased from 23 to 55, laundry workers from 18 to 48, seamstresses from 6 to 19. The number of domestics decreased from four wards maids in 1939 to three hospital aids in 1959: New Zealand Public Service List, 1939 and 1959-60.

<sup>84</sup> 'Job Analysis into the Work of Nursing in a Hospital Ward', AJHR, 1956, H-31, p.63-66.

## *Patient care*

### *Conveyer-belt care*

Managing large numbers of patients, with the least risk of harm, was the main priority of nursing care. Bathing, toileting, changing beds, and feeding occupied a considerable amount of nursing time. Juniors, in particular, were regularly assigned physical care tasks. In 1948, for example, Betty Dracevich was on bathing duties most days for six months. As the most junior nurse at Auckland Mental Hospital, she ‘bathed every patient who couldn’t bath themselves’.<sup>85</sup> A decade later, as a student nurse, Audrey was also frequently assigned to bathing duties.<sup>86</sup> Physical care on geriatric and intellectually disabled wards was heavy work made worse by staff shortages, numbers of patients, and absence of modern equipment. Toileting and bathing on such wards was a major focus of the day; rows of potties of various sizes were a common sight in the day rooms of wards for intellectually disabled children.<sup>87</sup> One nurse at Porirua commented, ‘We worked very hard. You didn’t lift your head all day. And it was heavy work. I remember in Montrose [geriatric ward] we physically lifted all those old people. We had no wheelchairs, no nothing.’<sup>88</sup>

Hospital routines and hierarchical systems of supervision enabled the nurses and attendants to process large numbers of patients with relative safety. Bathing, for example, was a very structured activity. ‘Bathing lists’ prescribed which day or days of the week each patient would be bathed. During the most short-staffed period of the war years, many patients were bathed only once a week.<sup>89</sup> Later, it was more usual for dependent patients to be bathed twice or three times per week.<sup>90</sup> Patients in geriatric or disturbed wards were bathed in communal bathrooms, such as that pictured below (Figure 14). Senior staff members oversaw the process.<sup>91</sup> One interviewee described the bathing routine at Park House at Auckland Mental Hospital in the late 1950s.

It was like a production line. Park House had a large, communal bathroom with rows of free-standing baths. It was necessary because

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<sup>85</sup> Betty Dracevich interview 30 August, 2003.

<sup>86</sup> Audrey (pseudonym) interview 9 December, 2003.

<sup>87</sup> Francis Gugich interview 29 August 2004.

<sup>88</sup> Williams, p.212.

<sup>89</sup> Kath McLeod interview 1 September 2004.

<sup>90</sup> At Seaview, most dependent patients were bathed every second day or daily if they had soiled themselves: Francis Gugich interview 29 August 2004.

<sup>91</sup> During the 1940s, at Seacliff, the sub-matron supervised bathing on the female wards: Kath McLeod interview 1 September 2004.

of the type of patients; it would not have been safe for someone to be by themselves with one or two of the patients. On either side of bathroom, was a room. In one of the rooms, there would be two-to-three of the more senior staff. They would undress the patients and pop them through the door, as you were ready for them. You bathed them, washed their hair, pulled them out of the bath, gave the bath a swish and pushed them into the other room where there would be two ward charges. They would dry them, dress them and check for any injuries.<sup>92</sup>



**Figure 14. Bathrooms, F6, Oakley Hospital before renovation, 1960.**  
Source: Personal collection.

‘Conveyer belt care’, at its best, achieved standardisation and protection from harm. At bathing time, for example, senior nurses checked each patient for abrasions, bruises and any other superficial irregularities. Mental hospital nurses took pride in their standard of care of physically debilitated patients. Regular bed changes and toileting prevented bedsores in the elderly. One nurse explained, ‘It was a challenge to show that we were better... than the general nurses because we were definitely second grade in those days’.<sup>93</sup> The conveyer belt processes, however, did not maintain an individual’s privacy or dignity.

### *Observation*

In the absence of many options for treatment, much of the work with patients comprised of little more than observation, containment and prevention of harm. Dracevich reflected that, ‘Your whole life was looking, watching over, making sure they didn’t do

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<sup>92</sup> Un-named interviewee.

<sup>93</sup> Peter Sanders interviewed by Margaret Whineray, 13 July 1989, OHInt-0139/1, NERF-PNOHP, ATL.

anything [to hurt themselves or others].<sup>94</sup> Airing court and day room supervision epitomised this approach (see Figure 15 for photo of an airing court). It was usually a junior's job to sit in the day room of a long-stay ward to monitor the patients. Nurses and attendants developed acute powers of observation. Some attendants, in particular, were known for their ability to maintain order with minimal interaction.<sup>95</sup> One man reflected that, 'watching for the signs almost came automatically... If you were sitting in the day room [of the disturbed ward] and had a massive hangover from a staff party from the night before, you could sit .... with your eyes closed waiting ...and you knew if there was a sound out of place. There was a steady murmuring and cries in the room, but when there was a strange cry you knew something was up – you just watched for little behavioural symptoms.'<sup>96</sup>



**Figure 15 Airing court at Sunnyside Hospital.**  
**Source: Personal collection**

Observation took on different qualities depending on the type of patients. In the more disturbed wards, observation was critical for self-preservation. Collins recalled, 'If I was in F Ward, we would have up to 131 patients milling and I would be lucky if there was one other person with me, so you had to develop good observation skills because you didn't want somebody who was grossly disturbed coming over and trying to throttle you... so you looked at them and did a 'top-to-toe' [assessment] on almost every patient'.<sup>97</sup> On the admission wards, observations followed a pattern more similar to those in general nursing. It was common for new patients to have several days of bed

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<sup>94</sup> Betty Dracevich interview 30 August, 2003.

<sup>95</sup> A comment made by more than one of the interviewees in this study.

<sup>96</sup> Male nurse interview.

<sup>97</sup> Joy Collins interview 27 January 2004.

rest during which nurses undertook physiological observations such as testing urine, taking regular recordings of temperature, pulse and blood pressure, and monitoring patients' sleep, diet and bowel patterns. Suicidal patients were placed, by doctor's orders, under 'constant observation'; they were not allowed out of sight of the nurse or attendant.<sup>98</sup>

### ***Rules and routines***

Nurses' and attendants' work was dictated by routines, the authority of charge nurses, and the last-word of the Department's 'Rule Book'. The book, which was first published in 1901, was issued to all new members of staff.<sup>99</sup> Departmental rules advocated attitudes such as respect, tact and truthfulness. They also emphasised the importance of encouraging patients' occupation and the necessity of avoiding physical force. The rules tightly circumscribed staff actions when managing high risk situations such as bathing, mealtimes, fires, and 'special observations'. They included directives about counting knives before and after meals, regulating the temperature of bath water between 98.4 and 100 degrees Fahrenheit, and not running the water deeper than seven inches.<sup>100</sup> With a vulnerable population of patients with disorders such as dementia, epilepsy, suicidal depression and intellectual impairment, the risk of scalding or drowning was high. Bathing was deemed to be such a risk that written permission by a medical officer was required for a patient to have an unsupervised bath.<sup>101</sup>

Hospital keys, such as those pictured in Figure 16 were a vital part of the process of maintaining control and safety. Most wards were locked for at least part of the day, many all the time. Potentially unsafe areas such as bathrooms, kitchens and medication rooms were kept locked. All new staff were issued a key on appointment and given instructions about the importance of its safe keeping. The Rule Book was clear; 'Nurses must have their keys securely attached to their person in an inconspicuous manner by means of a chain or a strap. On no account must she part from her keys...'<sup>102</sup>

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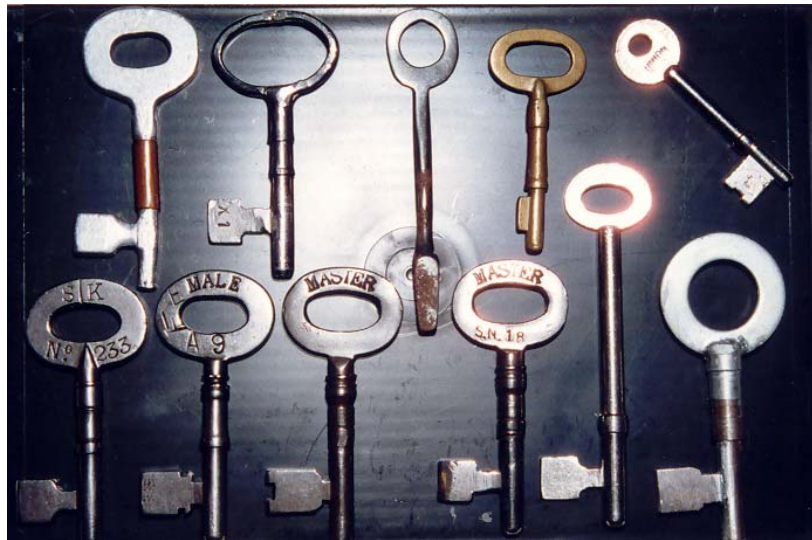
<sup>98</sup> Velda Kelly interview 26 August 2004.

<sup>99</sup> A copy of the Rule Book was issued to every new member of staff, who was expected to return it on their resignation or retirement: Brunton, 'A Choice of Difficulties', p.327.

<sup>100</sup> *Draft Rule Book*, 1939, H1/28739, ANZ, Wellington.

<sup>101</sup> See also: Bathing Lists, 1940-2, Seaview Hospital, CAHW, CH890/2b, ANZ, Christchurch.

<sup>102</sup> *Draft Rule Book*, 1939, H1/28739, ANZ, Wellington.



**Figure 16 Hospital keys, Seaview Hospital.**  
Source: Seaview Hospital photograph collection, Hokitika Museum

On the wards, tasks were allocated strictly according to a staff members' seniority. Attendants and nurses were numbered from the most junior to the ward charge and given duties accordingly. Routines were particularly strict on the disturbed (refractory) wards where each nurse or attendant had a list of duties and expected behaviour for each hour of the day (see example in Appendix I). Staff activities in the day rooms and airing courts were clearly prescribed. Bazley recalled the routines at Park House at Oakley Hospital where the most dangerous female patients were admitted from around the country. 'When I started, I was told you were to watch the nurses on either side of you. You all had a position on the court and you were to watch the fences and break up fights'.<sup>103</sup> The rules concerning seclusion were particularly strict at Oakley (Auckland Mental) Hospital. When entering a single room, the senior nurses went in first and out last. Each nurse knew exactly what her role was in the procedure.<sup>104</sup>

Nurses and attendants were guided almost entirely by verbal instructions from ward charges or the next most senior nurse. There was little room for independent decision-making. As Gugich commented, 'The charge nurse told us what to do for the day ... you just did what you were told'.<sup>105</sup> Nursing staff did not have access to clinical notes because it was considered unwise to trust them with patients' intimate information. Isla Frew, who worked as a nurse at Seacliff Hospital in her medical school holidays, felt that the hospitals were caught on this issue. Many of the female nurses were poorly

<sup>103</sup> Margaret Bazley interview 29 January 2004.

<sup>104</sup> Margaret Bazley interview 29 January 2004.

<sup>105</sup> Francis Gugich interview 29 August 2004.



qualified, transitional workers, who arguably should not have read patients' notes. Frew, however, believed that if psychiatric nurses were to 'fulfill their functions in the fullest sense' they would need to have access to patient information and participate in team discussions about patient care.<sup>106</sup>

Lack of access to information reflected institutional values and the status of attendants and nurses. Until the 1960s, a general code of secrecy was maintained throughout the Department of Mental Hospitals. This appeared to suggest a lingering belief in the need to hide madness and its management away from public view. Employees were not only barred from speaking to the media, they were also discouraged from providing information to patients' families or talking about hospital conditions outside work.<sup>107</sup> Some information about patients, for example homosexuality, was considered too sensitive to be known by people other than doctors.<sup>108</sup> Presumably, nurses and attendants were not considered of sufficient professional standing to be given access to such information.

In the absence of clinical information, nurses and attendants had little choice but to comply with the predominant methods of patient management. New staff, in particular, had little knowledge on which to base their care. Processes of orientation were almost non-existent; many found out what to do by asking the next most senior person. Sanders remembers his first day at Porirua, 'I was left on my own with 20 men all of whom I knew were 'mad'. I had really no idea what insanity was. I had no idea what to expect ... I was so frustrated, I was ready to quit'.<sup>109</sup> Sanders was relieved to meet two other attendants who had started the week before. It was they who gave him the support he needed to continue.<sup>110</sup>

### ***Abuse***

Physical abuse was outlawed by the Division, but nonetheless it happened. Rough treatment occurred on both the female and male sides from time to time, but it appears that, on the male sides, there was more of a language and acceptance of some degree of

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<sup>106</sup> Frew, p. 27.

<sup>107</sup> Williams, p.213.

<sup>108</sup> Margaret Bazley interview 29 January 2004.

<sup>109</sup> Peter Sanders interviewed by Margaret Whineray, 13 July 1989, OHInt-0139/1, NERF-PNOHP, ATL, Wellington.

<sup>110</sup> Peter Sanders interviewed by Margaret Whineray, 13 July 1989, OHInt-0139/1, NERF-PNOHP, ATL

physical abuse. The practice of ‘thump therapy’ appeared to be widely known, though officially denied.<sup>111</sup> Some attendants and nurses felt it was justified to retaliate against a patient who had been violent. In this study, two retired nurses (a man and a woman) independently recounted stories of staff coming to their aid when they had been attacked by a patient. In both occasions the other staff had offered to ‘teach the patient a lesson’ after the danger was over. The narrators remember having to stand firm to prevent this being carried out.<sup>112</sup>

Some staff, particularly on the male wards, became ‘roughshod’ in their treatment of patients. Shortages of clothing and linen were made worse by inattention to patient dignity and comfort. It was not unknown for patients to be undressed in the evening, their clothes dropped, clean or dirty, in a heap, then dressed in the morning with whatever was taken from the pile. In one hospital, patients were given the shoes that belonged to the ward rather than the person. When the person transferred to another ward, the shoes remained and were given to someone else.<sup>113</sup>

Standing up against a culture of roughshod care was difficult. Individual men clearly recall the times they risked disapproval by doing so. Questioning the way meals were served, refusing to take patients into a badly ventilated poultry barn or persisting in finding clean clothes for patients to put on in the mornings were all examples of such challenges. Within an environment of overcrowding, scarce resources and making do, these seemingly small challenges were not easy.

## **New therapies and new mental health disciplines**

### ***Somatic treatments***

During the 1930s and 1940s a number of new somatic (bodily) therapies were introduced to New Zealand mental hospitals. The four most significant were insulin therapy, Cardiazol treatment, electroconvulsive treatment (E.C.T.) and leucotomy (psychosurgery). Other new treatments included electro-narcosis and pentothal narcosis. Patients undergoing such treatments required varying degrees of nursing care in its

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<sup>111</sup> Several interviewees mentioned the term, ‘thump therapy’ when referring to physical abuse against patients.

<sup>112</sup> Un-named interviewees.

<sup>113</sup> F.A. Foster, Footwear Inspector for Department of Health re inspection of Avondale Mental Hospital, 21 March 1958, YCAA, 1081/29d, ANZ, Auckland.

more medical sense. The introduction of the somatic treatments not only shifted the nurses' and attendants' roles towards a more medical focus, but it also impacted on their work in other ways. Some treatments provided opportunities for staff to engage in one-to-one care of patients and to establish 'therapeutic relationships'. Because of their effectiveness, some treatments gave nurses and attendants hope that their patients could be cured or at least achieve early discharge from hospital. A more negative impact of the treatments was the coercive role expected of staff.

Insulin coma therapy for the treatment of schizophrenia was first trialled at Seacliff Hospital in 1938.<sup>114</sup> It was a recently developed treatment that was gaining popularity in European and North American psychiatry.<sup>115</sup> The treatment involved daily injections of insulin in gradually increasing doses until the patient's blood sugar was so low that he/she fell into a deep coma. An unconscious state was maintained for approximately four hours. The patient was brought back to consciousness by tube feeding with a glucose solution or, in an emergency, giving intravenous glucose. Patients were treated daily over a period of five to six weeks. Insulin was administered every day except Sundays, when patients were allowed to 'rest and replenish depleted reserves of carbohydrate material'.<sup>116</sup> Most serious risks included seizures, collapse and irreversible coma.<sup>117</sup> Other possible complications included respiratory difficulties, projectile vomiting and delayed coma.<sup>118</sup> Insulin therapy was considered to be 'intricate and exacting' and 'unremitting medical and nursing attention [was] required for its success'.<sup>119</sup>

Sub-coma shock treatment was a less intensive form of insulin therapy administered for the treatment of anxiety, hysteria, and anorexia. It entailed daily administration of insulin at high enough doses to produce symptoms such as drowsiness, weakness, sweating, and hunger. Because the patient did not usually go into a coma, it was not as risky.

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<sup>114</sup> AJHR, 1939, H-7, p.12.

<sup>115</sup> Manfred Shakel first noted the affects of insulin coma on schizophrenia symptoms in 1933, but it had gained popularity since a Swiss researcher, Max Muller, had arranged a conference on new therapies in 1937: Edward Shorter, *History of Psychiatry: From the Era of Asylum to the Age of Prozac*, New York, 1997, pp.522-30.

<sup>116</sup> KT, 32, 11, 1939, p.391.

<sup>117</sup> KT, 38, 2, 1945, pp.29-32.

<sup>118</sup> KT, 32, 11, 1939, p.390-2.

<sup>119</sup> AJHR, 1939, H-7, p.12.

Insulin therapy demanded a range of skills that the mental nurses would not usually have developed to such a level. Not only were they required to provide physical care, monitor symptoms, and regulate the patients' diets, but they also engaged in intensive psychological support in a manner that was usually not possible in their work on the wards. This support included managing agitated behaviour and listening sympathetically when the patients emerged from unconsciousness. The nurses created a structured and homely environment with daily routines including supervised meals, walks, picnics, sing-songs and games. It was generally thought that this personal attention was a vital part of the treatment.<sup>120</sup> Unlike the nurses on the wards, the insulin clinic nurse wrote detailed reports on her patients each duty.<sup>121</sup>

Monitoring and care for patients receiving insulin was reserved for senior (qualified) female nurses. Kath McLeod recalls that part of her duties in the 1940s was working on a men's ward at Seacliff to 'watch them come out' of insulin coma.<sup>122</sup> There was, at least in one hospital, an attempt to rotate junior nurses through the clinic to gain experience.<sup>123</sup> Because of the intensity of insulin treatment and the number of staff required, it was largely discontinued during the war years.

Convulsive or 'shock' therapy using the drug Cardiazol was introduced in 1939 at Tokanui, Porirua and Sunnyside Hospitals.<sup>124</sup> A drug usually used as a cardiac or respiratory stimulant, Cardiazol was in this case given in large doses intravenously to cause an epileptic convulsion. The treatment, which had been used internationally since 1936, had first been developed because of a belief that schizophrenia and epilepsy were biologically incompatible.<sup>125</sup> Used mainly with people suffering from schizophrenia, Cardiazol was given in a series of 12-20 injections.<sup>126</sup> In the majority of cases, treatment was administered twice, and sometimes thrice, weekly. It was considered less complicated than insulin therapy and required less time each day. Cardiazol shock treatment still had risks. One of its down-sides was that patients experienced a feeling of

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<sup>120</sup> KT, 38, 2, 1945, p.30.

<sup>121</sup> KT, 32, 12, 1939, p.437. The usual practice was for the nurse in charge of a ward to write brief notes in the daily report book on anyone who was causing concern.

<sup>122</sup> Kath McLeod interview 1 September 2004.

<sup>123</sup> KT, 32, 12, 1939, p.435.

<sup>124</sup> AJHR, 1940, H-7, pp.6-8.

<sup>125</sup> Ladislav von Meduna of Hungary had made the 'discovery' that the brains of people with schizophrenia and those with epilepsy were different. He first experimented with producing seizures by administering camphor, but when this was found to be unreliable, he changed to using Cardiazol: Shorter, p.211.

<sup>126</sup> NZMJ, 40, 215, 1941, pp.63-6.

fear of ‘dying and crumbling away’ just before losing consciousness.<sup>127</sup> Medicott commented that despite the fear, ‘when the time for the injection arrived it was rapidly proceeded with, no matter what resistance was offered’.<sup>128</sup>

Electroconvulsive therapy (ECT) replaced Cardiazol within a few years. This treatment entailed passing an electric current into the patient’s brain via metal electrodes placed on the temple(s). ECT had first been used in Rome by a professor of psychiatry, Ugo Cerletti and his assistant Lucio Bini in 1938.<sup>129</sup> It was first used in New Zealand at Sunnyside Hospital in 1943. By 1945 it had largely superceded Cardiazol and was being used on significant numbers of patients in several mental hospitals.<sup>130</sup>

Psychiatrists favoured ECT because it was ‘quicker, safer and not so frightening’.<sup>131</sup> There were, however, risks, mostly of fractures, particularly in the elderly. These risks were lessened from 1945 when the treatment began to include the use of an intravenous curare to cause paralysis a few moments before the seizure. Another common complication of shock treatment was loss of memory for events immediately preceding the treatment.<sup>132</sup> Although shock treatments had little effect on the prognosis of people with schizophrenia, they did appear to be quite successful in treating people with severe depression. In 1948, Medicott reported that 72 percent of his patients with severe depression and 61 percent with manic states, ‘fully recovered after treatment’.<sup>133</sup>

Both nurses and attendants were involved in the administration of shock treatment. They were responsible for preparing the patients, ensuring that they had not eaten before the treatment and attempting to allay their fears. To minimise the possibility of fractures, the treatment was given on a firm mattress placed on top of a fracture board and four to six nurses or attendants held the patient down firmly during the convulsion (see demonstration at Porirua in photograph below).<sup>134</sup> A gag was placed in the patient’s mouth to prevent biting of the tongue. A nurse or attendant commonly applied the

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<sup>127</sup> AJHR, 1940, H-7, p.7; See also: Shorter, p.211.

<sup>128</sup> NZMJ, 40, 217, 1941, pp.175-83.

<sup>129</sup> Edward Shorter, 'The History of ECT: Unsolved Mysteries', *Psychiatric Times*, 21, 2, 2004.

<sup>130</sup> In 1945, ECT was given to 191 patients at Sunnyside Hospital and 130 at Auckland Mental Hospital. Porirua had by 1946 treated over 500 people with ECT: AJHR, 1946, H-7, p.9.

<sup>131</sup> Report from Medical Superintendent, Auckland Mental Hospital, AJHR, 1946, H-7, p.5.

<sup>132</sup> NZMJ, 48, 260, 1948, pp.338-48.

<sup>133</sup> *ibid.*, p.341.

<sup>134</sup> Williams, p.164.

paddles to the patient's temples while a doctor switched on the current. Following treatment, they observed and reported any ill-effects.



**Figure 17 Psychiatric nurse administering ECT.**  
**Source: Wendy Hunter Williams, *Out of Mind Out of Sight The Story of Porirua Hospital*, Wellington, 1987. p. 165.**

ECT figures significantly in the stories men and women tell of their experiences of mental hospital nursing in the 1940s and 1950s. Their narratives contain a range of feelings and attitudes. Most experienced shock treatment as a major breakthrough for severe depression and mania. They reported almost 'miraculous' changes in just two or three treatments.<sup>135</sup> Kath McLeod, who witnessed the introduction of ECT at Seacliff Hospital, observed that it 'made a wonderful difference for a lot of patients'.<sup>136</sup> She noted, for example, that people were able to start wearing their own clothes again instead of being nursed in canvas frocks and footwear. ECT appeared to make an impact on the nurses' and attendants' working environment. Increased rate of discharge, successes with severely depressed patients and shortening of manic episodes created a foundation for nursing staff to begin working in a rehabilitative manner with some patients.

Nurses were also uncomfortable about aspects of ECT administration. Their stories include discomfort about patients' fear and their part in enforcing treatment. In the years, when ECT was given with no anaesthetic or muscle relaxant, the experience was

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<sup>135</sup> Adrian Moerenhout interview 11 April, 2004; Joy Collins interview 27 January 2004.

<sup>136</sup> Kath McLeod interview 1 September 2004.

often disturbing for both patients and staff. Nurses remember feeling nervous or horrified when seeing ECT for the first time. One nurse, who assisted Medicott with the first treatment at Porirua, recalls feeling very apprehensive.<sup>137</sup> At least 10 years later, Collins found it no less strange.

The first time I ever saw ECT, I thought, ‘My God!’ It was done in the dormitory. We had about a dozen patients. All you had between the beds was a screen. Being a junior, I had to stay in the dormitory, I had to remove the headpins from the hair, put a little saline on temples to de-grease the skin. We sat in this day room... It was very bizarre, that first time; this patient was playing the piano in the day room, playing all these merry songs, and these people were going through the door... I found it quite bizarre.<sup>138</sup>

Patients were often terrified of ECT and some took great lengths to avoid it; some went as far as attempting suicide. From a patient’s point of view, Janet Frame described the ward atmosphere on ECT days as resembling that in a prison on execution day.<sup>139</sup> It was the nurses’ and attendants’ responsibility to ensure that patients came for their treatments. Both male and female nurses recall having to chase patients down the corridors to take them forcibly to shock treatment.<sup>140</sup>

Nursing staff were aware that ECT was sometimes used to control behaviour or to treat disorders for which it had questionable efficacy. Their views, however, seemed couched in uncertainty about their ability to question. Collins commented, ‘It was used for a wide range [of disorders] – it seemed experimental... that was only my perception... I always saw a benefit for depressed patients but I saw very little benefit for anyone else’.<sup>141</sup> Barbara Milne agreed that there were two types of ECT use; the therapeutically, planned application for depressed patients and the reactive application to control behaviour on the refractory wards. ‘I remember thinking it [the latter] was awful, but I can’t remember knowing why it was awful’.<sup>142</sup> Moerenhout concurred, ‘Unmodified ECT was quite horrific really. Early on, it [was] used as a controlling mechanism. It was known for a long time that it didn’t do a thing for schizophrenics,

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<sup>137</sup> Un-named interviewee (KP1) 23 September 2003.

<sup>138</sup> Joy Collins interview 27 January 2004.

<sup>139</sup> Michael King, *Wrestling with the Angel: A Life of Janet Frame*, Auckland, 2000, p.97.

<sup>140</sup> James Nolan interviewed by Lois Wilson 3 November 1983, OHInt-0014/124, NERF-PNOHP, Donald Graham interviewed by Lois Wilson, 15 December 1983, OHInt-0014/061, NERF-OHP. Collins also recalled having the chase patients for ECT: Joy Collins interview 27 January 2004.

<sup>141</sup> Joy Collins interview 27 January 2004.

<sup>142</sup> Barbara Milne interview 7 September 2005.

but it was still used.<sup>143</sup> Looking back, one nurse summed up his attitudes to the use of un-modified ECT, ‘...when you didn’t have anything else, what did you use?’<sup>144</sup>

Perhaps the most dramatic of the somatic treatments was the prefrontal leucotomy (known as lobotomy in the United States). The treatment entailed brain surgery to cut the nerve fibres leading back from the prefrontal lobes. The goal was to interfere with negative, ingrained emotional and psychological patterns. Leucotomy was pioneered by Egas Moniz in Portugal in 1935, but made popular as a psychiatric treatment during the 1940s by Walter Freeman and James W. Watts, who introduced the procedure to the United States.<sup>145</sup> The surgery was first performed in New Zealand by a visiting American neurosurgeon in 1942.<sup>146</sup> After this, several operations were carried out each year by neurosurgeons at Dunedin and Auckland public hospitals and the number of operations grew towards the end of the 1940s.<sup>147</sup> Although leucotomies were thought to be useful for patients with longstanding depression or obsessional conditions, they were never accepted wholeheartedly by the psychiatric community. Even Medlicott, who promoted its use in the *New Zealand Medical Journal*, admitted that ‘the rationale for prefrontal lobotomy is still somewhat obscure and the use is largely empirical’.<sup>148</sup>

Leucotomies were performed at public hospitals, but patients were returned to the mental hospitals as soon as they could travel.<sup>149</sup> It was assumed that psychiatric nurses would be best able to provide the specialized care required to rehabilitate patients post-operatively.<sup>150</sup> Nursing care in the weeks following surgery was intensive, since the patients were usually confused and disorientated, uncooperative and incontinent. Frequent toileting was necessary to help patients regain bladder control. The patients usually suffered from lethargy, apathy and inattention in the early stages post-surgery and required intensive retraining in basic living skills, such as table manners and self-

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<sup>143</sup> Adrian Moerenhout interview 11 April 2004.

<sup>144</sup> James Nolan interviewed by Lois Wilson 3 November 1983, OHInt-0014/124, NERF-PNOHP, ATL.

<sup>145</sup> Grob, pp.182-3.

<sup>146</sup> The neurosurgeon was an officer with the United States army: Williams, p.164.

<sup>147</sup> At least 154 leucotomies were performed between August 1946 and November 1952 in Auckland: NZMJ, 52, 291, 1953, pp.405-21; In Dunedin, at least sixty-five leucotomies were performed between April 1944 and March 1950, fifteen were before 1948, the remainder afterwards: NZMJ, 49, 273, 1950, pp.522-30.

<sup>148</sup> NZMJ, 41, 227, 1943, p.118.

<sup>149</sup> AJHR, 1946, H-7, p.13.

<sup>150</sup> Dr. Malcolm Brown, of Seacliff Hospital, considered that immediate post-operative psychiatric nursing care was so important, that in the future it would be beneficial for leucotomies to be performed in a surgical unit at the mental hospital: *ibid*.



care. Improvement was slow. In most cases patients were found to require, ‘long-term aftercare by nursing staff experienced in details of rehabilitation and habit training’.<sup>151</sup>

Other new treatments included electro-narcosis and pentothal narcosis. Electro-narcosis, an alternative to insulin therapy, was pioneered by Medlicott at Porirua Hospital. He designed a machine that could administer an electric current to patients inducing a temporary state of unconsciousness. The treatment, used in schizophrenia, was considered to be safer and less time-consuming than insulin. The latter was an important consideration because of the shortage of nurses and doctors during and after the war.<sup>152</sup> Pentothal narcosis treatment was a process of reducing a patient’s defences with medication. It was used to elicit suppressed psychological material during patient assessment.<sup>153</sup>

Psychiatrists continued to use a variety of somatic therapies during the 1950s. They relied heavily on a combination of ECT, insulin therapy, sub-coma insulin treatment and, to a lesser degree, leucotomy, all of which had become ‘standard treatments for suitable cases’.<sup>154</sup> Treatments, such as ECT, tended to be administered in multiple sessions, sometimes over several weeks or months. If one treatment was not effective, another was tried.<sup>155</sup> Psychiatrists were proud of the fact that voluntary admissions continued to climb and recoveries appeared to increase. Lewis expressed confidence that ‘modern treatments shorten the stay in hospital of recoverable cases and reduce the conduct disorders and difficulties associated with the longer stay patients’.<sup>156</sup> Not everyone agreed with this view. Public criticism emerged towards the end of the 1950s and the Division found it necessary to defend itself against accusations of ‘indiscriminate use’ of physical treatments.<sup>157</sup>

### ***Medications***

Before the mid-1950s, mental hospital doctors prescribed only a small range of drugs: Luminal (phenobarbitone) for epilepsy, magnesium sulphate for constipation, and

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<sup>151</sup> NZMJ, 49, 273, 1950, p.524.

<sup>152</sup> NZMJ, 46, 254, 1947, pp.280-97.

<sup>153</sup> AJHR, 1946, H-7, p.5.

<sup>154</sup> AJHR, 1955, H-31, p.25.

<sup>155</sup> In the late 1940s and early 1950s, Janet Frame was treated with ECT and insulin coma therapy for months at a time; the decision for treatment appeared to be based on fairly loose criteria: King, *Wrestling*, pp.94-106.

<sup>156</sup> AJHR, 1954, H-31, p.26.

<sup>157</sup> AJHR, 1958, H-31, p.43.

paraldehyde for sedation. Another sedative, potassium bromide, was sometimes used, but not favoured because of its toxic side effects. During the 1940s, Dilantin was also introduced for seizure control. Medication administration was a simple process, usually undertaken by the charge nurse or charge attendant. In one hospital, for example, ward charges handed out the medications from a tin bowl in which all the tablets were mixed together; they knew the patients and medications well enough to know which pill was for whom.<sup>158</sup> Paraldehyde continued to be the main drug for calming disturbed behaviour. It was prescribed 'prn' (as necessary) for the more disturbed patients, and nurses administered it either orally or intramuscularly. Although not a common practice in all hospitals, it was known for nurses to carry small bottles of paraldehyde on the refractory ward airing courts so they could administer it quickly, if needed.<sup>159</sup> Refractory wards and patients carried the distinctive smell of paraldehyde.

The 1950s have often been viewed as a time when psychiatry was transformed by the introduction of neuroleptic (antipsychotic) and other psychotropic medications.<sup>160</sup> Kathleen Jones has referred to a 'pharmacological revolution' in Britain and Edward Shorter noted transformative effects of anti-psychotics and antidepressants on the practice of psychiatry in Europe, Britain and the United States.<sup>161</sup> Although the new preparations were introduced to New Zealand mental hospitals in the mid 1950s, the drugs had little effect on the majority of patients for several years. Prior to this, the medications were largely used experimentally and medical opinion was lukewarm about their efficacy. The new drugs had little impact on the work of nurses and attendants until the end of the decade.

Chlorpromazine (Largactil), an anti-psychotic, was first trialled at Avondale (Auckland Mental) Hospital in 1953, a year before it was approved for use in the United States.<sup>162</sup> A number of hospitals began to use Reserpine in the early 1950s, and Tokanui hospital participated in a trial of sodium succinate in 1954.<sup>163</sup> Over the next few years mental

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<sup>158</sup> Seaview Hospital nurses' focus group interview 29 August 2004.

<sup>159</sup> Margaret Bazley interview 29 January 2004.

<sup>160</sup> The term 'neuroleptic medications' or 'neuroleptics' refer to medications primarily used for the control of psychotic symptoms.

<sup>161</sup> Jones, pp.246-62; Shorter, *History of Psychiatry*, p.2.

<sup>162</sup> With few instructions (in French) about properties and dosage, Patrick Savage the medical superintendent doubled the dose monthly until he saw results: Patrick Savage interview January 2001.

<sup>163</sup> AJHR, 1955, H-31, pp.25-6.

hospital doctors experimented with a range of new psychiatric drugs.<sup>164</sup> Lewis was not, however, convinced about their efficacy or safety. Each year, he cautioned against undue reliance on new treatments.<sup>165</sup> He believed that physical therapies had their use, but ‘none by itself is of any great value unless it is co-ordinated with psychotherapy, occupational and recreational therapies, and the general routine activities of hospital life’.<sup>166</sup>

An abrupt change occurred in medication use at the end of the 1950s. With the widespread use of chlorpromazine and a proliferation of new medications, administration suddenly became more complex. Bazley recalled that, ‘...suddenly there was a big change; there were big trays with named medicine glass[es] for everyone’.<sup>167</sup> Chlorpromazine (Largactil), which was found to be effective in calming behaviour, was prescribed widely. As Bazley explained, its use had both direct and indirect effects on the nursing staff.

Giving everyone doses of Largactil was a massive operation, it kept nurses occupied full-time... We used to have to crush the pills; it was a big job. They put everyone was on Largactil. They were on hundreds of milligrams; people were on a thousand milligrams. A lot of nurses developed allergies and had to give up nursing; some would just go into a ward where someone was on Largactil, and that was enough – they got terrible skin rashes.<sup>168</sup>

One problem with the new medications was the shortage of medical staff to oversee treatment. Not only were the drugs largely experimental, but the prescribing doctors were often inexperienced. There was a severe shortage of psychiatrists and hospitals relied on temporary appointments of general physicians to provide basic cover.<sup>169</sup> With no psychiatric training available in New Zealand, and poor conditions in mental hospitals, the Division was hard-pressed to attract young doctors into the specialty.<sup>170</sup> Medication prescribing in these conditions was somewhat haphazard.

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<sup>164</sup> In 1955 for example, chlorpromazine, Serpasil and Suavitil were all being used as sedatives at Avondale (Oakley) Mental Hospital: Annual Report, 1955, YCAA, 1081/22c, ANZ, Auckland.

<sup>165</sup> AJHR, 1955, H-31, p. 26, 1956, p.33; AJHR, 1957, H-31, p.37; AJHR, 1958, H-31, p.43.

<sup>166</sup> AJHR, 1950, H-31, p.23.

<sup>167</sup> Margaret Bazley interview 29 January 2004.

<sup>168</sup> Margaret Bazley interview 29 January 2004.

<sup>169</sup> In 1959, there were only 33 medical staff on permanent appointments: New Zealand Public Service List, 1959-60, ATL, Wellington.

<sup>170</sup> AJHR, 1958, H-31, pp.41-2.

### ***Open door policies, therapeutic community, psychotherapy, and rehabilitation***

New Zealand mental hospitals were influenced by social psychiatry developments that had originated in Britain during the Second World War. Open door policies and concepts of ‘therapeutic community’ were gaining international popularity after the successes of J.R. Rees, Tom Main and others in treating traumatised servicemen. These military psychiatrists had broken away from concepts of individualised psychotherapy and treatment to suggest that it was the patients’ own community that was the most therapeutic tool.<sup>171</sup> Open door approaches called for the removal of physical restraints, such as walled hospitals, fenced airing courts, and locked wards. Although the idea of unlocked wards was not new, it gained traction in British mental hospitals during the 1950s.<sup>172</sup>

Therapeutic community was predicated on the value of democratic processes and group therapy. Tom Main described the work of his team at Northfield Hospital as ‘an attempt to use a hospital not as an organization run by doctors in the interests of their own greater technical efficiency, but as a community with the immediate aim of full participation of all its members in its daily life’.<sup>173</sup> Group discussion and decision making was a central facet of the therapeutic community. Another British psychiatrist, Maxwell Jones, was influential in applying the ideology to the whole of the mental hospital community life. His ideas on democratic processes and ‘reality confrontation’ through group process were widely adopted in both Britain and North America.<sup>174</sup>

Although the language of therapeutic community began to be adopted in New Zealand during the 1950s, it was used more in relation to a general improvement in the hospital environment rather than implementation of its core principles. Hospitals began to be viewed as therapeutic in their own right. Lewis claimed that, ‘the psychiatric hospital offers a degree of understanding and acceptance that is available nowhere else in the community. The intangible but critically important “atmosphere” is the most valuable

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<sup>171</sup> For a description of the development of concepts of therapeutic milieu and therapeutic community, see: Sandra Bloom, *Creating Sanctuary: Toward the Evolution of Sane Societies*, New York, 1997, pp.100-3.

<sup>172</sup> Jones, p.151.

<sup>173</sup> Bloom, p.101.

<sup>174</sup> Jones, p.152.

therapeutic agent.’ He emphasised that this ‘atmosphere’ depended on ‘the skill, knowledge and sense of purpose which animate all members of the staff’.<sup>175</sup>

An open door policy was promoted during the 1950s.<sup>176</sup> This fitted well with the villa system. It was also compatible with a trend towards rehabilitation and a more liberal approach towards psychiatric hospitalisation. By 1959, although open door wards or villas were considered ‘common practice’, nurses and attendants were not altogether comfortable with their use. Greater freedom for patients created conflicting demands. While expected to support self-responsibility, nurses and attendants were also charged with maintaining patient safety. Psychiatric nurses’ responses in the state examination in 1959, suggest that their three years’ experience in mental hospital nursing had taught them more about the need to maintain custodial care rather than to promote patient autonomy. Examiners bemoaned the fact that, in most responses, the ‘emphasis was all on negative aspects of nurse-patient relationships, in fact, on just those things which are likely to hinder the effective running of an open villa’.<sup>177</sup>

Psychotherapy was not given precedence within the treatment of mental hospital patients, but its principles were applied in certain situations. Psychiatrists, for example, emphasised the importance of supplementing somatic treatments with psychotherapy.<sup>178</sup> Some psychiatrists were strongly of the opinion that psychotherapeutic approaches were of no use for people suffering from psychosis.<sup>179</sup> It is likely that psychotherapeutic techniques were used more within the out-patient clinics and psychiatric wards at general hospitals. Medical and nursing staff at Queen Elizabeth Hospital in Hanmer Springs also used psychotherapeutic approaches with individuals and groups, first with returning servicemen, then with a wider group of patients suffering from alcoholism and neurotic disorders.

The concept of rehabilitation began to find a place in mental hospital care during the 1950s. Successes with somatic treatments and an increase in the number of voluntary

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<sup>175</sup> AJHR, 1958, H-31, p.43.

<sup>176</sup> AJHR, 1955, H-31, p.25.

<sup>177</sup> Examiner’s comments on the State Examination for Psychiatric Nurses, December 1959, H-1, 28503, 30/25/12, ANZ, Wellington.

<sup>178</sup> Medlicott emphasised the need to provide psychotherapy, rehabilitation and occupation between insulin therapy treatments: KT, 38, 2, 1945, pp.30; Dr Emery provided psychotherapy in relation to ECT at Seacliff Hospital in 1948: Fennell, p. 148.

<sup>179</sup> Kenneth Stallworthy made a scathing attack on the claims of psychotherapists, accusing them of focusing their attentions of the less unwell population: Editorial, NZMJ, 55, 309, 1956, p.354.

patients made it possible to move the focus of attention onto preparing some patients for life outside the hospital. Social workers and welfare officers assisted patients with finding work and establishing support systems in the community. A few largely experimental programmes of rehabilitation were established for long-term patients. Nurses and attendants were charged with assisting the patients to learn basic living skills, and in some cases, prepare for work outside the hospitals. With no preparation for this more active rehabilitation role, they had to work out what to do for themselves. Russell Flahive was appointed a second in charge of a 'rehabilitation ward' in 1958. He worked with a group of male patients who had spent years in a closed ward. His first task in preparing the men for work outside the hospital was to take them to the hospital stores to be fitted out with personalised clothing. The men's work trial was on the construction site of a new bridge just outside the hospital grounds. In Flahive's view, the trial was 'fairly successful'.<sup>180</sup>

### ***Occupational therapy***

Mental hospital administrators had, for many years considered occupation to be a beneficial force in mental patients' lives. As well as the common practice of employing patients in farm or domestic work, there had been a growth of more specialised occupational programmes during the 1930s. By 1939, there were classes in weaving, cane, woodwork and simple handcrafts in most of the mental hospitals.<sup>181</sup> Classes were usually taught by volunteers, part-time tutors, or by the nurses and attendants.<sup>182</sup> Charlie Pilgrim, an attendant at Auckland Mental Hospital, for example, had established a woodwork shop for male patients in the old Borough Council pumping station.<sup>183</sup> With no training in carpentry or teaching, and minimal access to equipment, Pilgrim begged and borrowed tools from around the hospital, and employed patients to help sweep out the rooms ready for work.<sup>184</sup> Another attendant, Wallie Williamson, was given charge of a boot-making workshop. Williamson was a war-amputee and an ex-boot-maker by trade.<sup>185</sup> Occupational therapy skills were considered sufficiently important that the

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<sup>180</sup> Russell Flahive interview 1 June 2004.

<sup>181</sup> AJHR, 1940, H-7, pp.3-4.

<sup>182</sup> AJHR, 1937, H-7, pp.3-4.

<sup>183</sup> AJHR, H-7, 1939, p.3; AJHR, 1940, H-7, p.3.

<sup>184</sup> Hazel Skilton, *Work for your Life*, Hamilton, 1981, pp.27,38-9.

<sup>185</sup> *ibid.*, p.38.

Department sent four nurses from Porirua Hospital for weekly instruction at the Wellington Training College.<sup>186</sup>

Occupational therapy was introduced in a more formalised manner during the 1940s, largely at the instigation of Dr. Buchanan, the Medical Superintendent of Auckland Mental Hospital. During a visit to England in 1938, Buchanan had been impressed with the way in which occupational therapy permeated the work of mental hospitals. He gained Departmental approval to recruit a head occupational therapist for his hospital.<sup>187</sup> Margaret Inman, a trained nurse, midwife and occupational therapist, arrived from England in January 1940. Despite initial resistance, particularly from the older, male staff, she quickly familiarised herself of the existing programmes and extended them to a greater number of patients. Initially, however, classes for male patients, continued to be taught by male attendants.<sup>188</sup>

Inman opened an occupational therapy school at Auckland Mental Hospital in 1940.<sup>189</sup> This initiative was largely in response to appeals by Mary Lambie, the Director of Nursing, who was concerned about the needs of injured servicemen.<sup>190</sup> A six-month course was initially established for both mental nurses and others. The first four students were from outside the Department but they were joined a few months later by six others, three of whom were seconded from Seacliff Hospital; two nurses and one attendant.<sup>191</sup>

It is unclear how many mental nurses attended occupational therapy school during the 1940s. Most students were young female school leavers; on average, six commenced training every six months.<sup>192</sup> The curriculum was lengthened, initially to one year, then two years. Shortened courses were offered for mental hospital attendants. In the absence of sufficient numbers of fully-trained therapists, hospitals sent their attendants to the occupational therapy school for three months' training. In 1948, for example, Seaview Hospital sent a charge attendant, W.J. Pready, who subsequently instituted a programme

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<sup>186</sup> AJHR, 1940, H-7, p.4.

<sup>187</sup> AJHR, 1939, H-7, p.5.

<sup>188</sup> Attendants also provided instruction on such things as wood turning and French polishing to the first occupational therapy students: Skilton, p.61.

<sup>189</sup> Audrey Trotter, another trained occupational therapist from England, joined the staff in 1940: AJHR, H-7, 1941, p.4.

<sup>190</sup> Skilton, p.7.

<sup>191</sup> *ibid.*, p.13.

<sup>192</sup> *ibid.*, p.14.

with the male patients.<sup>193</sup> Occupational therapy was, however, emerging as a female profession and the work that had previously been conceived as exclusively male was being redefined as women's work.

By the late 1950s, trained occupational therapists were offering classes for patients in most mental hospitals. Expansion was only restricted by the lack of designated buildings and the shortages of nurses to assist with classes. The growth of occupational therapy had implications for mental nursing. Although not significantly affecting the core work of most staff members, the presence of designated therapists had a significant impact on the conceptual understanding of the mental hospital environment. For the first time, some activities with patients were defined as 'therapeutic' in themselves. Attendance at occupational classes was carefully differentiated from the activities in the 'utility' departments such as gardens, farms, kitchens, laundry and ward work.<sup>194</sup> It was not so clear that supervision of the latter work was conceived as therapeutic in its own right. Occupational therapy also redefined some tasks as female. It cut across the assumed practice of male staff working with male patients. In some instances, the attendants resented the intrusion of women and made their views known.<sup>195</sup>

### ***Social Work, psychology, and welfare officers***

Social work began to be established as a distinct role in New Zealand psychiatry during the 1930s and 1940s. The first psychiatric social worker was appointed in 1929 to work in a clinic set up at the Department's head office. Her work was mostly with families of 'backward' or 'problem' children and included obtaining personal and family histories, helping families carry out clinical recommendations, and assisting with admissions to institutions. She also worked with adult patients in the psychiatric observation ward at the general hospital, providing assistance with social aspects of their admissions and discharges. It was expected that this position was filled by a registered nurse. M.E. Dick, who held the position for many years, described the extra qualities required for

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<sup>193</sup> AJHR, 1949, H-7, p.6. Pready was at 'charge attendant' level, New Zealand Public Service List, ATL, Wellington, 1949.

<sup>194</sup> For many patients, the aim of occupational therapy was to instil work habits that would enable them to contribute to the 'utility' activities of the hospitals: AJHR, 1947, H-7, p.5.

<sup>195</sup> Skilton, p.12.



the job: 'previous insight into home visiting and the capacity to observe on broad lines and with perhaps some personal experience of the difficulties of life'.<sup>196</sup>

During the 1940s, the Department began to recognise the need for social workers at the mental hospitals, but lack of specific psychiatric social work training delayed the creation of positions.<sup>197</sup> In 1948, however, a social work position was created at each of the four metropolitan hospitals, that is, Auckland, Porirua, Sunnyside and Seacliff. Four women were appointed, one a registered (general) nurse and one a qualified mental nurse. One of the others held a non-nursing qualification, and the fourth had no qualifications.<sup>198</sup> This initiative was almost immediately considered such a success that it was decided to extend the scheme to all the other mental hospitals. Their contribution was especially valued because of the shortage of nurses.<sup>199</sup> The number of social workers did not expand rapidly. More positions were established but could not always be filled. By 1959, there were only seven employed across all mental hospitals.<sup>200</sup>

The beginnings of psychiatric social work were significant on two counts. It was considered by many to be an extension of nursing. Medical social work training had been offered for some time as a stream in the one-year programme at the New Zealand Postgraduate School for Nurses.<sup>201</sup> The New Zealand Registered Nurses' Association (NZRNA) recognised psychiatric social work as a specialist nursing position. There was, for example, a place for a social worker on the Association's National Mental Hygiene Committee.<sup>202</sup> Although not all early psychiatric social workers were qualified nurses, this role was probably the first extramural position available for nurses in mental health.<sup>203</sup> The other area of significance was that psychiatric social work was instigated because of an identified need that mental nurses, in their existing capacity, were not considered able to fill. Whether this was because of shortage of staff or limited skills, this was an early move towards greater diversification of the mental hospital workforce.

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<sup>196</sup> KT, 39, 11, 1946, p.303.

<sup>197</sup> J. Russell, Medical Superintendent, Avondale Hospital to Director-General, 26 January, 1948, H-MHD, 1, 8/116/0, ANZ, Wellington.

<sup>198</sup> New Zealand Public Service List, ATL, Wellington, 1949.

<sup>199</sup> AJHR, 1949, H-7, p.4.

<sup>200</sup> New Zealand Public Service List, 1959-60, ATL, Wellington.

<sup>201</sup> KT, 43, 7, 1950, pp.220-1.

<sup>202</sup> KT, 43, 2, 1950, p.35.

<sup>203</sup> There was some suggestion that recruitment should be extended to both male and female psychiatric nurses who could be supported to attend university: Lewis to medical superintendents, 3 September 1958, YCBG, 5929/6b, 5/4, 255, ANZ, Auckland.

Other disciplines were introduced in small numbers to the mental hospital workforce in the 1950s. Some hospitals, for example, began to employ welfare officers to organise recreational activities.<sup>204</sup> In 1958, a decision was made to appoint one psychologist for each of the four metropolitan hospitals.<sup>205</sup> Although the number of occupational therapists, social workers, psychologists and welfare officers was not high, their presence signalled a shift in psychiatric ideology from custody to rehabilitation. They also contributed to the creation of a more diverse workforce, no longer could nurses and attendants claim that they ‘did everything’ (see Appendix O).

### **A therapeutic role for nurses?**

There is no doubt nurses and attendants provided the day-to-day structure and care for patients. To what extent this care was conceived to be ‘therapeutic’, however, is questionable. Their role was perceived by some to be as important as the new treatments. Malcolm Brown, the medical superintendent of Seacliff Hospital, suggested that ‘...none of these treatments in itself is sufficient. The care and attention, which only a well trained staff of psychiatric nurses can give, are perhaps even more important than the mechanical aids to treatment.’<sup>206</sup>

Ideas of interpersonal relationships as a basis for psychiatric nursing were emerging in international nursing literature during the 1940s and 1950s. In Britain, this was largely related to the development of social psychiatry. Therapeutic community in particular, demanded that psychiatric nurses develop psychodynamic skills for use in both group and individual therapeutic communication. In the United States, nursing theorists, strongly influenced by interpersonal psychological theories, began to articulate an understanding of psychiatric nursing practice founded on therapeutic, interpersonal roles.<sup>207</sup> The two earliest contributions to this conceptualisation were Helena Willis Render in 1947 and Hildegard Peplau in 1952.<sup>208</sup> Their views were reflected in a report by the World Health Organisation’s Expert Committee on Psychiatric Nursing in 1956. The report identified three aspects of psychiatric nurses’ work: technical, social and

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<sup>204</sup> 1 April 1955, H-1, 28618, ANZ, Wellington.

<sup>205</sup> AJHR, 1958, H-31, p.78.

<sup>206</sup> AJHR, H-7, 1948, p.14.

<sup>207</sup> O'Brien, 'The Therapeutic Relationship', pp.4-5.

<sup>208</sup> Hildegard Peplau, *Interpersonal Relations in Nursing. A Conceptual Frame of Reference for Psychodynamic Nursing*, New York, 1952; Helena Willis Render and M.Olga Weiss, *Nurse-Patient Relationships in Psychiatry*, 2nd edn, New York, 1947.

interpersonal. Of these, the report considered the interpersonal to have central importance.<sup>209</sup>

Although the language of nurse-patient relationship was beginning to appear in the psychiatric nursing education in New Zealand during the 1950s, the concept of 'therapeutic relationships' did not take a central place in practice.<sup>210</sup> There was, however, some recognition of the unique interpersonal qualities inherent in the role. In 1957, for example, the PSA claimed that the majority of the nurse's role entailed the use of a '...particular kind of human relationship'.<sup>211</sup> In order to build the patients' confidence, they argued, nurses required a great deal of tolerance and a 'natural authority'. The union asserted that without these attributes, a young person might resort to undesirable methods to control patients' behaviour.<sup>212</sup> The PSA's message provides an insight into the attendants' and nurses' views of their own practice. It seems that they valued their ability to assist patients towards recovery, but their concept of how to achieve this was imbedded in the reality of a custodial environment. Doing the physical work, controlling the environment, and containing undesirable behaviour were central to their role.

## Conclusion

By the end of the 1950s, despite new therapeutic approaches to mental illness, asylum ideologies of care persisted within New Zealand psychiatric institutions. This situation was largely the result of hospital overcrowding, limited resources, the increasing numbers of chronically ill and disabled patients, and a need for manual labour to sustain economic self-sufficiency. The 'enduring asylum' phenomenon was not unique to New Zealand.<sup>213</sup> Large, poorly resourced and overcrowded hospitals were a phenomenon of mental health care in Britain, North America, and Australia.<sup>214</sup> In countries where these

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<sup>209</sup> *Technical Report Series* (First Report), 1956, 105.

<sup>210</sup> In the June 1960 state examination for psychiatric nurses, trainees were asked, 'How do you think the concept of a hospital as a therapeutic community affects the relationship between nurse and patient?': ABYO, 7891, W5148, 50, ANZ, Auckland.

<sup>211</sup> Jack Turnbull, PSA General Secretary circular to members, 26 July 1957, 82-046-031/5, ATL, Wellington.

<sup>212</sup> *ibid.*

<sup>213</sup> David Rothman describes mental hospitals in the twentieth-century USA as 'enduring asylums': Rothman, 'The Enduring Asylum,' p.65.

<sup>214</sup> For examples of hospital conditions and their effect on nurse/attendant care see: Gittins; Rebecca Bouterie Harmon, 'Nursing Care in a State Hospital, 1950-1965', PhD thesis, University of Virginia, 2003; Doris Kordes, 'From Herd Care Practices to the Therapeutic Community Approach: Moral

conditions persisted, the attendant culture of practice resisted the new ideologies promoted by medicine and nursing. The effect of asylum-type conditions in New Zealand was to maintain custodial care into the 1960s. Little had changed in the day-to-day practice of mental hospital nurses and attendants.

New Zealand mental hospitals in this period possessed many of the characteristics of 'total institutions' as described by Erving Goffman.<sup>215</sup> There was limited contact with the outside world, tightly scheduled daily activities, usually in large groups, and few staff. Control was largely maintained by surveillance. The division between 'them and us' was retained. Hierarchical structures, strict rules and judicious use of time and space maintained a tight level of control. Manual work, observation, containment and order continued to be valued; safe management of disorder was an overriding goal. Roles within these conditions remained gendered. The men cared for male patients and undertook a range of manual tasks, often outdoors. Supervision of farm and gardening gangs occupied much of their time. The women's work was almost entirely located indoors, either providing nursing care or doing domestic tasks. Their supervisory activities centred on cleaning, laundry and cooking duties. Despite these divisions, the overriding imperative that identified the work of psychiatric nursing was to maintain supervisory control.

The work culture within the hospital system continued to reflect attendant rather than nursing values. By the end of this period, however, the cultural balance was beginning to shift. Somatic therapies and new treatment approaches demanded nursing care of a type that was usually associated with women's work. Male attendants were faced with difficult choices that were to challenge their unique identity and position within the mental hospital system. Educational changes during this period also began to challenge the male attendant culture. The establishment of a register of psychiatric nurses under the Nurses and Midwives Board drew mental hospital nurses to a closer relationship with the nursing profession. Chapter IV explores the changes the attempts at educational and professional reform between 1939 and 1959.

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Treatment in Kenmore Hospital, New South Wales', paper presented at the *Health and History: International Perspectives. The 9th Biennial Conference of the Australian Society of Medicine*, Auckland, February 2005; Nolan, *A History of Mental Health Nursing*; William Vogel, 'A Personal Memoir of the State Hospitals of the 1950s', *Hospital and Community Psychiatry*, 42, 6, 1991.

<sup>215</sup> Goffman.

## **Chapter IV**

### **Educational and Professional Issues 1939 to 1959**

‘In general the pupil mental nurse is not interested in a career, or in an interesting work, but in securing a well-paid ‘job’.<sup>1</sup>

Reforms were introduced into mental hospital nursing education between 1939 and 1959. These were driven by a desire to raise the status of mental nurses, and by association, the reputation of the hospitals in which they worked. Although the changes did not initially result in significantly improved standards, they did bring male and female staff into contact with the broader nursing profession. Two very different cultures met. Initially, the male-dominated, ‘attendant culture’ remained undisturbed. When it became apparent that the nursing profession was gaining authority over their occupation, the mental attendants (and nurses) fell back on their traditional means of redress; they used their union to fight for the right to determine their own professional pathways.

#### **Training for mental hospital attendants and nurses**

A system of training and registration for mental nurses and attendants had been in place in New Zealand since 1905. This was administered by the Mental Hospitals’ Department and followed the system established in the United Kingdom by the Medico-Psychological Association (MPA), which later became the Royal Medico-Psychological Association (RMPA). Although by 1939 the training had become somewhat more demanding, the general structure of the course and the content of the examinations remained essentially the same.<sup>2</sup> The syllabus included preparation for the Junior Mental Examination in basic nursing, first aid, anatomy and physiology at the end of six months and a final, ‘Senior’ examination on more advanced nursing and mental diseases, at the end of three years. The lectures, usually given in a series before an

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<sup>1</sup> Elizabeth Bridges, Nurse Instructor, Division of Nursing, Report of Visits to Mental Hospitals at Porirua, Avondale, Kingseat, Tokanui, Nelson and Sunnyside – August to December 1941, H1, 33340, 1/11/77, ANZ, Wellington.

<sup>2</sup> Margaret McRae, a matron at Tokanui Hospital considered that the standard of training had gradually improved: NZRNA Mental Hygiene Committee minutes, 17 January 1936, H, 1, 22764, 21/18/6, ANZ, Wellington.

examination, were taught by medical officers and tutor sisters or matrons.<sup>3</sup> The doctors generally gave the lectures on mental illness and anatomy and physiology, while the nurses taught practical nursing skills. This was not a strict division; hospitals made use of whichever qualified staff (medical officers or registered nurses) were available. Dedicated classroom space was rare; lectures were often given in the wards. In contrast to general hospitals, teaching resources in mental hospitals were very basic. All nurses were issued with a copy of the Handbook for Mental Nurses (commonly known as the Red Book). First published by the MPA in Britain in 1885, it was the only textbook available to most nurses.<sup>4</sup>

Staffing the wards, grounds, and farms took priority over classroom training. Lectures had to be fitted in around the nurses' and attendants' long hours of work, and were often given in the evenings. The roster system of two days-on and one day off, and the bi-annual leave, caused considerable challenges to nurses' ability to attend. It was expected that staff attend in their time off, but this was a source of tension and did not always occur. The ruling that all staff should attend at least 75 percent of the prescribed lectures was also not consistently enforced.<sup>5</sup> It appears there may have been a gender difference in the approach to formal classes. Women who undertook their training at this time recall a strict expectation that they attend lectures, even if it meant doing so on their day off, or having to find a colleague to relieve them on night duty.<sup>6</sup> Some of the men recalled a more relaxed approach to formal training. Percy Atkinson, who started at Seaview Hospital in 1934, remembers that there were only classes for '... an hour or two, occasionally – [there was] not much training – practical experience, mainly'.<sup>7</sup> James Nolan, who started in 1939, was surprised when he achieved 89 percent in the Junior Examination; he remembers that he and his colleagues, '... didn't apply ourselves too greatly in those days'.<sup>8</sup>

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<sup>3</sup> Tutor sisters were a relatively recent addition to the staff most hospitals. Porirua, for example, employed a tutor sister for the first time in 1929: AJHR, 1930, H-7, p.6.

<sup>4</sup> The 'Red Book' was first published as *The Handbook for the Instruction of Attendants on the Insane*. For a description of its editions and use, see: Nolan, *A History of Mental Health Nursing*, pp.63-4.

<sup>5</sup> 21 July 1939, J.U. Williams, Medical Superintendent, Nelson Mental Hospital to Theodore Gray, H-MHD, 1, 8/94/0, ANZ, Wellington.

<sup>6</sup> Irene Smith, interviewed by W.H. Lyon, 8 March 1983, OHInt-0014/185, NERF-OHP.

<sup>7</sup> Percy Atkinson interview 28 & 29 August 2004.

<sup>8</sup> James Nolan interviewed by Lois Wilson, 3 November 1983, OHInt-0014/124, NERF-OHP.

Nurses and attendants were employed on a probationary basis for the first two years during which their employment could be annulled by the medical superintendent.<sup>9</sup> They were expected to pass the Junior Examination within two attempts to ensure ongoing employment. Again, the Department at times overlooked its own regulation. Medical superintendents argued that some attendants were reliable workers and excellent with work gangs but would never be able to pass an exam.<sup>10</sup>

Examinations were set by the Department's head office. The Junior Examination consisted of a written paper, while for the Senior Examination, nurses and attendants answered a written paper, oral and practical examinations. The oral was taken either by a medical superintendent or, quite commonly, by the Director-General himself. The hospital matron usually administered the practical test. Those who passed the Senior Examination were awarded a medal (a move instigated in 1932), had their names published in the annual report, and were promoted to 'Senior Nurse' or 'Senior Attendant'.<sup>11</sup> There was a sharp fall-off in numbers of both men and women during the three years of training. Between 1935 and 1945, a lot more women than men qualified in the Senior Examination (see Table 6 below).

Year	Attendants	Nurses	Institutional Officers, Templeton (sex not always specified).
1935	9	41	
1936	19	42	4
1937	15	44	5
1938	24	39	2
1939	*69	*62	8
1940	15	42	5
1941-44	-	-	- (not recorded during war)
1944	16	29	4
1945	21	25	-

**Table 5 Senior Examination passes, 1935-1945.**

**Source: AJHR, H-7, 1936 – 1946**

\* It is unclear why there was a much larger number of passes in 1939.

### **Agitation for change:**

During the 1930s, both mental hospital administrators and leaders of the nursing profession expressed a desire to improve nursing standards in mental hospitals. For the

<sup>9</sup> Draft Rule Book, 1939, H1/28739. ANZ, Wellington.

<sup>10</sup> Gray response to medical superintendents, 16 February 1943, H-MHD, 1, 8/94/0, ANZ, Wellington.

<sup>11</sup> Theodore Gray instigated a medallion in 1932, AJHR, 1933, H-7, p.3.

medical administrators, a closer affiliation with general nursing promised to raise the status of their employees and convince the public that their institutions were no longer places to be feared. They also hoped that an improved image for their nurses would help attract female recruits. Desire for closer affiliation with general nursing was not new. Since the early 1900s, the Department had encouraged its qualified female nurses to undertake their general hospital training, and had followed a policy of employing double-trained nurses in matron and tutor sister positions. Registered (general) nurses were entitled to a concession of one year on their mental nursing training. One formal connection between the mental hospitals and the nursing profession was through the reporting systems for registered general nurses working in mental hospitals. The Department of Mental Hospitals informed the Nurses' and Midwives' Board (N&MB) of any registered nurse (RNs) who qualified in the Senior Mental Nursing Examinations.<sup>12</sup> Theodore Gray was not however convinced that these measures were sufficient. He was particularly concerned about the international standing of the mental nursing qualification, since it was not recognised in the United Kingdom.<sup>13</sup>

National nursing leaders were cognisant of the need to address mental health as a core aspect of nursing care. The mental hygiene movement of the 1920s and 1930s had raised awareness internationally about the need for prevention and early treatment of mental problems.<sup>14</sup> A resolution passed by the International Council of Nurses (ICN) in 1933 endorsed the principle of inclusion of mental hygiene in the curriculum of all schools of nursing.<sup>15</sup> Member associations, which included the New Zealand Registered Nurses' Association (NZRNA), were charged with exploring ways to action the recommendations in their own countries. In 1934, Mary Lambie promised to establish a committee within the NZRNA. She predicted difficulties, however, since there were few registered nurses working in mental hospitals, and only a small number of these

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<sup>12</sup> In December 1934 13 (general) RNs qualified, another five in December 1935, and four in 1936: H-1, 22719, 12, ANZ, Wellington.

<sup>13</sup> Presumably, Gray was referring to recognition with the General Nursing Council (GNC), since the RMPA continued to offer their own training and examinations in the United Kingdom alongside the GNC qualifications until 1951. See: Dingwall, Rafferty, and Webster, *An Introduction*, p.137.

<sup>14</sup> The Mental Hygiene movement is usually considered to have dated from the publication of Clifford Beer's exposé of mental hospitals in 1908 in the United States, but it was most influential in the post-World War One years. The First International Congress for Mental Hygiene in 1930 received particularly wide international interest: Gerald Grob, *Mental Illness and American Society, 1875 to 1940*, Princeton, 1985, pp.144-66; National Mental Health Association, *National Mental Health Association and the History of the Mental Health Movement 2005*; available at: <http://www.nmha.org/about/history.cfm>

<sup>15</sup> Daisy Caroline Bridges, *A History of the International Council of Nurses, 1899 - 1964*, Philadelphia, 1967, p.88.



belonged to the Association. In Lambie's opinion, mental nursing reform was constrained by the fact that the hospitals were administered by a state department.<sup>16</sup> Presumably, she referred to the lack of influence she and other nursing leaders were able to exert over nurses in the mental hospitals.

Lambie's first move was to call for opinion papers from within NZRNA on mental health and mental hygiene. These reflected the breadth of current nursing opinion and knowledge on the subject. Some nurses were concerned to improve general nurses' education by weaving concepts of mental hygiene and psychology into the curriculum. Others made detailed suggestions on how to improve mental nurses' training. Margaret McRae, who was a matron at Tokanui Hospital, used the opportunity to challenge the assumption that general nurses were superior to mental nurses. McRae suggested that many RNs did not have a suitable temperament for mental nursing. She claimed that the Department preferred its nurses to prove themselves first in mental hospital work before undertaking general nursing education.<sup>17</sup> McRae's main plea was for reciprocity between general and mental nursing education; she bemoaned the fact that mental nurses were granted no concession towards general nursing training.<sup>18</sup> Lambie was inclined to agree that there was scope for reciprocity. She indicated that a common first year examination, similar to that offered in Britain, would soon be introduced in New Zealand.<sup>19</sup>

The NZRNA's Mental Hygiene Committee was formally established in 1938.<sup>20</sup> The committee initially focused more on mental hygiene principles in general nursing education and preventative health than on addressing nursing standards in mental hospitals. In 1940, for example, it surveyed nursing curricula and concluded that there was, 'satisfactory evidence that mental hygiene is given prominence. It is not placed as a separate subject in the curriculum but is combined and interwoven throughout'.<sup>21</sup> The committee also addressed the need for nurses to promote the foundations of mental

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<sup>16</sup> Mary Lambie to Karin Neuman-Rahn, Chair, ICN Committee of Mental Nursing and Hygiene, 11 October 1934, H-1, 22719, 12, ANZ, Wellington.

<sup>17</sup> This was an interesting viewpoint from someone who had started her career as a registered (general) nurse.

<sup>18</sup> Committee papers on Mental Nursing and Mental Hygiene, 17 January 1936, H-1,22719, 12, ANZ, Wellington.

<sup>19</sup> Lambie to Miss McKeeney, Pahiatua, 28 January 1936, H-1,22719, 12, ANZ, Wellington.

<sup>20</sup> There is evidence that the committee was engaged in some activity prior to this date. Papers on mental hygiene were forwarded to Mary Lambie from a committee on 17 January 1936: H-1, 22719, 12, ANZ, Wellington. Kai Tiaki, however, cites 1938 as the establishment date: KT, 63, 2, 1950, p. 35.

<sup>21</sup> KT, 33, 3, 1940, p. 87.

health for infants and children through the provision of fresh air, good nutrition and regular habits.<sup>22</sup>

The next step towards reciprocity between general and mental nursing came, not from the nursing profession, but from the Department of Mental Hospitals. Keen to increase the number of double-trained, female nurses in senior positions, Gray approached the N&MB with a request that mental hospital nurses could be permitted to sit the State Preliminary Examination. He was clear, at this juncture, that the opportunity should not be open to the men.<sup>23</sup> Gray claimed that it was 'farical to expect our male attendants to pass the same examination as our nurses. The aptitudes of our men are not directed towards nursing, with a few brilliant exceptions, but rather towards outside work on the farm'.<sup>24</sup> The Board agreed to seek the required legislative changes on the condition that the nurses follow the course of training as laid down by the N&MB and that the schools be open for inspection.<sup>25</sup>

In 1939, an amendment to the *Nurses' and Midwives' Registration Act* was passed that allowed for mental nurses to sit the Nurses' State Preliminary Examination after one year's training. Nurses who passed the examination and completed three years' mental nurse training could be granted one year's concession towards their general training. Not only was this the first step towards some form of amalgamation of general and mental nursing, it also heralded the possibility that nurse education in mental hospitals would come under the control of the N&MB.<sup>26</sup> Male attendants were not included in the provisions. Gray was however keen to ensure that they would not miss out on opportunities for advancement. He instituted an examination to allow men to gain promotion to head attendant 'with a view to accelerating the promotion of our most promising younger male staff'.<sup>27</sup>

Passing the legislation was relatively easy. Preparing nurses for the State Preliminary Examination was more difficult. Some hospitals were quick to provide the necessary

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<sup>22</sup> KT, 34, 3, 1941, pp.85-6.

<sup>23</sup> Warwick Brunton argues that Theodore Gray had an underlying prejudice against male attendants and worked to stretch the career progression for females by creating new jobs such as tutor sisters and nurse's home supervisors. He also narrowed the salary gap between male and female attendants at the top end of the scale, so that by 1947 matrons were paid 83% of a head attendant's salary. Brunton, 'A Choice of Difficulties', p.344.

<sup>24</sup> Gray to Public Service Commissioner, 26 January 1937, H-MHD, 1. 8/125, ANZ, Wellington.

<sup>25</sup> 2 August 1938, J.W. Buchanan, Secretary, N&MB to Gray, CH890, 8a, ANZ, Christchurch.

<sup>26</sup> KT, 33, 3, 1940, p.84.

<sup>27</sup> AJHR, 1941, H-7, p.3.

support. Others were either reluctant or unable to comply because of lack of personnel and equipment. The first eight mental hospital nurses sat and passed the examination in 1940.<sup>28</sup> The next year, the N&MB began to formalise its role in mental nurse training. It approved six mental hospitals as ‘B Grade’ training schools, suitable for partial preparation of general nurses.<sup>29</sup> This approval was given despite a damning report on the hospitals by Elizabeth Bridges, a nurse instructor with the Division of Nursing.<sup>30</sup>

Bridges was shocked by conditions in mental hospitals. She noted female staff shortages of up to 30 percent. Nurses worked long hours of overtime and often could not be relieved from duty to attend lectures. She suspected that some hospital officials discouraged nurses from going for the Preliminary Examination because they were worried that the nurses would get a taste for general nursing and never return to mental hospitals. Her report highlighted the paucity of training facilities. There were few books, little demonstration equipment and classrooms were not always set aside for teaching purposes. At Sunnyside Hospital, for example, a patients’ dayroom was used for lectures and at Porirua, a visitors’ lounge. Bridges was also uncomplimentary about the standard of recruits. She claimed that, ‘In general the pupil mental nurse is not interested in a career, or in an interesting work, but in securing a well-paid “job”’.<sup>31</sup>

Nurses’ memories of training during this period are consistent with Bridges’ observations. Irene Smith was completing her training at Seacliff when the Preliminary Examination provision was introduced. She was on night duty, so was not given an opportunity to attend preparatory lectures. After qualifying as a mental nurse, she transferred to general nursing and had to undertake the whole training.<sup>32</sup> Rita McEwan and a friend were training at Nelson Mental Hospital when they heard about the possibility of gaining a concession towards general nursing. The medical superintendent was not keen on the idea, but agreed to allow them to prepare for the examination if there were six nurses who wanted to do it. McEwan and her friend found four other

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<sup>28</sup> AJHR, 1941, H-7, p.3.

<sup>29</sup> KT, 35, 1, 1942, p.86.

<sup>30</sup> Lambie to medical superintendents of Kingseat, Avondale and Tokanui Hospitals, 20 November 1941, H-1,22719,12, ANZ, Wellington.

<sup>31</sup> Report of Visits to Mental Hospitals at Porirua, Avondale, Kingseat, Tokanui, Nelson and Sunnyside – August to December 1941, H-1, 33340, 1/11/77, ANZ, Wellington.

<sup>32</sup> Irene Smith, interviewed by W.M. Lyon, 8 March 1983, OHIInt-0014/185, NERF-OHP.

willing nurses. They attended lectures at the general hospital, a seven mile cycle-ride away.<sup>33</sup> McEwan passed the examination in late 1942.<sup>34</sup>

Gray was determined to raise the standard of mental hospitals' training and prove that it merited recognition by the N&MB. He was no doubt aware that in Britain, the General Nursing Council (GNC) had refused to accept the RMPA qualification as the psychiatric nursing registration, with the result that a parallel system of examinations had been in place there since 1922.<sup>35</sup> One of his first moves was to introduce external supervisors for the Senior Examinations.<sup>36</sup> He followed this by suggesting a raft of other upgrading measures. These included a proposal that all applicants should be interviewed by the medical superintendents and past educational attainment taken into consideration. Junior Examinations should continue twice yearly and Senior Examinations annually. Both should be based on the Red Book. Greater control should be given to head office doctors over setting and conducting tests for the Senior Examinations. Gray's suggestions culminated in May 1943 with a proposal for a new, three-year training with lectures each year, annual examinations, and a national syllabus, that was yet to be formulated.<sup>37</sup>

In the meantime, Gray had started discussions with the N&MB over recognition. In July, he approached Michael Watt, the Director-General of Health, to inquire about having the mental hospitals' examinations recognised by the Board, claiming that this was necessary so that New Zealand qualified mental nurses could be recognised overseas. Gray argued that the standard of the Department's training and examinations were at least equivalent to those in Great Britain.<sup>38</sup> The request was put to the next meeting of the N&MB and was approved in principle.<sup>39</sup>

While awaiting the necessary legislative change, Gray established a Publications' Committee to write a new text to replace the Red Book and to work on developing the

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<sup>33</sup> Rita McEwan interviewed by Judy Heffer, 30 September 1988, OHInt-0139/2, NERF-PNOHP.

<sup>34</sup> On 23 February 1943, five nurses, including Rita McEwan of Nelson, were recorded as having passed the 'recent' (presumably December 1942) State Preliminary Examination. Three were from Christchurch and one from Auckland: H-1, 33340, 1/11/77, ANZ, Wellington.

<sup>35</sup> Nolan, *A History of Mental Health Nursing*, p.81.

<sup>36</sup> By 1942, Department of Health officials adjudicated the exams in mental hospitals around the country. See: November 1942, H-1,22719,12, ANZ, Wellington.

<sup>37</sup> Gray to medical superintendents, 20 May 1943, H-MHD, 1, 8/94/0, Vol.1, ANZ, Wellington.

<sup>38</sup> It is not clear whether he was referring to the RMPA or the GNC qualifications: Gray to Watt, 29 June 1943, H-1, 22719, 12, ANZ, Wellington.

<sup>39</sup> Watt to Gray, 24 August 1943, H-1, 22719, 12, ANZ, Wellington.

new syllabus.<sup>40</sup> The committee, established in April 1944, was initially comprised of five psychiatrists but within a few months was joined by Rose Connor a registered nurse from Wellington Hospital. Connor, who had trained as a mental nurse at Porirua Hospital, had recently finished her general training.<sup>41</sup> She was invited to join the committee to provide advice on practical nursing.<sup>42</sup>

In September 1944, Gray circulated a proposed curriculum for comment. The most significant suggestion was that the old junior exam should be combined with the N&MB Preliminary Examination to form a new 'state' preliminary examination. The committee had reviewed the British syllabus for mental nurses (GNC) and decided that there was considerable overlap with the New Zealand state preliminary curriculum.<sup>43</sup> Medical superintendents generally responded positively to the proposed syllabus.<sup>44</sup> Dr John Williams, of Nelson Mental Hospital, however, raised the perennial problem, 'What of the attendants? Are they to take the whole course?' If some were to be weeded out by the first exam, what, he asked, would become of their salary increments?<sup>45</sup>

### **State registration of psychiatric nurses**

The *Nurses and Midwives Registration Amendment Act* passed in September 1944, made provision for the establishment of a register of psychiatric nurses under the N&MB. The new title, 'psychiatric nurse' reflected a desire to create a professionalized workforce associated with modern psychiatry. Gray explained that recent therapeutic innovations had 'instituted a greater individualisation of treatment and a corresponding requirement of more knowledge on the part of the nurse'.<sup>46</sup> The NZRNA concurred. *Kai Tiaki's* editor claimed that the title 'psychiatric nurse' would be not only more dignified, but would also bring New Zealand nurses in line with those overseas and reduce the feeling of isolation between 'those who care for the mentally sick and those in other spheres of the nursing profession'.<sup>47</sup> Lambie reinforced the message of unity at

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<sup>40</sup> The Publications Committee was established in April 1944: H-MHD, 1, 8/94/6, ANZ, Wellington.

<sup>41</sup> KT, 62, 11, 1969, p.21.

<sup>42</sup> H-MHD, 1, 8/94/6, ANZ, Wellington.

<sup>43</sup> 31 July & 1 September 1944, H-MHD, 1, 8/94/0, Vol.1, ANZ, Wellington.

<sup>44</sup> Medical superintendents to Gray, October – November 1944, H-MHD, 1, 8/94/0, Vol.1, ANZ, Wellington.

<sup>45</sup> 20 September 1944, H-MHD, 1, 8/94/0, Vol.1, ANZ, Wellington.

<sup>46</sup> AJHR, 1945, H-7, p.3.

<sup>47</sup> KT, 38, 1, 1945, p.3.

the NZRNA's next conference and encouraged the Association to assist in bringing about a closer affiliation between the two groups of nurses.<sup>48</sup>

The legislation allowed for two new positions on the N&MB, one for the Director-General of Mental Hospitals and the other for a psychiatric nurse, nominated by a nursing organisation. With the support of the Nursing Division and the Department of Mental Hospitals, the NZRNA assumed the nomination right. The 1945 conference nominated Margaret McRae, the matron of Auckland Mental Hospital and she was duly appointed by the Minister of Health in May that year.<sup>49</sup>

Regulations concerning the *Nurses and Midwives Registration Amendment Act* were issued in February 1945. Psychiatric trainees were required to sit three examinations. The Preliminary Examination for Pupil Psychiatric Nurses, conducted by the N&MB, was to be attempted between 18 months and two years of training. The Institutional Final Examination was to be attempted at the end of the three year training, within two months of the Final State Examination. It was to be administered by the Department of Mental Hospitals, with the Board reserving the right to approve examiners and vet standards. Lastly, the N&MB would be conducting the Final Qualifying Examination for Psychiatric Nurses (State Examination). Trainees were required to be at least 20 years of age before sitting the Final Examination and 21 years before gaining registration as a psychiatric nurse. Registered (general) nurses were entitled to complete the training in two years, all others were required to complete three years. There were provisions for men and women holding the old Senior Mental Nursing qualification to have this commuted to psychiatric registration.<sup>50</sup>

Over the next year, a process for delivering the psychiatric nursing training and examinations was gradually established. The Department of Mental Hospitals continued to retain considerable control over the curriculum, training and examination. At an administrative level, Gray made it clear that all correspondence from the N&MB to mental hospitals should pass through him.<sup>51</sup> At Gray's request, the N&MB approved eight hospitals as 'Grade A' training schools; these were authorised to provide the full

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<sup>48</sup> KT, 38, 3, 1945, p.54.

<sup>49</sup> H-1,22765, 21/18/3, ANZ, Wellington.

<sup>50</sup> In May 1945, qualified mental nurses and attendants began applying to the Nurses' and Midwives' Board for registration; 104 men and 126 women were granted registration in 1945: Register of Psychiatric Nurses, 1945-66, ABYO, 7889, W5148, 30, ANZ, Wellington (see also Appendix J).

<sup>51</sup> 26 March 1945, H-1,22719,12, ANZ, Wellington.

psychiatric training.<sup>52</sup> A further three hospitals, Templeton, the Chateau and Wairakei were authorised as ‘Grade B’ schools.<sup>53</sup> Trainees at these hospitals were required to spend six months at a ‘Grade A’ hospital before sitting the Final Qualifying Examination. Gray also provided the Board with an outline of the new syllabus and a process for setting and marking state examinations. With no psychiatric nursing expertise available, the Board was happy to leave this in the hands of the psychiatrists. It was agreed that Lewis would set and mark the elementary psychiatry paper for the Preliminary Examination while Gray and Lewis would be examiners for the Final Qualifying Examination. Both doctors would work with the medical superintendents and tutor sisters of each institution to conduct the oral and practical examinations.<sup>54</sup>

The Publicity Committee saw the introduction of state registration as an opportunity for female mental hospital nurses to adopt the external trappings and nomenclature of professional nursing while retaining elements of training distinctive to their specialty. They suggested that the terms, ‘sister’ and ‘staff nurses’ should replace ‘charge nurse’ and ‘senior nurse’. Outward signs of seniority should be made more explicit. Sisters should wear white uniforms and flowing veils. Sisters’ sleeves should be short and matrons’ long. Staff nurses should wear blue, and all nurses below this rank should wear pink uniforms with white caps with a distinguishing mark (stripe) for each year of service.<sup>55</sup> The committee did not seem concerned about the appearance or titles of male psychiatric nurses. The implication was that the women, not the men, were to rescue the image of mental hospitals. New titles were introduced soon afterwards. New, coloured uniforms came a little later (see Figure 16 for a photo of three sisters in the coloured uniforms).

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<sup>52</sup> Gray to N&MB, 4 April 1945, H-1, 22719, 12, ANZ, Wellington.

<sup>53</sup> The Chateau and Wairakei were being used temporarily as psychiatric hospitals because of an earthquake at Porirua; Williams, pp.184-92.

<sup>54</sup> J. Waldron, secretary, N&MB, to Gray, 18 April 1945, H-1, 22719, 12, ANZ, Wellington.

<sup>55</sup> Summary of Proceedings of the Publicity Committee, 16-8 December 1944, H-HMD, 1, 8/94/6, ANZ, Wellington, p.2.



**Figure 18** The Hillary sisters, Seaview Hospital, circa 1960s. Source: Seaview Hospital photograph collection, Hokitika Museum.

### *What to do with the men?*

Psychiatric registration posed some dilemmas for the Department of Mental Hospitals. Arguably the most difficult was the question of how to deal with the attendants' expectations surrounding promotion. Although Gray continued to espouse the goal of creating a female nursing workforce, he did not want to risk jeopardising the Department's relationship with its male attendants, who provided a larger and more stable workforce. For those with the existing Senior Mental Nurse qualification, the issue was simple; their old qualification was commuted to psychiatric registration on application to the N&MB. For those still in training or joining the Department, insistence on new standards was problematic. With staffing shortages at their most critical, professional ideals were sacrificed to administrative expediency.

Each attempt to improve the training requirements was matched by moves to protect the conditions of male staff. Soon after announcing the finalised syllabus in June 1945, Gray circulated a new process for promotion. While the circular emphasised that, 'It should be the aim of each probationer nurse and attendant to acquire the status of a Registered Nurse', it was clear that failure to do so would not be held against an individual staff member.<sup>56</sup> The biggest compromise was the retention of the Junior Examination which would be offered twice a year. Attendants and nurses could gain promotion after one year's service and success in the Junior Examination. Multiple

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<sup>56</sup>'Training, Examination and Promotion', a circular to staff, circa June 1945, H-MHD, 1, 8/94/0, Vol.1, ANZ, Wellington.



attempts were to be allowed. The Institutional Final Examination was to serve a dual purpose. Offered once a year, it would replace the old Senior Examination for promotion purposes. A 50 percent mark was sufficient for promotion to senior nurse or senior attendant. Its other function was to allow entry to the Final Qualifying (State) Examination. For this purpose a 60 percent grade was required.<sup>57</sup>

Rules for promotion were different for men and women. If an attendant failed the Institutional Final, he would still become a senior attendant after four years service, but was not eligible to apply for promotion to charge or deputy charge attendant. The women did not have the same right to promotion after four year's service. They could, however, having attained senior nurse status, apply for staff nurse or sister positions, but preference would be given to registered nurses (RNs).<sup>58</sup>

The Department's ambivalence over the status of male staff was accentuated by the needs of returning servicemen. A large number of such men sat the Institutional Final Examination in late 1945 in the belief that a pass would automatically give them registration. In fact this concession only applied to people who had passed the Senior Mental Examination before 1945. The Division faced a predicament when very few (33 of the 81 candidates) met the 50 percent pass mark. Russell, the Acting Director-General, decided to lower the pass mark to 46 percent to allow an extra 18 people to pass and appealed to the N&MB to grant registration to the successful candidates.<sup>59</sup> He also requested that this arrangement be extended to any returned serviceman who passed the Institutional Final up to 31 December 1947.<sup>60</sup> The Board agreed.

There were different professional expectations for men and women. Women were to be rewarded for their commitment to educational achievement and links to the nursing profession, while men were to be rewarded for loyalty and economically protected as bread-winners. Women were given access to general nurse training and expected to take responsibility for professional leadership. This was recognised in the next salary settlement, when it was agreed that matrons holding both general and psychiatric registrations could, for the first time, earn a higher rate than head attendants. The

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<sup>57</sup> John Russell, Acting D-G Mental Hospitals to medical superintendents, 23/8/1945, H-MHD, 1, 8/94/0, Vol.1, ANZ, Wellington.

<sup>58</sup> 'Training, Examination and Promotion', H-MHD, 1, 8/94/0, Vol.1, ANZ, Wellington.

<sup>59</sup> The Department reported that 21 attendants and 25 nurses passed the Senior Mental Nursing Examination in November 1945. The discrepancy could be due to partial passes; AJHR, 1946, H-7, p.4.

<sup>60</sup> 16 November 1945, H-MHD, 1, 8/94/0, Vol. 1, ANZ, Wellington

decision, agreed to reluctantly by the PSA, recognised the matron's role as head of the training school. It was the only mental nursing position in which a woman could earn the equivalent of, or above, a man.

Not all workers were happy with the changes to promotion regulations. Some argued that head attendants carried much greater responsibilities than matrons, even with their new roles.<sup>61</sup> Some female nurses were unhappy with the expectation that they undertake general training to attain higher positions in the hospital system. 'Loyal Nurse' wrote to the PSA Journal complaining that there was too much emphasis on general training in the new salary scale and not sufficient on 'psych' skills.<sup>62</sup> How would the men respond, she asked, if they were required to do two more years' training and sit another examination before being promoted?<sup>63</sup>

Numbers of staff passing the Final Qualifying Examination were, initially, very low. Over the first five years (1946-50), a total of only 92 women and 31 men qualified as RPNs by passing the examination.<sup>64</sup> On the male side, with promotion pegged to the Institutional Examinations, there was little incentive to pass the State Examination.<sup>65</sup> Because the rate of turnover of male staff was very low, there were also few men coming up through the ranks.<sup>66</sup> Russell, who became the Director of the new Division of Mental Hygiene in 1947, predicted that it would be many years before qualifications by State Examination would mean anything on the male side.<sup>67</sup>

For the women, their high turnover was a significant factor in the relatively low pass rate. Many nurses did not stay past their first year of employment; others did not complete their three-year training. Many of the nurses recruited from the United Kingdom in the post-war years were reluctant to even attend classes because they planned to resign as soon as their two-year contracts expired.<sup>68</sup> For those nurses who

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<sup>61</sup> PSJ, 38, 8, 1946, p.357.

<sup>62</sup> PSJ, 38, 7, 1946, p.308.

<sup>63</sup> PSJ, 38, 9, 1946, p.406.

<sup>64</sup> Register of Psychiatric Nurses, 1945-1966, ABYO, 7889, W5148, 30, ANZ, Wellington.

<sup>65</sup> In the first five years, 378 attendants became registered psychiatric nurses based on their Senior Mental Nurse qualification: Register of Psychiatric Nurses, 1945-1966, ABYO, 7889, W5148, 30, ANZ, Wellington.

<sup>66</sup> In 1949, there were 484 (352 men and 132 women) New Zealand Registered Psychiatric Nurses (NZRPNs) employed in mental hospitals: New Zealand Public Service List, 1949.

<sup>67</sup> Russell to Secretary, N&M Board, 28 January 1949, H-MHD, series 1, 8/116/8, ANZ, Wellington.

<sup>68</sup> J.D. Hunter, Medical-Superintendent, Tokanui Hospital to Gray, 8 April 1947, H-MHD, 1, 8/116/8, ANZ, Wellington.

did achieve registration as psychiatric nurses, relatively few actually stayed in the mental hospital service. By 1949, although over 300 women had qualified as RPNs (through commuting their old qualifications or by examination), there were only 132 still employed in the Division of Mental Hygiene.<sup>69</sup>

### ***Making it happen: resources***

The Department was slow to provide the resources necessary to support the new curriculum. Demonstration equipment, library books and anatomical charts were all in woefully short-supply in post-war years. The Department compiled a list of anatomical training charts in 1945 but these were unobtainable, and were not reordered for another three years.<sup>70</sup> Requests from hospitals for items such as forceps, kidney trays, scalpels and suture needles revealed an extreme shortage of these basics.<sup>71</sup> Other than ordering a subscription for two nursing journals in 1946 and commissioning significant spending on a 16mm film projector for each hospital, little was achieved.<sup>72</sup> It took the Department three years to realise that it was common practice for nurses' training schools to have a range of textbooks available for students.<sup>73</sup> In 1948, a list of six basic texts was compiled and orders taken from each hospital.<sup>74</sup>

Gaining consensus over a new psychiatric nursing textbook proved more difficult than making decisions on other resources. The Publicity Committee failed to produce a handbook because of the procrastination of some of its members.<sup>75</sup> Dr Kenneth Stallworthy, a psychiatrist and member of the committee, completed his chapters quickly and became frustrated over the delays with the rest of the script. He eventually requested the return of his manuscripts and produced his own textbook.<sup>76</sup> First published in 1950, 'A Manual of Psychiatry', was initially dismissed by Lewis, the new

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<sup>69</sup> By 1949, 339 women had qualified as RPNs; Register of Psychiatric Nurses, 1945-1966, ABYO, 7889, W5148, 30, ANZ, Wellington. There were 132 RPNs employed in the Division of Mental Hygiene; New Zealand Public Service List, 1949.

<sup>70</sup> Russell to medical-superintendents, 23 July 1948. Also, list of ordered charts, 17 September 1948, H-MHD, 1, 8/94/8, part 2, ANZ, Wellington.

<sup>71</sup> Nursing Staff Training: Standard Equipment inventory and requirements, 11 July 1947, H-MHD, 1, 8/94/8, part 2, ANZ, Wellington.

<sup>72</sup> November 1946, order for subscription for *Nursing Mirror* and *Kai Tiaki* for each training school, H-MHD, 1, 8/94/8, part 2, ANZ, Wellington.

<sup>73</sup> 26 January 1948, H-MHD, 1, 8/94/8, part 2, ANZ, Wellington.

<sup>74</sup> 23 March 1948, H-MHD -1, 8/94/8, part. 2, ANZ, Wellington.

<sup>75</sup> Minutes of a committee convened to prepare a new handbook, 1944, H-MHD, 1, 8/94/6, ANZ, Wellington.

<sup>76</sup> Stallworthy to Russell, 21 May 1948, H-MHD, 1, 8/94/6, ANZ, Wellington.

Director of Mental Hygiene, as ‘not very good’.<sup>77</sup> When a new edition of the Handbook for Mental Nurses (‘the Red Book’) was delayed, however, Stallworthy’s manual became the standard psychiatric nursing text.<sup>78</sup> It ran to six editions, and was still in use in the late 1960s.<sup>79</sup> Stallworthy, who died suddenly in 1963, was respected by many psychiatric nurses for his innovation, teaching skills and support for nursing. Among other contributions to psychiatry, he published a general information book for the public in an attempt to counter ignorance and stigma concerning mental illness.<sup>80</sup>

### *Tutor sisters at the frontline*

Mental hospitals struggled to attract and retain sufficient teaching staff.<sup>81</sup> Tutor sisters were required to hold a registered (general) nursing qualification. They were therefore all women.<sup>82</sup> The Division preferred applicants to be registered psychiatric nurses but did accept single-trained general nurses as assistant tutors.<sup>83</sup> Any psychiatric nurses who completed general training were automatically expected to step into the role. McEwan, who had undertaken general training during World War Two in the hope of being accepted into the armed forces, was instead directed back to Ngawhatu Mental Hospital and simply told by the Medical Superintendent that she would be the tutor. Her first task was to organise male attendants to clear out hay bales from an old house on the hospital grounds so it could be used for classes. With no tutor training, she was glad of a supportive ‘proper matron’ (general trained), who gave her full reign to organise the training school. As the only double-trained nurse at the hospital, she was responsible for all the teaching, looking after sick nurses and dispensing medications for the whole hospital.<sup>84</sup> These tasks were usual for tutor sisters throughout the mental hospitals.

Tutor sisters were expected to organise classes to fit around nurses’ and attendants’ shifts, a situation that often necessitated repeating classes for small groups of nurses.<sup>85</sup>

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<sup>77</sup> Lewis to Director of Mental Health, Western Australia, 5 December 1950, H-MHD, 1, 8/94/8, part.2, ANZ, Wellington.

<sup>78</sup> 4 June 1952, Lewis to medical superintendents, H-MHD, 1, 8/94/8, part.2, ANZ, Wellington.

<sup>79</sup> Kenneth R. Stallworthy, *A Manual of Psychiatry*, 6th. edn, Christchurch, 1963 (first published 1950).

<sup>80</sup> Kenneth R. Stallworthy, *The Facts of Mental Health and Illness*, 1st edn, Christchurch, 1956.

<sup>81</sup> In 1950, for example, the Department was advertising for seven tutor sisters; KT, 63, 4, 1950, p.133.

<sup>82</sup> Training and registration was commenced for Male (general) Nurses in 1945 but this was shortened course of two years, and because of its status, and the poor career prospects, very few men took the opportunity to train.

<sup>83</sup> KT, 43, 4, 1950, p.133.

<sup>84</sup> Rita McEwan, interviewed by Judy Heffer, 30 September 1988, OHInt-0139/2, NERF-PNOHP, ATL, Wellington.

<sup>85</sup> *ibid.*

Staff members attended classes when they could be released from duty or in their own time. There was no 'block' system (a series of days or weeks in class) such as was in place in most general hospitals.<sup>86</sup> Hospitals usually appointed nursing applicants with meagre regard to educational ability, and commenced them at any time of year, with little orientation. McEwan recalled that when she started tutoring, new recruits were employed, brought to her to be put through the Rule Book, told to obey it, and then sent to the wards.<sup>87</sup> There was support among medical superintendents for the idea of starting a new class every few months, but with the critical shortage of nurses, hospitals were reluctant to ask applicants to wait for a set time to start classes.<sup>88</sup>

For most tutor-sisters, improved psychiatric nursing standards equated with the introduction of physical nursing skills and more individualised care. Irene Smith, for example, who returned to Seacliff Hospital in 1947 after completing her general training at Wellington Hospital, felt that she could do more as a general nurse to improve mental hospital conditions. She remembers that people were aware by this time of the necessity for more trained nurses to teach the 'fundamentals of nursing'.<sup>89</sup> McEwan, on the other hand, gradually became aware that psychiatric nursing may encompass a different kind of practice. It was not until several years after becoming a tutor sister, once she had moved to Auckland Mental Hospital, that she began to, 'realise what psychiatric nursing was all about'. By then she was exposed to a lot more books and articles on psychiatry and was influenced by some forward-thinking psychiatrists such as Stallworthy.<sup>90</sup> This experience, and her involvement with the NZRNA, inspired McEwan to apply for the Postgraduate Nursing Diploma. This one year course at the Postgraduate Nursing School in Wellington was the only formal ongoing education available to registered nurses. The Division supported McEwan to attend in 1952. Later, describing the experience as 'exciting' and 'wonderful', McEwan reflected that it had opened up a 'whole new world' of nursing literature and exposed her to the discipline of

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<sup>86</sup> Nursing Division Report, 20 October 1950, H-1, 32287 (1/3/3), ANZ, Wellington.

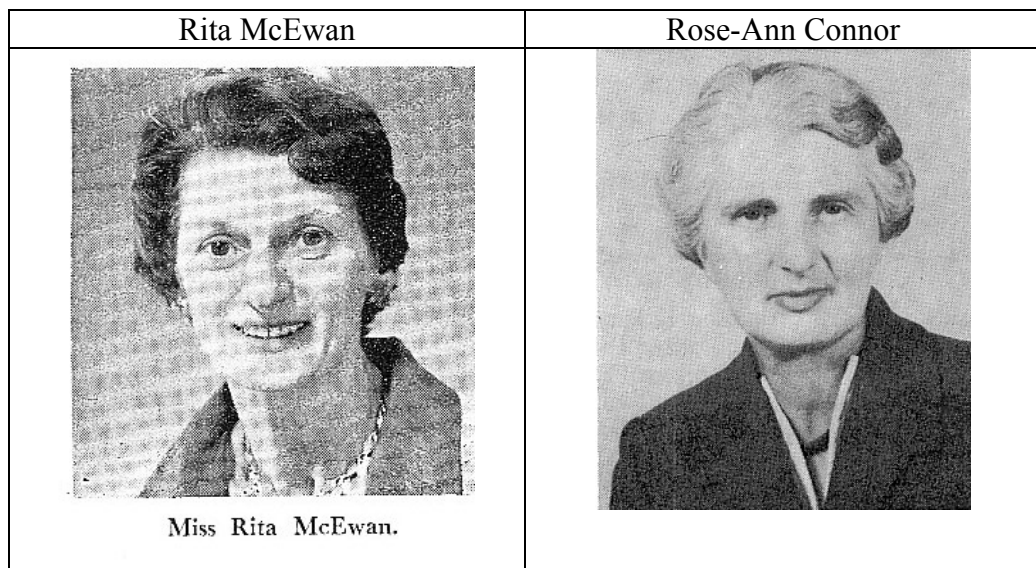
<sup>87</sup> Rita McEwan interviewed by Judy Heffer, 30 September 1988, OHInt-0139/2, NERF-PNOHP, ATL, Wellington.

<sup>88</sup> M.E.A. Neads, Matron, Sunnyside Hospital to Russell (through medical superintendent), 18 February 1949, H-MHD, series 1, 8/116/8, ANZ, Wellington.

<sup>89</sup> Irene Smith interviewed by W. M. Lyon, 8 March 1983, OHInt-0014/185, NERF-OHP.

<sup>90</sup> Rita McEwan interviewed by Judy Heffer, 30 September 1988, OHInt-0139/2, NERF-PNOHP, ATL, Wellington.

psychology.<sup>91</sup> Rose Connor was the only other psychiatric nurse to attend the Postgraduate Nursing School before the 1960s.



**Figure 19 Rita McEwan and Rose-Ann Connor.**  
 Source: KT, 61, 2, 1968, p.25; KT, 56, 2, 1963, p.28.

McEwan's experience was unusual amongst the psychiatric tutor sisters. She held national positions with the NZRNA throughout most of the 1950s and had at least one term on the N&MB representing psychiatric nursing. In these roles she was exposed to nursing politics and educational thinking and was one of few psychiatric nurses to be actively involved in curriculum development and setting and marking state examinations.<sup>92</sup> Most tutor sisters were ill-prepared for their roles and isolated professionally. They generally worked in sole appointments and depended on the support of their matrons and medical staff. They also relied on the cooperation of head and charge attendants for access to the male sides of hospitals. The level of support and was variable and depended on the particular hospital and the relationships that had developed over time.

### **Tensions between the nursing profession and the Division of Mental Hygiene**

State registration brought mental nurses and attendants into the authoritative domain of general nursing. Within a few years, tensions began to surface between the Division of Mental Hygiene and the Division of Nursing. Lambie initially withheld criticism of mental hospital schools but this changed in early 1948. Concerned about the large

<sup>91</sup> *ibid.*

<sup>92</sup> Connor was also involved in the NZRNA for much of this time.

number of failures in nursing subjects in the State Preliminary Examination for Psychiatric Nurses, Lambie inspected all the mental hospitals except Ravelthorpe. Her report cited significant difficulties because of shortages of staff, lack of basic resources such as sanitary facilities, insufficient discipline of junior nurses and inadequate health and safety protection for nurses. Most mental hospitals had no ward telephone system for a nurse to call for help and at Sunnyside the nurses had to use a whistle. There was no one responsible for ensuring that nurses had Mantoux tests for tuberculosis and annual medical examinations and x-rays.<sup>93</sup>

Lambie made her concerns known to Thomas Ritchie, the Director-General of Health. She claimed that she had told Russell earlier in the year of the tutor sisters' concerns about the 'serious difficulty being met in attempting to teach proper technique with the appliances and amenities at their disposal'. Russell, who at the time was the Acting Director of the Division of Mental Hygiene, was not happy with Lambie's interference. 'Had I not told Miss Lambie long before this?' he scribbled in the margin of the memo.<sup>94</sup>

Lambie recommended that the Division of Mental Hygiene employ a registered nurse in the head office to provide a nurse's and woman's view on training and hospital conditions. Russell was privately very opposed to the idea. 'Never!' he added in the margin.<sup>95</sup> Publicly, however, Russell stated his intention to appoint such a person once sufficient equipment had been supplied for the wards.<sup>96</sup> Russell claimed that the responsibility for equipment lay with the Health Department who had promised supplies from war assets. He told the medical superintendents that, so long as they carried out his recommendations there was no need to worry about 'outside inspectors'.<sup>97</sup> His Deputy, Gilbert Tohill, assured the Director-General that a great deal of teaching equipment had been purchased and that the problems lay in the delays in the building programme, the overcrowding, and unsuitable buildings for sick and elderly.<sup>98</sup>

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<sup>93</sup> Mary Lambie, Report on Nursing Staff – Mental Hospitals, 25 August 1948, H-1, 33430, 1/11/77, ANZ, Wellington.

<sup>94</sup> 24 August 1948, T.R. Ritchie to Russell, Acting Director of Division of Mental Hygiene, H-MHD, 1, 8/94/0, Vol. 2, ANZ, Wellington.

<sup>95</sup> Ritchie to Russell, 24 August 1948, H-MHD, 1, 8/94/0, Vol. 2, ANZ, Wellington.

<sup>96</sup> No such appointment was made during the 1950s.

<sup>97</sup> Russell to B. D. Hart, Porirua Hospital, 8 November 1948 and to all Medical Superintendents, 24 November 1948, H-MHD, 1, 8/94/0, Vol. 2, ANZ, Wellington.

<sup>98</sup> Tohill to Director-General of Health, 7 September 1948, H-MHD, 1, 8/94/0, Vol. 2, ANZ, Wellington.

Another area of contention between nursing and mental hospital leaders concerned general nurses undertaking psychiatric training. With the greater emphasis on physical nursing in the psychiatric curriculum, it was assumed by the N&MB that general nurses could easily transfer their skills. The regulations were altered in 1949 to allow registered (general) nurses to complete their psychiatric training in one year.<sup>99</sup> Mental hospital staff questioned the wisdom of this regulation. Lewis, the Director of Mental Hygiene from 1950, thought it was 'quite wrong'. He did not doubt the nurses' ability to pass the exams, but argued that a nurse should have at least 'two years experience of psychiatric nursing, before she would be able to consider herself to be a psychiatric nurse'.<sup>100</sup> At a local level, mental hospital nurses and attendants were wary of any situation in which general nurses assumed mental nursing expertise without proving themselves. At Seaview Hospital, the PSA sub-group objected when a registered (general) nurse applied to sit the state final examination without first passing the two institutional examinations.<sup>101</sup>

Mental hospital matrons and tutor sisters were caught between the expectations of the nursing profession and the cultural mores of the hospitals in which they worked. Although generally respected and at times revered within their hospitals, their sphere of influence was bounded by the professional and gendered structure of the hospitals' hierarchy. Ultimate power lay with Director of Mental Hygiene who delegated authority to the medical superintendents. Head attendants controlled the male wards and male staff. While matrons held considerable authority over the female sides, the matrons and tutor sisters' ability to influence practice on the men's sides depended on the support of the medical superintendents and the goodwill of the head and charge attendants.

The Division supported matrons' and tutor sisters' engagement with professional nursing activities, but within certain constraints. Many of them belonged to the NZRNA and some were active in the local or national committees. Difficulties were, however, sometimes experienced at a local level. McEwan, for example, came into conflict with her matron and medical superintendent when she asked for permission to attend local NZRNA committee meetings. Her request was denied on the grounds that she was

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<sup>99</sup> KT, 43, 6, 1950, p.176.

<sup>100</sup> Ronald Lewis to Medical-Superintendent, Sunnyside Hospital, 17 January 1951, H-MHD, 1, 8/94/0, vol. 2, ANZ, Wellington.

<sup>101</sup> 5 August 1949 L. Constantine, to medical superintendent, Seaview Hospital, CAHW, CH890/17k, ANZ, Christchurch.



already too busy and that other meetings, such as union committees, were not permitted in work time. McEwan appealed directly to Russell, who overrode the decision.<sup>102</sup>

During the 1950s, several matrons were granted permission and funding to attend the matrons' conference held annually prior to the NZRNA conference.<sup>103</sup> Lewis insisted that communication about such events passed through his office. His rationale was that leave had to be arranged by the Public Service Commission. One has to wonder, however, if it was more an attempt to retain control over the flow of information through the mental hospital system.<sup>104</sup> Even when responding to a call for agenda items, matrons had to pass their comments through their medical superintendents and Lewis before reaching Flora Cameron, the Director of Nursing.<sup>105</sup> Despite several polite requests, Cameron was denied the opportunity to communicate directly with mental hospital matrons.<sup>106</sup>

### **Professional organisation**

Mental hospital nurses were not generally involved with the activities of the NZRNA or its affiliated organisation, the Student Nurses Association (SNA), neither of which admitted men. These organisations' female, middle-class ideals did not fit well with the male-dominated, working-class culture of mental hospitals. The NZRNA's Mental Hygiene Committee, whose membership included several matrons and tutor sisters, had mixed success in bringing mental hospital nurses' issues to the attention of the association. They achieved membership rights for female psychiatric nurses in 1946, but failed to convince the Association of the need to recognise the men, despite warning of the possibility that male psychiatric nurses may form their own organisation, or worse, resort to unionism.<sup>107</sup> NZRNA leaders and many members tended to view unionism as being antithetical to professionalisation for nurses.<sup>108</sup> In 1947, the Mental Hygiene Committee gained representation for psychiatric nurses on the Education Committee,

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<sup>102</sup> 17 – 24 May 1949, H-MHD, 30, 34932, 30/7/3, ANZ, Wellington.

<sup>103</sup> In 1953, only Matron Little from Sunnyside Hospital attended but in 1955 ten psychiatric hospital matrons attended: KT, 48, 3, 1955, p.97.

<sup>104</sup> Lewis was known for his attention to detail and ability to remember names and information about staff at each hospital.

<sup>105</sup> 3 March – 12 April 1955, correspondence between Flora Cameron, Ronald Lewis and medical superintendents, H-MHD, 30, 34932, 30/7/3, ANZ, Wellington.

<sup>106</sup> 6 March 1954, 3 March 1955, 6 May 1956, H-MHD, 30, 34932, 30/7/3, ANZ, Wellington.

<sup>107</sup> KT, 38, 3, 1945, p.61.

<sup>108</sup> KT, 34, 1, 1941, p.39.

but by the 1950s, it appeared to have lost any edge it may have possessed in advocating for psychiatric nurses.<sup>109</sup> In 1955 its work was incorporated into the Nursing Services Committee.<sup>110</sup>

There were pockets of interest among female psychiatric nurses in joining the professional organisations. Sunnyside Hospital nurses were more active than any other group. Two Sunnyside students attended the SNA conference every year from 1947.<sup>111</sup> Velda Kelly was a member during her student years and became president of the local hospital SNA branch. She recalls the somewhat condescending attitude of the Christchurch Hospital matron to the Sunnyside student nurses' presence and the generally elitist feeling about the NZRNA. It seemed to her at that time, that the organisation was mostly for matrons and senior nurses.<sup>112</sup>

The NZRNA did make attempts to include psychiatric nurses in its activities. In 1951, it established an annual essay competition for pupil psychiatric nurses and designed a trophy for the winner in 1955. A new topic was set each year. Nurses were invited to discuss such issues as 'the role of occupational therapist', 'nursing care for a child' and 'treating the patient as an individual'.<sup>113</sup> There were few entries, though a prize was awarded in most years.<sup>114</sup> The task set for the competition in 1959 perhaps best reflects the ideological gap between the NZRNA's and SNA's professional goals and the trainee psychiatric nurses' daily reality. Pupil nurses were asked to, 'prepare a brochure that could be used to interest men and women in taking up psychiatric nursing as a career'.<sup>115</sup> For the unionised mental hospital nurses, who daily experienced the effects of severe staffing shortages, the marketing role may not have seemed appealing. There were no essay competition entries that year.<sup>116</sup>

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<sup>109</sup> KT, 40, 3, 1947, p.62.

<sup>110</sup> KT, 43, 2, 1950, p.35 and NZNJ, 48, 3, June, 1955, p.87. Rita McEwan became the psychiatric nursing representative on the Nursing Services Committee.

<sup>111</sup> No other hospital applied for leave for nurses to attend the conference: H-MHD, 30, 34932, 30/7/3, ANZ, Wellington. There is evidence however that student nurses from Avondale (Auckland) Mental Hospital attended the SNA conference when it was held in Auckland in 1951: KT, 44, 5, 1951, p.135.

<sup>112</sup> Velda Kelly interview 26 August, 2004.

<sup>113</sup> KT, 45, 1, 1952, pp.18-9; KT, 47, 1, 1954, p.5; KT, 50, 1, 1957, p.4.

<sup>114</sup> The prize in 1952 went to Gwendoline E. Cook, Sunnyside Hospital; in 1953 to (Mr) E.L. Theeman, Porirua Hospital, and in 1954, to Rouina T. K. Maniapoto of Tokanui Hospital: KT, 46, 6, 1953, p.166 and KT, 47, 6, 1954, p.215.

<sup>115</sup> KT, 52, 1, 1959, p.4.

<sup>116</sup> KT, 52, 6, 1959, p.213.

## 1950s: Struggling to raise standards

The 1950s were a frustrating period for those working to improve the standards of nursing education in New Zealand. There was talk of reducing pupil nurses' workload, particularly of 'non-nursing' or domestic duties, protecting classroom hours from the intrusion of work, and introducing a higher educational requirement for entrance to nursing.<sup>117</sup> Ultimately, nurse leaders hoped that student status could be achieved for at least part of the nurses' training and that university education could be introduced for the more promising students. They particularly looked to Canadian systems for inspiration.<sup>118</sup> It was, however, extremely difficult to be innovative when nursing shortages were so serious. These affected nurse education in various ways: educational pre-requisites were difficult to enforce, classroom time became eroded by the hospitals' demands for labour, and teaching standards were hard to maintain.<sup>119</sup> There was also a shortage of tutor sisters and recognition that they were badly prepared and under-resourced for the role.<sup>120</sup>

All these problems were worse in the mental hospitals than in general hospitals. While, for example, most general hospitals were able to provide some preliminary classroom time for new recruits, this remained unattainable in most psychiatric hospitals. Pupil nurses and attendants usually attended class for a few hours once a week, but if the wards were short-staffed, even that time could be denied. One Porirua nurse recalled that although they were unable to attend all classes, they still had to sit the exam; the result was predictable, 'Out of a field of nineteen I think I was the only one who passed [the first time] without failing'.<sup>121</sup>

While the Nursing Division reported a steady improvement in the standard of general hospital recruits during the 1950s, the same could not be said of the mental hospital applicants. Hospitals were inclined to employ applicants with little regard for educational credentials. One problem peculiar to the mental hospitals was the

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<sup>117</sup> KT, 45, 3, 1952, pp.94 & 100; KT, 47, 6, 1954, p.216; KT, 52, 3, 1959, pp.74-5.

<sup>118</sup> KT, 48, 4, 1955, pp.155-7

<sup>119</sup> In 1953, for example, student nurses called for one day per week to be set aside for classes: KT, 46, 3, 15, 1953, p.83.

<sup>120</sup> A 1955 study of tutors' workloads discovered that a high proportion withdrew from tutoring after a very short time. More than half the respondents undertook more than five hours' unpaid overtime per week. The study concluded that there was a need for more supervision and guidance of new teachers: KT, 48, 5, 1955, pp.185-7.

<sup>121</sup> Williams, p.209.

promotions policy based on the old institutional examinations. In the absence of incentives to pass state examinations, many staff, particularly on the men's sides, did not bother. The physical-care (anatomy and physiology and general nursing skills) focus in the State Preliminary Examination was an added deterrent for psychiatric nurses (see Appendix K). Although Departmental administrators were aware of the problems, they were unwilling to insist on a promotion system based on the state examinations, because it might have caused recruitment problems, particularly with attendants.<sup>122</sup>

The quality of nurse training at the hospital level depended largely on the skills and enthusiasm of the individuals involved. Psychiatrists such as Stallworthy and H.M. Buchanan, and tutors such as Rita McEwan and Maggie Knight, are remembered as innovative and effective teachers. Some psychiatric nurses who trained in the 1950s recalled their training as providing them with a solid understanding of psychiatry and of medical conditions.<sup>123</sup> Others remember the extra support and tuition provided for promising students.<sup>124</sup> Many nurses, however, recall the deficiencies of the system and the inadequacies of individual teachers. One tutor sister was remembered for setting books for students to read rather than giving lectures. Another discovered the tape recorder during the 1950s. She pre-recorded her lessons then played them back to the students.<sup>125</sup>

The most serious gap in training was in the area of practical nursing. Nurses often had to teach themselves new skills or seek out advice from whoever was around. Adrian Moerenhout was on night duty when he gave his first injection,

I had never given an injection before or been taught how to or told anything like it. So I rang the guy in charge; "Look, Johnny, I've got to give an injection and I don't know how to do it". He told me over the phone how to do it. I still remember to this day, this man had leathery skin and those flipping needles you had at the time – half of them had burrs on them. I tried the first time and it bounced!<sup>126</sup>

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<sup>122</sup> Lewis to medical superintendents, 10 January 1955, DAHI, Acc D266 357e, file 6/26/4, ANZ, Dunedin.

<sup>123</sup> Russell Flahive interview 1 June 2004.

<sup>124</sup> Barbara Milne who started training at Avondale Hospital in 1960, recalls being was 'taken under wing' by one of the matrons and became one of her protégées: Barbara Milne interview 7 September 2005.

<sup>125</sup> Audrey (pseudonym) interview 22 January 2004.

<sup>126</sup> Adrian Moerenhout interview 11 April 2004.

Joy Collins has similar experiences, ‘There was not much teaching on the physical [skills]. We had to teach ourselves - giving insulin, catheterisation – we learned on patients’.<sup>127</sup>

One challenge psychiatric nurses faced when sitting the State Preliminary Examination was the examiners’ assumption of ideal general hospital conditions. The nurses had to learn about such things as testing urine with chemicals and setting up trays for injections, even though these things did not happen in their hospitals. Urine sticks were used in the mental hospitals and injection techniques were adapted for the more volatile, crowded environment. Bazley recalled, ‘We used to get a syringe with a swab on the end of the needle, and that was it.’<sup>128</sup> She also remembered that the only way she was able to prepare for the Preliminary Examination was by getting the manuals from the local general hospital to learn the theory of basic practical nursing. She reflected, ‘I’ve never swotted for anything in my life as I did for that exam.’<sup>129</sup>

There were occasional efforts to up-skill the tutor sisters and ward charges, and to include psychiatric nurses in professional nursing events. In 1952, some psychiatric nurses attended a nurses’ study week sponsored by the Nursing Division and the NZRNA. The aim of the week was to review the, ‘Place of the Nurse in the Health Services of a Country’.<sup>130</sup> In 1952, the Department of Health approved funding for a refresher course for mental hospital nurses. The week-long course was held at the Postgraduate Nursing School in Wellington. Hospitals were each invited to send two charge attendants and two charge nurses. Topics included psychiatric nursing care, staff education and professional issues, such as information about the relationship of the NZRNA and N&MB to psychiatric nursing.<sup>131</sup> In 1955 the Division of Nursing invited mental hospitals to nominate one psychiatric nurse to join other nurses on a refresher course on ward supervision.<sup>132</sup>

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<sup>127</sup> Joy Collins interview 27 January 2004.

<sup>128</sup> Margaret Bazley interview 29 January 2004

<sup>129</sup> *ibid.*

<sup>130</sup> AJHR, 1952, H-31, p.40; KT, 45, 3, 1952, p.94.

<sup>131</sup> Lewis to medical superintendents, 6 October 1952, DAHI, Acc D266 357e, file 6/26/4, ANZ, Dunedin.

<sup>132</sup> Lewis to medical superintendents, 8 July 1955, DAHI, Acc D266 357e, file 6/26/4, ANZ, Dunedin.

## A new curriculum

By the mid-1950s, there were calls for a review of all nursing curricula. Problems with recruitment and retention were attributed to certain aspects of the current programmes. Specifically, the focus in the first year on anatomy and physiology rather than subjects reflecting students' ward experience, was seen as a deterrent for new nurses. The age requirement for sitting Final Qualifying (state) examinations was also considered problematic. Well-qualified high school leavers were being lost to nursing because they could not move straight from school into nursing programmes.

Much of the work on reviewing the curricula was undertaken by the NZRNA. The National Florence Nightingale Committee (education) gave specific attention to the psychiatric syllabus.<sup>133</sup> The committee's goal was to bring the psychiatric curriculum into line with 'present day thought' and to standardise the training concessions between the psychiatric and other nursing programmes.<sup>134</sup> An address by Dr. Harold Turbott, the Deputy-Director of Health indicates that the NZRNA was beginning to grapple with the need to prepare psychiatric nurses for a specialised role. Turbott called for mental nurses to be trained in the basic skills of nursing, but not necessarily 'to the pattern of general nursing'.<sup>135</sup> He suggested that the central task of a psychiatric nurse is to supervise the 'community life' of the ward and that this would involve, 'teaching patients to be socially and morally conscious, to understand the responsibility and consequences of their actions and regain a purpose in life'.<sup>136</sup>

In October 1957, an amendment to the *Nurses and Midwives Act* made way for the introduction of new curricula for general, psychiatric, and male nurses and nursing aids.<sup>137</sup> Among other things, the legislation reduced the concessions for registered (general and male) nurses undertaking psychiatric training to one year. This was now equivalent to the requirement for psychiatric nurses transferring to general or male nursing.<sup>138</sup> There was also an attempt to bring the psychiatric training into closer alignment with the general curricula. Anatomy and physiology were to be deleted from the Preliminary Examination so that more general aspects of nursing could be covered

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<sup>133</sup> Rose Connor, Matron of Porirua, was the psychiatric nursing representative.

<sup>134</sup> KT, 50, 3, 1957, p.92.

<sup>135</sup> KT, 50, 3, June, 1957, p. 110.

<sup>136</sup> *ibid.*

<sup>137</sup> KT, 50, 6, 1957, pp.226-7.

<sup>138</sup> Registered male nurses also gained a one year concession in psychiatric nursing training.

in the first year. There would be a greater focus on public health, social sciences and nursing sciences and arts. The psychiatric nursing curriculum was also to include subjects such as psychiatry, functional nervous disorders, psychiatric nursing and care of the mentally deficient child.<sup>139</sup> Perhaps the most significant change, however, was the proposed increase in lecture hours. The new syllabus was to be based on an eight-week preliminary school followed by 85 four hour study days interspersed throughout the three year programme.<sup>140</sup>

The Division of Mental Hygiene cautiously welcomed the new syllabus. Lewis conceded that there would be difficulties, but hoped it could eventually be fully implemented in all hospitals.<sup>141</sup> Most medical superintendents viewed the proposed curriculum as a huge improvement but questioned the practicality of its implementation.<sup>142</sup> They were concerned about staffing levels and the continuing need for male staff to provide manual labour. Some questioned how it would be possible to implement a preliminary school 'block' system because of the constant trickle of applicants, shortage of tutor sisters and restraints of the roster system. Others worried about the effect on recruitment, especially on the men, because of loss of opportunities for overtime during training weeks and having to make job applicants wait for the next training block. One superintendent suggested that for the new curriculum to succeed, staff would need to be divided into trained and assistant nurses, particularly on the male side.<sup>143</sup>

It soon became apparent that changes would need to be gradual.<sup>144</sup> The challenge of providing an eight-week block seemed too difficult for most hospitals, and the requirement was debated throughout 1958. As a compromise, Lewis suggested that hospitals try four intakes each year, with four week preliminary schools.<sup>145</sup> This was, however, considered too labour intensive for tutor sisters and medical staff. A variety of

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<sup>139</sup> Dr Lewis, the Director of Mental Hygiene, circulated a proposed revised curriculum to the medical superintendents: 10 October 1957, H-MHD, 1, 8/94/0, Vol.2. , ANZ, Wellington.

<sup>140</sup> *ibid.*

<sup>141</sup> *ibid.*

<sup>142</sup> G. Blake-Palmer, Medical Superintendent, Seacliff Hospital to Director of Mental Hygiene, 16 October 1957, H-MHD, 1, 8/94/0, Vol.2, ANZ, Wellington.

<sup>143</sup> Mental hospital superintendents responses to the Director of Mental Hygiene, between 16 October 1957 and 13 February 1958, H-MHD, 1, 8/94/0, Vol.2, ANZ, Wellington.

<sup>144</sup> Dr. Stan Mirams to medical superintendents, 10 December 1957, H-MHD, 1, 8/94/0, Vol.2, ANZ, Wellington.

<sup>145</sup> Lewis circular entitled 'Male Nursing Staff: Recruitment', circa July 1958, H-MHD, 1, 8/94/0, Vol.2, ANZ, Wellington.

other proposals were suggested, including one from Auckland Mental Hospital that staff could be rostered onto alternating short and long days from Monday to Friday and undertake ward work before and after class during study block. The rationale was that the pupil nurses would be able to claim overtime rates during their study weeks.<sup>146</sup>

The Auckland proposal tested the patience of the Division of Nursing officers. Audrey Orbell, the Deputy Director of Nursing, reminded Lewis that the eight week curriculum had been planned with the view to increasing the chances of psychiatric nurses succeeding. She objected strongly to the suggestion that the new curriculum could be used as a means of facilitating overtime for staff and warned Lewis that ‘If the psychiatric nurses are to continue to be given a concession if they take up their general training, they must come up to the required First Professional Standard for male and female nurses, whichever the case may be’.<sup>147</sup>

Sunnyside Hospital was the first to pilot the new curriculum. In May 1958, they started an eight week long preliminary school during which the nurses worked six, seven hour days. On Saturdays, they worked without a tutor sister so that the Division did not need to pay her overtime rates. The pilot had some teething problems; male pupils, for example challenged the requirement to work on Saturdays. Matron Little advocated shortening the week to 40 hours but was adamant that some Saturday work should be retained, because ‘nursing is not a Monday to Friday service and it is important that student nurses should appreciate this early’.<sup>148</sup> Despite the hiccoughs, the matron and medical superintendent were positive about the general outcomes. They argued that eight weeks were necessary to cover the curriculum.<sup>149</sup>

### *New curriculum: a solution for the men?*

Underlying much of the debate about the new curriculum was the perennial question of what to do with the attendants. Some were unable or unwilling to sit the state examinations. At one hospital, attendants agitated for their right to indefinite opportunities to sit the Institutional Final Examination and to continue attending classes

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<sup>146</sup> Responses from medical superintendents to Lewis in response to his memo, ‘Male Nursing Staff: Recruitment’, 29 July 1958 to 1 October, 1958, H-MHD, 1, 8/94/0, Vol.2, ANZ, Wellington.

<sup>147</sup> Audrey Orbell to Lewis, 12 November 1958, H-MHD, 1, 8/94/0, Vol.2, ANZ, Wellington.

<sup>148</sup> Hunter, Sunnyside, 30 July 1958 & Matron Little, Sunnyside 1 October 1958, to Director, Mental Hygiene, H-MHD, 1, 8/94/0, Vol.2, ANZ, Wellington.

<sup>149</sup> Matron M.E. Little, Sunnyside, memo to medical superintendent, 6 October 1958, H-MHD, 1, 8/94/0, Vol.2, ANZ, Wellington



if they failed.<sup>150</sup> One medical superintendent suggested that hospitals should develop a differentiated workforce in which male workers would not all be required to complete a full nursing training.<sup>151</sup> Lewis, however, resisted the pressure to institute assistant attendants and instead instructed the hospitals to endeavour to recruit people who had the academic ability.<sup>152</sup>

Lewis decided it was time to tighten the promotions policy. A decision was made that all nurses and attendants appointed after 1 May 1957 would be required to pass the State Final Examination if they wished to be promoted beyond the junior grade.<sup>153</sup> Lewis, however, was keen to treat the existing employees fairly. He agreed that those who had already passed the Institutional Examination would be considered, for promotion purposes, as if they had passed the State Final Examination. He approached the N&MB with a proposal to allow these nurses and attendants to be admitted to the Register of Psychiatric Nurses. Admission would be available for those who had passed the Institutional Final Examination before 1 May 1957. It would also be available for those currently in training, who passed the Institutional Final Examination (re-named the Hospital Final Examination for Psychiatric Nurses) before 1 June 1960.<sup>154</sup> The Board approved the recommendations and the necessary amendments were made to the Nurses and Midwives Act.<sup>155</sup>

The Division's stand on the promotion's policy indicated its resolve to finally view its male workers as nurses. As Dr B. D. Hart, the Medical Superintendent of Porirua explained, 'We should not – cannot – on the one hand have this new policy and its emphasis on nursing training and at the same time maintain the old policy of trying to do all our outdoor work.'<sup>156</sup> Up to this point, it had been acceptable for the attendants to be less academically able than the nurses. They had been appointed whenever they applied (with little question of educational ability), promoted on the basis of passing (or not passing) the institutional exams and had been used largely to carry out, and

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<sup>150</sup> 9 July 1958, John U. Williams, Medical Superintendent to Lewis, H-MHD, 1, 8/94/0, Vol.2, ANZ, Wellington.

<sup>151</sup> B.D. Hart, Medical Superintendent, Porirua Hospital to Lewis, 13 February 1958, H-MHD, 1, 8/94/0, Vol.2, ANZ, Wellington.

<sup>152</sup> Lewis circular, 'Male Nursing Staff: recruitment', circa July 1958, H-MHD, 1, 8/94/0, Vol.2, ANZ, Wellington.

<sup>153</sup> Lewis to N&MB, 22 July 1958, H-MHD, 1, 8/94/0, Vol.2, ANZ, Wellington.

<sup>154</sup> Lewis to N&MB, proposed amendments to the Nurses and Midwives Act 1945, 22 August 1958, H-MHD, 1, 8/94/0, Vol.2, ANZ, Wellington.

<sup>155</sup> Lewis to N&MB, 28 July 1958, H-MHD, 1, 8/94/0, Vol.2, ANZ, Wellington.

<sup>156</sup> Williams, p.223.

supervise, manual work. Although, from 1960, male and female psychiatric nurses were required to achieve the same educational standard for registration, circumstances related to employment longevity on the male side meant that the men who had registered under the old regulations held positions of authority and influence for many years. This created an imbalance in nursing skills, knowledge and attitudes, that affected relationships between the two sides and became most apparent when the male and female wards were being integrated in the early 1970s.

### **Union challenge to nursing profession's influence**

Changes to the psychiatric nursing curriculum and regulations prompted a reaction from the PSA. The Mental Health Group (MHG) had been relatively quiet during the 1950s, and had relied heavily on Jack Lewin to carry their concerns at a national level. Lewin, who was disgruntled with the union's lack of socialist backbone, suggested that the Group's activity was a 'pale shadow' of its national profile in the late 1940s when they had been, 'the envy of most other sections of workers in the Public Service Association'.<sup>157</sup> Lewin's challenge and his threat to resign as the MHG's representative on the PSA Executive appear to have galvanized the members into action. A decision was made in mid-1957 to restructure the group by establishing a central committee.<sup>158</sup> At about the same time, the MHG became aware of the content of the Nurses and Midwives Amendment Bill. One of the proposed changes was to lower the registration age for both general and psychiatric nurses to 20 years. The MHG objected strongly; 'Girls or men', they argued were not sufficiently tolerant at 17 (proposed minimum age for starting training) to, 'supply human relationship that builds confidence'.

The PSA took the issue of registration age to the Attorney-General and made a detailed submission on the Bill to the Public Health Committee of the House of Representatives.<sup>159</sup> They claimed that the qualities required for psychiatric nursing such as tolerance, sympathy, and authority were more likely to be found in mature adults. Young people, they argued, could be harmed by their experience in mental hospitals and sometimes 'find it difficult to withstand the immoral and perverse practices of some

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<sup>157</sup> 1956, J.P. Lewin speech, reported in minutes of Mental Health Group Committee, PSA, 1956-8, 82-046-031/5, ATL, Wellington.

<sup>158</sup> Prior to this, the MHG had been structured into two groups, North Island and South Island, 12 July 1957, Minutes of Mental Health Group Committee, PSA, 1956-8, 82-046-031/5, ATL, Wellington.

<sup>159</sup> 26 July 1957, Jack Turnbull circular, Minutes of Mental Health Group Committee, PSA, 1956-8, 82-046-031/5, ATL, Wellington.

types of mental patients, [and] that they may be revolted by many of the things they have to see and the duties they have to perform...'<sup>160</sup> The union suggested that retention was a much bigger problem than recruitment and that if the Division had responded to their calls for improvements in working conditions for trainees, then there would not be such a high drop-out at early stages of training.<sup>161</sup>

Before hearing from the PSA's four witnesses to the Public Health Committee, the Minister of Health, J. Hanan, agreed to delete the proposed amendments as far as they related to psychiatric hospitals.<sup>162</sup> Furthermore, he increased the minimum age that nurses could sit the Psychiatric State Final Examination from 20 years to 21 years. It is unclear why Hanan acquiesced so quickly when the Director of Nursing and the NZRNA were strongly in favour of lowering the age. He may, however, have been influenced by Lewis, who believed that men should never be appointed younger than 19 years, and only in exceptional circumstances, should a 17 year old woman be appointed. A young woman, he believed, would need to possess 'the maturity and necessary physique' to undertake training.<sup>163</sup>

If the PSA's actions over the registration age puzzled national nursing leaders, their next move was clearly a challenge their authority. In October 1957, Jack Turnbull, the General Secretary of the PSA, appealed to the Hanan over the psychiatric nursing position on the Nurses and Midwives Board.<sup>164</sup> Turnbull questioned the NZRNA's mandate for nominating a psychiatric nurse. He argued that the Association had few psychiatric nurse members and excluded men. In contrast, the PSA represented a large number of male and female psychiatric nurses. Turnbull requested that the Minister act on a nomination from their organisation.<sup>165</sup>

Hanan took his advice on the issue from Flora Cameron, the Director of Nursing. She was absolutely opposed to the PSA having any say on the N&MB appointment. She pointed out that the NZRNA had been accepted as the most able body to nominate all types of nurses since the *Nurses and Midwives Act* of 1925. She also suggested that

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<sup>160</sup> Attached to letter from Dan Long to Director of Mental Hygiene, 29 May 1961, H-1, 31000, 30/7/6, ANZ, Wellington.

<sup>161</sup> 13 August 1957, submission attached to letter from Dan Long to Director of Mental Hygiene, 29 May 1961, H-1, 31000, 30/7/6, ANZ, Wellington.

<sup>162</sup> 29 May 1961, Dan Long to Director of Mental Hygiene, H-1, 31000, 30/7/6, ANZ, Wellington.

<sup>163</sup> 30 July 1957, Lewis to medical superintendents, DAHI, Acc D266, 357j, file 6/26/6, ANZ, Dunedin.

<sup>164</sup> Matron M. Little who had been nominated by the NZRNA, had recently commenced a three year term.

<sup>165</sup> 1 October 1957, Turnbull to Hanan, H-1, 33374, 2/1/2, ANZ, Wellington.

there was quite sufficient representation of psychiatric nursing already. The Director of Mental Hygiene was a member of the Board and he could speak, 'with authority on all matters relevant to training and registration of both male and female psychiatric nurses'.<sup>166</sup>

The PSA's challenge created a conflict with the NZRNA that would last for many years. The union refused to let the issue go. They tried to discuss the problem with the NZRNA, but when that failed, took a delegation to the new Minister of Health, H. G. R. Mason. They complained about the NZRNA's gendered assumption that their members were, 'responsible women who knew best who should represent psychiatric nurses'.<sup>167</sup> The union then took the issue to the Prime Minister, Walter Nash, who suggested that they negotiate directly with the NZRNA.<sup>168</sup>

Despite receiving some sympathy from Mason and Nash, the PSA was unable to counteract the resistance and co-ordinated lobbying by officers of the NZRNA and the Division of Nursing. Margaret Pickard, the Secretary of the NZRNA refused to compromise. She provided Nash with information about her organisation and sought support from the psychiatric hospital matrons. When the next round of nominations was about to begin, she asked the matrons if they would be, 'good enough to explain to the registered members of your staff (i.e. on the female side) the machinery [of the nomination process]...'<sup>169</sup> She added that of course, the nurses would need to be members of the NZRNA.

Flora Cameron proved to be a strong ally for the NZRNA. She kept them informed about the PSA's discussions with the Prime Minister and advocated for them with Mason.<sup>170</sup> Cameron reminded the Minister that the NZRNA had always been recognised as the organisation, 'most fitted to speak for all categories of nurses as nursing education and professional status is concerned'.<sup>171</sup> She also raised doubts about the PSA's competence to speak on professional questions as evidenced by their actions over the registration age issue. Finally, Cameron warned Mason that NZRNA's approximate

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<sup>166</sup> 8 October 1957, draft letter for Minister of Health, H-1, 33374, 2/1/2, ANZ, Wellington.

<sup>167</sup> 2 June 1958, PSA deputation to Minister of Health, H-1, 33374, 2/1/2, ANZ, Wellington.

<sup>168</sup> 11 May 1959, Turnbull to Mason, Minister of Health, H-1, 33374, 2/1/2, ANZ, Wellington.

<sup>169</sup> 30 October 1959 Pickard to psychiatric hospital matrons, NZNO Records, 79- 032-02/06, ATL, Wellington.

<sup>170</sup> 10 September 1958, Cameron to Pickard, NZNO Records, 79- 032-02/06, ATL, Wellington.

<sup>171</sup> 6 July 1959 Cameron to Minister of Health, H-1, 33374, 2/1/2, ANZ, Wellington.

9,000 members would object strongly to a union being permitted to make decisions on matters affecting the education and status of their professional body.<sup>172</sup>

The PSA failed to make any headway during the 1960 nomination round. Neither Nash nor Mason appeared to want an open conflict with the union but they were reluctant to disturb the status quo. Mason promised to speak with the NZRNA on the union's behalf but did not appear to do so. A letter from the union went unanswered for several months while the nomination process was completed.<sup>173</sup> When Mason finally responded, it was to quote Cameron's advice. He praised the NZRNA as being largely responsible for gaining greater recognition for psychiatric nurses and 'closer harmony' with other types of nursing. Mason assured the PSA that he had given the matter considerable thought and had decided that it would be 'unwise to disturb the present representations on the Board'.<sup>174</sup>

The battle between the PSA and NZRNA was indicative of a clash of cultures. As the female, middle-class leaders of the nursing profession gained influence over psychiatric nursing, they met with resistance from male, working-class union leaders. The elitist, 'professional' mode of the nurse-leaders did not sit comfortably with the egalitarian, socialist principles of the male attendants. Margaret Miers has suggested that the challenge that men in nursing presented in early twentieth century Britain was their 'self-perception as workers and employees, untroubled by ideas of vocation or profession'.<sup>175</sup> The same could be said for mid-twentieth-century New Zealand mental hospital attendants. Most men joined the workforce for reasons of finance, conditions or convenience. Their primary vehicle for collective expression was the trade union through which they contributed to shaping the hospitals as tolerable work places. Psychiatric nursing registration and the subsequent educational reforms threatened to disturb the power structures within the mental hospital workforce. By the end of the 1950s, however, mental hospital attendants and nurses were beginning to adopt the rhetoric of professionalisation, but on their own terms. They used working-class, union processes to challenge what they saw as an intrusion of feminised general nursing into their working world.

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<sup>172</sup> 6 July 1959, Cameron to Minister of Health, H-1, 33374, 2/1/2, ANZ, Wellington.

<sup>173</sup> 10 June 1960 (received 8 August 1960), Turnbull to Mason, H-1, 33374, 2/1/2, ANZ, Wellington.

<sup>174</sup> 11 August 1960, H-1, 33374, 2/1/2, ANZ, Wellington.

<sup>175</sup> Miers, pp.88-9.

## **Conclusion**

During the 1940s and 1950s, attempts were made to improve the standard of training for mental hospital nurses, feminize the workforce, and bring it under the authority of the nursing profession. Psychiatric nursing registration, introduced in 1945 and initially intended for women, was seen as a significant step in this direction. The collective strength of the male attendant workforce, however, ensured that men were included in registration provisions. Plans for reform were slow to be realized. Hospital conditions such as understaffing, overcrowding, and poor resources prevented the wholesale implementation of improvements. New educational standards were also difficult to enforce because hospital administrators were reluctant to jeopardize their relationship with their relatively stable, male workforce.

Educational reforms brought the male-dominated, working-class mental hospital workforce into contact with the female nursing profession. Initially, this contact had little impact on the working lives of psychiatric nurses. By the late the 1950s, however, as it became evident that the nursing profession had gained a degree of authority over their workforce, male attendants, in particular, resisted what they perceived as the interference from middle-class, female nursing leaders. This union-based resistance to general nursing's authority continued to be played out over the next ten to fifteen years.

## **Chapter V**

### **Psychiatric Nurse Staffing and Culture 1960-1972**

Between 1960 and 1972, significant changes occurred to the employment, practice and professional contexts in which psychiatric nurses worked. Although most psychiatric care remained located in large public institutions, the focus moved from custody and containment to treatment and rehabilitation. Assessment and treatment services were expanded beyond the walls of the mental hospitals to outpatient clinics and psychiatric units at general hospitals. Integration of mental health with other health services came to be seen as a solution for poor conditions in mental hospitals and for the ongoing stigma associated with mental illness. During this period, the nursing profession was active in its pursuit of educational and practice reform. A belief in the unitary nature of nursing was central to the profession's call for change. The second half of this thesis explores psychiatric nurses' responses to these changes.

In this chapter I explore changes to the structure, composition and culture of psychiatric nursing between 1960 and 1972. Therapeutic and professional developments created a demand for a more diversified and treatment-orientated workforce in psychiatric hospitals. It became important to differentiate professional nursing from auxiliary roles, and qualified nurses from attendants and nursing assistants. These structural changes challenged the systems of authority and status within the male workforce and ultimately led to the integration of the male and female sides. Although psychiatric nursing appeared to gain wider appeal with women, it remained an occupation that many men and women joined by default or 'by accident' rather than as a planned career choice.<sup>1</sup> Stigma and marginalization continued to play a significant role in recruitment patterns and the collective culture of psychiatric nurses.

#### **Staffing**

Maintaining an adequate nursing workforce became a more complex task in the 1960s and early 1970s. Staffing patterns were affected by New Zealand's sustained economic growth that occurred from after the war until 1973.<sup>2</sup> In the context of full-employment,

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<sup>1</sup> One of the interviewees for this study described herself as an 'accidental nurse'.

<sup>2</sup> Brian Roper, *Prosperity for All? Economic, Social and Political Change in New Zealand since 1935*, Southbank, Victoria, 2005, p.4.

recruitment to psychiatric nursing remained problematic. Except for a brief period of increased national unemployment in 1967-8, psychiatric hospitals struggled to attract workers in a highly competitive employment market. Although actual numbers of nurses increased, so too did the number of patients. Overtime hours remained high and there was general agreement that staffing levels were inadequate.

The Division of Mental Health (re-named in 1960) approached staffing problems in new ways. Rather than employing most workers as full-time nurses or attendants, hospitals attempted to create a differentiated workforce comprised of nurses and auxiliary workers. Part-timers, non-trained assistants and vacation workers were also employed.

### ***Part timers, untrained workers, tertiary students and domestics***

In the early 1960s employment of part-time nurses eased the staffing situation on the female side.<sup>3</sup> The part-timers were mostly married women, some of whom were registered psychiatric or general nurses. Although they provided relief from staffing shortages, their presence sometimes caused conflict with the permanent staff.

Administrators were accused of giving part-timers the best shifts. This problem was mostly alleviated in 1966 when a new shift system, based on an 8-hour day, was introduced.<sup>4</sup> Evening shifts were introduced for the first time; the head office began reserving day-shifts for permanent staff and restricting part-timers to evening work.<sup>5</sup>

Untrained workers, again mostly women, were employed as either nurse or hospital aides. Some were not considered capable of undertaking training, some did not wish to, and others were too young. Many prospective trainees were employed as nurse aides until the next available block course commenced.<sup>6</sup> In theory, nurse aides were employed to assist with nursing tasks while hospital-aides were to assist with domestic duties. Ex-patients were sometimes employed as hospital-aides as a way to support them back into paid employment.<sup>7</sup> At Sunnyside, the distinction between the two roles was clear. The ward sisters were responsible for training and supervising assistant nurses (nurse aides)

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<sup>3</sup> Numbers of part-timers are difficult to estimate since they were not recorded in the New Zealand Public Service List.

<sup>4</sup> For more detailed discussion of shifts and rosters, see Chapter VIII.

<sup>5</sup> Mirams to medical superintendents, 14 September 1966, H-1, 32503, 30/35/51 ANZ, Wellington.

<sup>6</sup> This practice was contested by the PSA who argued that people who had been accepted as suitable for training should be employed as student nurses (at a higher rate) while they waited for the next block course; Dan Long, General secretary, PSA to Stan Mirams, 24 March 1964, H-1, 31000, 30/7/6, ANZ, Wellington.

<sup>7</sup> AJHR, 1962, H-31, p.63.



who, after a year, were given a practical examination by one of the matrons. Hospital aides were trained and supervised in domestic duties by the home sister.<sup>8</sup> Because of staff shortages, other hospitals were less successful maintaining the distinction. Tokanui, for example, employed 26 assistant nurses. Six acted as cooks and four did full-time domestic duties. The others undertook domestic and nursing duties, as required.<sup>9</sup> The degree of training offered to nurse-aides varied from hospital to hospital.<sup>10</sup> One problem was the temporary nature of some workers' employment. In 1960, ten percent of new employees stayed less than three months; many did not stay long enough to be trained or sit an exam.<sup>11</sup>

Although employment of non-trained staff filled a gap, the Division recognised that it was not an ideal solution to nursing shortages. The Public Service Association (PSA) was also wary about the practice and sometimes raised questions about nurse aides being given too much responsibility. In 1962, for example, the PSA complained that a hospital aide was acting as second-in-charge on a ward at Porirua and that nurse aides at Tokanui were in charge of patients and wards.<sup>12</sup> In the Porirua instance, the Division was able to reassure the union that it was not unusual or inappropriate for a sister to be in sole charge of a ward with the assistance of a nurse aide. The use of nurse aides at Tokanui, however, seemed to have grown beyond the level of acceptability. In response to this situation, Head Office asked hospitals to report on their proportion of untrained and non-training 'nurses'. Administrators were required to ask permission for the level to exceed 20 percent.<sup>13</sup> Some hospitals were well above 20 percent, particularly on the female sides. At Seacliff Hospital, 32 percent of female nurses and ten percent of male nurses were non-training; most held permanent positions.<sup>14</sup>

University students became an important, if sporadic, source of nursing labour.

Although employment of students during the summer was not new, the practice grew during the 1960s. In December 1969, approximately 500 tertiary students were

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<sup>8</sup> Medical-Superintendent, Sunnyside Hospital to Geoffrey Blake-Palmer, Director of Mental Health, 8 November 1961, H-1, Acc. W2191, 30/35/53, 34604, ANZ, Wellington.

<sup>9</sup> Kenneth Stallworthy to Blake-Palmer, 27 Sept 1961, H-1, Acc. W2191, 30/35/53, 34604, ANZ, Wellington.

<sup>10</sup> Blake-Palmer to medical superintendents, 22 September 1961, H-1, Acc. W2191, 30/35/53, 34604, ANZ, Wellington.

<sup>11</sup> Blake-Palmer to PSC, 30 November 1960, H-1, 31000, 30/7/6, ANZ, Wellington.

<sup>12</sup> PSA to Blake-Palmer, 11 June 1962, H-1, 31000, 30/7/6, ANZ, Wellington.

<sup>13</sup> 3 August 1965, H-1, 30779 30/35/51, ANZ, Wellington.

<sup>14</sup> 19 November 1965, H-1, 32503, 30/35/51, ANZ, Wellington.

employed. They temporarily comprised approximately one-tenth of the hospital workforce.<sup>15</sup> Some filled clerical positions but most were employed as nurse aides. The influx allowed hospital administrators to plan annual leave for permanent staff and provided nursing relief with basic, physical and supervisory care. Some students returned yearly and became au fait with hospital procedures and patient care. Others stayed only one season, creating yet another group of short-term workers requiring orientation by senior nurses. A few tertiary students left university to take up psychiatric nursing.<sup>16</sup>

Vacation workers have been credited with providing a much needed ‘outsider’s view’ that challenged psychiatric hospital practice of the time. Katherine Truman argues that university students were a ‘thorn in the side’ for hospital administrators at Porirua because they campaigned for better social and physical conditions for patients.<sup>17</sup> Margaret Bazley, Matron, then Principal Nurse, at Sunnyside from 1965 to 1973, welcomed them as a radical force in the psychiatric nursing programme. She reflects that she ‘had to put up with quite a bit from some of them and yet most of them have gone on to be very good nurses’.<sup>18</sup>

As psychiatric nurses’ roles became identified more as a therapeutic endeavour, the Division came under pressure to employ more domestic staff so that nurses could focus on their work with patients. Changes, however, were slow to eventuate. The loss of able-bodied patients due to improved treatments, and the dearth of domestic workers, meant that nurses continued to carry the bulk of non-nursing duties through most of the 1960s. The issue became a source of discontent for nurses and eventually spilled into industrial action (discussed further in Chapter VIII).<sup>19</sup> In the early 1970s, under pressure, the government agreed to increase the numbers of domestic, catering staff and other nursing support roles.<sup>20</sup> While the Division claimed that these increases were an

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<sup>15</sup> On 31 December 1969, there were 4,732 staff in total; AJHR, 1970, H-31, p.70.

<sup>16</sup> Several psychiatric nurses interviewed for this study had commenced work as nurse aides in their university holidays.

<sup>17</sup> Truman, p.186.

<sup>18</sup> Margaret Bazley interview 23 February 2004.

<sup>19</sup> Psychiatric nurses instigated a ‘Nurses Care Only Campaign’ in which they refused to do non-nursing duties. See Chapter VIII for fuller discussion on industrial issues.

<sup>20</sup> AJHR, 1970, H-31, 3, pp. 69 - 70.

‘indirect but very substantial reinforcement of nursing resources’, it also conceded that nursing numbers remained too low at some hospitals.<sup>21</sup>

### **Nursing structure and organisational systems**

Changes to the structure of the nursing workforce reflected a growing recognition of registered psychiatric nurses as mental health professionals as opposed to being ‘just another pair of hands’. During the 1960s and early 1970s, greater attention was given to delineating the position of the registered psychiatric nurse, rewarding competence rather than occupational longevity, and ensuring an even spread of qualified staff across the wards. Consequent changes to staffing policies disrupted long-established relationship patterns, particularly on the male side. By the early 1970s, the changes had also led to dissolution of the gender divide.

### ***Promotion policies***

New promotion policies contributed to a greater distinction between qualified and unqualified workers. From 1960 nurses who failed their final examinations were ‘remustered’ as attendants (men) or assistant nurses (women). Both men and women still had to achieve in the Junior Examination to receive the highest salary rate for these positions.<sup>22</sup> Those who succeeded in the Hospital Final but failed the State Examination were able to assume the role of senior attendant or senior assistant nurse. This new promotion policy had more impact on the men than the women for two reasons. Hospitals had already been employing a number of women as assistant nurses. These women had either chosen not to train or had not been accepted for the course. There was therefore already a distinction between students and assistants on the female side. In contrast, attendants (later called assistant nurses or psychiatric assistants) were, for the first time, differentiated from male registered nurses and trainees. The new promotion policy also affected only a small number of female nurses. Very few women had remained on staff after failing their final examinations. Again, in contrast, it had been common for men to continue working despite failing their exams. The number of senior attendants grew from 30 in 1964/5 to 90 in 1969. They were a small, but stable, part of the nursing workforce and were often valued for their experience and reliability.

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<sup>21</sup> AJHR, 1971, pp.69-70; AJHR, 1972, H-31, p.76.

<sup>22</sup> 14 October 1965, H-1, 32119, 30/35/52, ANZ, Wellington.

Winston Maniapoto's experiences at Lake Alice in the late 1960s led him to comment, 'When you see a good psychiatric assistant, they are worth ten staff nurses.'<sup>23</sup>

Another level of nurse was introduced to psychiatric hospitals in the late 1960s. 'Community Nurse' was a new category of nurse whose eighteen-month training and registration were controlled by the N&MB. Although not specifically trained in mental health, a few community nurses were employed in psychiatric hospitals, particularly to work in older adult or children's wards. Sunnyside Hospital instigated a training programme for community nurses in 1967 and, several years later, supplemented this with 'psychiatric endorsement' training for registered community nurses.<sup>24</sup>

By the 1960s, a grading system that had been introduced almost a decade earlier was beginning to affect the promotion patterns for qualified psychiatric nurses. The 'marking' system, introduced in the early 1950s, was part of a public service process of grading employees for promotion purposes. Each year, charge nurses, sisters, head nurses and matrons allocated grades to those below them in the hierarchy. Matrons and head attendants then met in Wellington with the medical superintendents to finalise grading across the country. Prior to the introduction of marking, promotion had been largely based on seniority, though medical superintendents' recommendations had considerable influence. Afterwards, a nurse with a high grade theoretically had a better chance when applying for a senior nursing position. Marking, however, continued to be just one criterion considered for promotion. On the female side, it was generally understood that matrons identified and favoured some nurses over others for promotion to charge nurse, sister or tutor positions.<sup>25</sup> On the male side, length of service carried considerable weight in the promotion process.

The introduction of marking created somewhat more movement in the nursing hierarchy. Male attendants/nurses, in particular, were more inclined to transfer to another hospital in a bid to attain a higher position. Their grades allowed them to compete, though not necessarily, succeed, against existing staff. The men also had a better chance of gaining promotion early in their careers. Russell Flahive recalls, that at the age of 29, he was the youngest deputy-charge nurse in the country when he gained

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<sup>23</sup> Winston Maniapoto interview 10 August 2004.

<sup>24</sup> Margaret Harraway, *End of an Era: A History of Nursing Education at Sunnyside Hospital 1904 - 1987*, Christchurch, 1992, p.45. Educational issues are discussed further in Chapter VII.

<sup>25</sup> Barbara Milne interview 7 September 2005.

the position in 1958. A colleague, Colin Parry, had become the youngest charge nurse a few years earlier.<sup>26</sup> It appears, however, that even with the new system the tradition of seniority based on longevity persisted on the male side. The formal appeal system no doubt contributed to this. By 1970 it was still unusual for relatively young men to gain charge nurse positions. When Bob Elliott and two of his colleagues achieved the highest marks at Tokanui, they applied for, and gained, charge nurse positions. Being in their mid-30s, they were considered to be ‘young whippersnappers’.<sup>27</sup>

### ***Integration of male and female staff***

Although overall nursing numbers grew steadily throughout the 1960s, registered nurses were unevenly distributed across the male and female wards. Hospitals struggled to fill their ward sister and deputy-sister positions. In 1965, only 24 of the 121 deputy-sister positions were filled by registered nurses. Twenty-one positions were vacant and the remainder were filled by ‘basic grade’ (student) nurses.<sup>28</sup> In contrast, there were so many registered, experienced male nurses that there was stiff competition for the charge and deputy-charge positions.

The Division’s head office looked for various solutions to the shortage of registered nurses on the female wards. In 1965, hospitals were given permission to advertise in local papers in the hope they might attract married nurses or ‘qualified overseas tourists’ to deputy sister positions.<sup>29</sup> Although it is unclear whether any hospital put the recommendations into action, it seems unlikely that the strategy would have resulted in many applications. The Division’s next move was to suggest allocation of nurses to positions, irrespective of their sex. Faced with an overall shortage of 300 nurses, John Hall, the Deputy-Director of Mental Health, suggested that hospitals consider their vacancies as a whole and appoint male or female staff wherever there was a vacancy.<sup>30</sup> A year later, Stan Mirams, the Director of Mental Health, advised that hospitals could consider advertising sisters’ positions in female wards as suitable for either a ‘charge nurse’ (male) or ‘sister’ (female).<sup>31</sup> Neither of the suggestions was welcomed wholeheartedly. Some medical superintendents and senior nurses supported the idea of

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<sup>26</sup> Russell Flahive interview 1 June 2004.

<sup>27</sup> Bob Elliott interview 2 June 2004.

<sup>28</sup> 29 June 1965, Departmental circular, H-1, 30779, 30/35/51, ANZ, Wellington.

<sup>29</sup> 29 June 1965, H-1, 30779, 30/35/51, ANZ, Wellington.

<sup>30</sup> 29 July 1965, H-1, 32119, 30/35/52, ANZ, Wellington.

<sup>31</sup> 4 July 1966, YCBG, 5929, 16b, 6/10/2, 388, ANZ, Auckland.

more flexible use of male and female staff in principle but felt they were unable to implement it at the time. Others were most reluctant to place men in charge of female wards. As a compromise, Mirams suggested that hospitals could make trial appointments for three-month periods. Three hospitals were willing to experiment.<sup>32</sup>

Suggestions that men and women should work on each others' wards exposed attitudes about men in psychiatric nursing. Despite the fact that men had been able to register as psychiatric nurses since 1946, their suitability for the nursing role was still being questioned. Mirams, for example, wondered if hospitals should make use of the improved level of recruitment of female trainees as an opportunity to revert to the policy of staffing male wards with female nurses.<sup>33</sup> Patrick Savage, the Medical Superintendent of Oakley Hospital, on the other hand, was concerned not to undermine the men's control of their own wards. He believed that women should only be employed on the male wards as domestics or cooks and the men's role on the female side should be confined to tasks such as driving. Savage warned that the older, experienced men would be most reluctant to take orders from a young female sister.<sup>34</sup> John Crawshaw, the Medical Superintendent of Kingseat, discussed the matter with his head nurse, matron and secretary. They agreed that a male nurse could only have a limited role on a female ward, 'doing little more than the ward domestic chores and dispensing tablets'. One of their major concerns was the risk of contact with sexually active female patients.<sup>35</sup>

Despite concerns about men and women working on each other's wards, there was some movement towards integration of male and female staff during the next few years. In 1966, the role of deputy charge nurse was abolished and a new role of 'supervising charge nurse' or 'supervising sister' was established. The new positions were situated just below the matrons and head nurses in the hospitals' hierarchy and provided opportunities for greater flexibility in the allocation of senior nurses. The supervisors' responsibilities differed from hospital to hospital but, generally, they supervised a group of wards, organised in-service education, and co-ordinated various activities for patients. They also relieved head nurses and matrons of much of the clinical

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<sup>32</sup> 22 & 28 July 1966, Mirams to medical superintendents, YCBG, 5929, 16b, 6/10/2, 388, ANZ, Auckland.

<sup>33</sup> 27 October 1966, YCBG, 5929, 16b, 6/10/2, 388, ANZ, Auckland.

<sup>34</sup> 21 August 1965, Savage to Mirams, H-1, 30779 30/35/51, ANZ, Wellington.

<sup>35</sup> 11 August 1965, Crawshaw to Mirams, H-1, 30779 30/35/51, ANZ, Wellington.

responsibility. Hospitals were not overly rigid in maintaining male and female segregation for the supervisors' positions. When Cherry Farm, for example, had difficulty recruiting supervising sisters, it relied on its supervising charge nurses to cover both male and female wards.<sup>36</sup>

In 1968, in an attempt to create more flexibility in the mental hospitals' workforce, the Department of Health instigated a staffing review. The Organisation and Management (O&M) Team was given the task of reviewing the rosters, assessing nursing establishments and addressing staffing structures.<sup>37</sup> One of the Team's preliminary recommendations was that hospitals should move towards sex integration. Implementation was not, however, undertaken for some time, largely because of resistance from male nurses represented by the PSA. The nurses sought reassurance that they would be legally protected against possible accusations of sexual impropriety towards female patients.<sup>38</sup>

Faced with delays in the O&M staffing review, administrators at Sunnyside Hospital took a proactive approach. Edwin Hall, the Medical Superintendent, and Margaret Bazley, the Matron, decided to restructure the nursing administration from the top down. In early 1969, when the Head Nurse (male) was transferred to another hospital, Hall and Bazley decided to leave the position unfilled. Senior male and female nurses' positions were re-structured into a single nursing administration under Bazley as the 'Principal Nursing Officer'. The hospital was divided according to types of wards rather than sex of patients and senior nurses' responsibilities were reassigned accordingly. Two 'Senior Nursing Officers' assumed responsibility for running half the hospital each. Under their control, 'nursing supervisors' oversaw a group of male and female wards. Integration at the ward level gradually followed the restructuring of the senior nursing team. Bazley and Hall reassured the PSA that no-one would be forced to work on a mixed ward. Initially they relied on volunteers, but eventually, only six men refused to work with women.<sup>39</sup>

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<sup>36</sup> In the absence of supervising sisters, two supervising charge nurses provided cover for both male and female wards at Cherry Farm; 26 July 1967, H-1, 30/35/51, 33901, ANZ, Wellington.

<sup>37</sup> AJHR, 1969, H-31, p.79.

<sup>38</sup> Practice issues in relation to male/female integration are discussed further in Chapter VI.

<sup>39</sup> 'The Structure of the Nursing Administration at Sunnyside Hospital', circa 1970-1, Margaret Bazley personal papers.

In the process of restructuring, the senior nurses at Sunnyside discovered differences in practice between the male and female sides. Some of these were superficial and had little to do with nursing. Female nurses, for example, had been responsible for the chapel while male nurses had responsibility for the bowling greens and driving. These and other non-nursing tasks were transferred to other workers. Some traditions were more to do with fundamental differences in attitudes and approach. As the senior nurses began to manage nurses of the opposite sex they noted that, ‘the women are softer and will agree to anything that is said to be for the good of their patients, while men are much more realistic and conscious of their financial obligations’.<sup>40</sup>

Integration of the male and female staff was comprehensively applied across the psychiatric hospitals in the early 1970s. By this time, the Division had acceded to the PSA’s request for guidelines for nurses working in an integrated environment.<sup>41</sup> Many nurses worked with the opposite sex for the first time. Their experience of the different approaches to practice was refreshing for some but shocking for others (see Chapter VI for discussion of practice issues). Integration, however, had implications beyond clinical practice. It represented the merging of two very different cultures and opened the way for men to gain access to much faster promotion. For some men, the promotional opportunities only marginally compensated for their loss of a male-only work environment. Dissolution of the male and female sides was arguably the most profound change to the structure of psychiatric hospital nursing since the beginning of the Department of Mental Hospitals.

### **Composition of the nursing workforce**

During the 1960s the composition of the psychiatric nursing workforce began to change. As the older generation of ‘depression recruits’ moved on, they were replaced by people from a broader range of backgrounds. Psychiatric hospital training programmes continued to attract people from working-class backgrounds and new immigrants, but other aspects of recruitment were changing. Patterns of age, sex, ethnicity and educational background of new recruits suggest that psychiatric nursing was beginning to be perceived as a semi-professional career option, rather than merely a well-paid job.

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<sup>40</sup> Division of Mental Health, inspection report on a ‘Visit to Christchurch: 29-30 April’, 5 May 1969, H-1, 45597, 49/5/9, Bundle 2772, ANZ, Wellington.

<sup>41</sup> ‘Integration: Staff and Patients, Some Guidelines for Policy and Practice’, 29 July 1969, p.2, ABQU632, W4452, 30/35/19/1, Box 139, ANZ, Wellington.



The occupation that had formerly been associated with custodial care and manual labour was becoming associated with nursing and with interpersonal skills.

### *Passing of the 'old guard'*

A large proportion of men who had been recruited during the 1930s economic depression retired during the 1960s. The number of men who had been employed in the years surrounding the war also declined. These depression and wartime recruits had provided considerable stability to the hospitals. Their dependability had been valued in an institutional environment in which order and safety took precedence. They had set the tone and culture of the male wards. In 1959, most of the charge attendant positions were held by men who had commenced employment before 1950. In contrast, less than a quarter of the ward sisters had been employed before 1950.<sup>42</sup>

Men who worked during the 1960s have spoken about the influence of the 'old guard'. Tony Moran remembers the number of male nurses at Tokanui who had been in the armed forces. He believed their experiences contributed to a custodial 'mentality and operation' that was still evident in 1965.<sup>43</sup> Adrian Moerenhout recalled the advice he was given by one of the 'old guard' charge nurses. 'Now, if you become a charge nurse and get a ward, you change the furniture in the office – that shows initiative. Don't do anything else because that would show bad judgment.'<sup>44</sup>

During the 1960s and early 1970s, the influence of the 'old guard' diminished. On a purely numerical measure, by 1969, less than a third of male charge nurse positions were held by men who had been employed before 1950.<sup>45</sup> Those who took their place were influenced by a different set of cultural expectations and values. They were part of a post-war workforce that generally hoped for better economic times and greater social freedom. When they joined the mental hospitals, therapeutic innovations were offering possibilities for patient recovery, rehabilitation and discharge; terms such as 'open door' and 'therapeutic environment', though not always applied, were in common parlance. Although custodial practices often persisted on the male side, another discourse was beginning to compete, particularly in the nursing classroom. Male recruits of the 1960s

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<sup>42</sup> New Zealand Public Service List, 1959/60.

<sup>43</sup> Tony Moran interviewed by Cathy Coleborne, 10 March 2004, Tokanui Oral History Project (TOHP), Te Awamutu Museum, Awamutu.

<sup>44</sup> Adrian Moerenhout interview 11 April 2004.

<sup>45</sup> In 1969, 110 of the 257 male charge nurse positions were held by men employed before 1950: New Zealand Public Service List, 1969.

were exposed to discourses of ‘therapy’ and ‘relationship’. These cohorts of male nurses were, arguably, more able to adjust to the changing demands of ‘modern’ psychiatric services than their predecessors, who had entered the occupation in an era when ‘asylum-type’ psychiatry dominated.

Although trainee numbers remained fairly stable during the 1960s, male and female recruitment patterns changed. Female applications increased while male ones decreased (see Table 6 below). Low male recruitment numbers led the Department to consider alternative options for staffing male and female wards.<sup>46</sup> By the late 1960s, some hospitals had difficulties filling their ‘basic-grade’ male nursing establishments.<sup>47</sup>

	Male	Female	Total
1959	388*	385**	773
1969	295	446	741

**Table 6 Psychiatric Nurse Trainees, 1959 and 1969.**

**Source: NZPSL, 1959-60 and 1969.**

\* Includes all basic-grade ‘attendants’.

\*\* Includes all basic-grade ‘nurses’.

Some hospital schools experienced a considerable increase in the number of nursing recruits. At Sunnyside, numbers almost doubled between the beginning and end of the 1960s. Classes were so big in the early 1970s that they had to be divided into two. Although the qualifications of psychiatric nurses were below that of general nursing trainees, they were improving.<sup>48</sup> Across all hospitals, an increasing proportion of recruits held school certificate, a few university entrance, and some entered with tertiary educational experience. On average male recruits entered with lower qualifications than female recruits. In 1972, 54 percent of psychiatric nursing trainees held school certificate.<sup>49</sup> At the time, school certificate had become mandatory for general nursing.

During the 1960s, the average age of male trainees fell. There was also a slight drop in the age of the women. At the beginning of the decade, the Division’s policy was to appoint men from 21 years and women from 18 years. This changed after the *Nurses and Midwives Act* was amended in 1963 to allow psychiatric nurses to register at 20

<sup>46</sup> 27 October 1966, YCBG, 5929, 16b, 6/10/2, 388, ANZ, Auckland.

<sup>47</sup> In 1968, for example, Tokanui Hospital requested permission to use three of their male trainee vacancies to employ female assistant nurses on a temporary basis; 25 March 1968, YCBG, 5929, 16b, 6/10/2, 388, ANZ, Auckland.

<sup>48</sup> See Chapter VII for discussion on entry qualifications.

<sup>49</sup> Helen Carpenter, *An Improved System of Nursing Education for New Zealand*, Wellington, 1971, pp.10-1.

years, rather than 21 years.<sup>50</sup> This amendment brought psychiatric nursing into line with general nursing and was a minor defeat for the PSA, who had been opposed to the employment of young people. After this, it was possible, though not common, for hospitals to appoint female trainees at 17 years of age. Divisional policy on the minimum age of male trainees also relaxed during the 1960s. By the end of the decade, the average age of first-year trainees had dropped to from 29.3 years to 24.6 years for men (see Table 7 below).

	Male (age)	Female (age)
1959	29.3 years	21.8 years
1969	24.6 years	20.6 years

**Table 7 Average age of first year trainees, 1959 and 1969.**

**Source: NZPSL, 1959-60 and 1969.**

For the first time, there was a small cohort of young men in training. In 1969, more than one-third (31) of male first-year trainees were below 21 years. This compared with just under one half (118) of female first-year trainees.<sup>51</sup> The photograph in Figure 20 shows young trainees at Sunnyside Hospital in the early 1970s.



**Figure 20 Sunnyside student nurses, L-R: unknown, Sally Caulfield, Gavin Burgess, early 1970s.**

**Source: Sunnyside Hospital collection, Canterbury District Health Board.**

### *Maori*

Maori had been well represented in psychiatric hospital nursing since the post-war years. From oral history accounts, it appears that most Maori nurses were women and many occupied relatively junior positions. A small number were registered psychiatric

<sup>50</sup> AJHR, 1964, H-31, p.84.

<sup>51</sup> In March 1969 there were 78 male and 255 female first-year psychiatric nursing trainees: New Zealand Public Service List, 1969.

nurses. Ethnicity was not recorded on the Register, but it would appear, based purely on names, that one or two Maori women had achieved psychiatric nursing registration in most years since 1946, when the register was opened. A few Maori men also became registered during this time.<sup>52</sup> In 1963, the number of female Maori nurses of all rankings was 16.5 percent of the total female nursing staff. Numbers at North Island Hospitals were larger than in the South (see Table 8 below for details).

	Total Female Nurses	Maori Female Nurses
Oakley	103	17
Kingseat	77	28
Tokanui	78	29
Levin	65	10
Porirua	97	27
Ngawhatu	73	3
Seaview	39	2
Sunnyside	125	4
Templeton	45	2
Seacliff	75	4
Total	777	126

**Table 8 Female Maori nurses employed at Psychiatric Hospitals, January 1963.**

**Source: H, 1, 30779 30/35/51, ANZ, Wellington.**

During the 1960s and early 1970s there was a small but growing number of Maori men training and registering as psychiatric nurses. Tokanui Hospital had the greatest number of Maori nurses and, for this reason, attracted others to the work. When Bob Elliott started work at Tokanui in 1965, he was mindful of the fact that there were approximately six other Maori men nursing there. This helped him accept the role as an acceptable career option.<sup>53</sup> Wi Keelan, who started training at Porirua Hospital in 1968, was one of two Maori trainees. There was also a small group of Maori senior assistant nurses at the hospital. Keelan recalls that they were keen to see the Maori trainees succeed and provided substantial informal support.<sup>54</sup>

Although some people in the Division were keen to increase the number of Maori nurses, psychiatric hospitals in the 1960s were not, on the whole, sensitive to cultural differences in staff or patients. Even at Tokanui where Maori were relatively well represented in the hospital hierarchy, there was little recognition that Maori may want or

<sup>52</sup> This measure of Maori ethnicity cannot be taken as accurate, but provides a crude estimate of numbers; Register of Psychiatric Nurses, 1945-1966, ABYO, 7889, W5148, 30, ANZ, Wellington.

<sup>53</sup> Bob Elliott interview 2 June 2004.

<sup>54</sup> Wi Keelan interview 26 July 2004.

need to do things differently. Winston Maniapoto, who started work at the hospital in 1960, was particularly shocked by how older people were treated. It was the first time that he had realized that older people may be labelled as psychiatrically unwell rather than respected and honoured for their age. On a personal level, Maniapoto encountered problems when the head nurse refused him leave to attend his grandfather's tangi (funeral). Divisional rules restricted funeral leave to immediate family. Maniapoto risked losing his job when he asserted his right to go. He believes that he was saved from dismissal by his own high grades in the nursing exams and by the intervention of the medical superintendent and hospital secretary. Both men believed that psychiatric hospitals needed more Maori nurses.<sup>55</sup>

### *New immigrants*

Immigrants comprised a significant proportion of the psychiatric nursing workforce, particularly in the urban hospitals. Many had arrived during the 1950s. Richard Rillstone who started work at Seacliff in 1963 recalled the large numbers of Englishmen who had emigrated after the Second World War and members of the Dutch Foreign Legion who had been evicted from Indonesia in the early 1950s.<sup>56</sup> Savage, medical superintendent of Oakley, noted with pride the number of Dutch nurses at his hospital in the mid-1960s.<sup>57</sup> At Lake Alice Hospital, the Head Attendant employed a high proportion of nurses from the UK and the Netherlands. As Keelan who had transferred there after registering noted, 'He didn't appear to like to employ a Kiwi nurse because they ask too many questions.'<sup>58</sup>

Psychiatric nursing was a popular career choice for unskilled immigrants. It gave them opportunities to gain a qualification, while providing a relatively good income during the training period. Paul Alexander's 1972 research indicated that psychiatric nursing had provided a 'route of upwards social mobility' for unskilled men from the Netherlands. It had been the first of several 'white collar' jobs for a number of Dutch men in his Dunedin study.<sup>59</sup>

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<sup>55</sup> Winston Maniapoto interview 10 August 2006.

<sup>56</sup> Richard Rillstone interview 25 March 2004.

<sup>57</sup> 24 December 1965, YCAA, 1081, 33d, ANZ, Auckland.

<sup>58</sup> Wi Keelan interview 26 July 2004.

<sup>59</sup> Paul Alexander, 'Occupational Adjustment of Male Dutch Settlers in Dunedin, New Zealand', *Australian and New Zealand Journal of Sociology*, 8, 3, 1972, pp.164-73.

During the 1960s, the Division continued to field a steady stream of inquiries from people seeking work in New Zealand. Some were registered; many were not. Under the assisted immigration scheme, registered nurses from the United Kingdom and some other European countries were granted almost free passage to New Zealand if they had guarantee of employment and accommodation.<sup>60</sup> Between 1960 and 1972, 191 psychiatric nurses with overseas' registration were added to the Register of Psychiatric Nurses. The largest group, by far, were from the United Kingdom, followed by Australia, then the Netherlands. This pattern of immigration largely followed the general pattern of immigration to New Zealand (see Appendix J).<sup>61</sup>

Under the assisted immigration scheme, the Division was unable to 'sponsor' registered nurses, but they could guarantee that they would provide employment conditional on satisfactory medical certificates and interviews.<sup>62</sup> Offering employment was not a problem for the Division, but accommodation was more difficult, particularly for married nurses. On at least one occasion, the Division lost the opportunity to recruit a male psychiatric nurse because it was unable to provide family accommodation at any of its hospitals. Following protracted negotiations between the Division, the Department of Labour and the applicant, the nurse gave up his attempts to immigrate to New Zealand. He instead accepted a position in Australia.<sup>63</sup>

Overseas inquiries from people wanting to train in psychiatric nursing were treated more cautiously. The standard response was that employment depended on New Zealand residency. During the 1960s, there was an increase in applications from the Pacific Islands. The most common source of such applications was from Fijians of Indian ethnicity.<sup>64</sup> Those who applied from their country-of-residence to train in a New Zealand hospital were rejected. The N&MB regulations prohibited the acceptance of 'girls' from the Pacific Islands unless they were sponsored by their government, the

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<sup>60</sup> 9 June 1965, H-1, 32119, 30/35/52, ANZ, Wellington. See Chapter II for discussion of the assisted immigration scheme that became known as the 'Ten-Pound Pom' scheme.

<sup>61</sup> The United Kingdom, followed by Australia, then the Netherlands were the greatest contributors of immigrants during the 1960s and early 1970s: *New Zealand Year Book*, 1960-72. Immigration from the Netherlands had been highest during the 1950s, with an average of 1,834 per year arriving in New Zealand. In the 1960s, this dropped to approximately 600 per year: Hank Schouten, *Tasman's Legacy: The New Zealand-Dutch Connection*, Wellington, 1992, p.256.

<sup>62</sup> August 1966, H-1, 32119, 30/35/52, ANZ, Wellington. Conditions of the Assisted Immigration scheme were adjusted during the 1960s in response to fluctuations in the economy and the changing needs for labour: Hutching, pp.70-3.

<sup>63</sup> 22 September 1965 – 18 April 1964, H-1, 32119, 30/35/52, ANZ, Wellington. `

<sup>64</sup> See examples of applications: H, 1, 30779 30/35/51 and H-1, 30779 30/35/51, ANZ, Wellington.

World Health Organisation (WHO) or the Islands' Education Division of the Department of Education.<sup>65</sup> The policy was consistent with WHO recommendations that 'developed' nations should not accept 'girls' for nurse training if there was a training school in their own country.<sup>66</sup>

### *Pacific people*

Psychiatric hospitals were cautious about accepting Pacific Island people into nursing training.<sup>67</sup> On the advice of the Division of Nursing, hospital schools carefully checked on a person's educational standards, residency qualification, and English skills.<sup>68</sup> Pacific Island people were employed, but not often as trainee nurses. Instead, they were given positions as domestics or cooks, or encouraged to undertake the shorter community nurse training. The use of Pacific Island workers to fill gaps in the low-skill labour market during the 1960s and 1970s has been well-documented. Immigration procedures were loosened and tightened in response to New Zealand's labour requirements. Full employment during most of the 1960s created a shortage of workers to fill low-status roles. Pacific Island people tended to take low-skilled positions because of difficulties with language, poor education and racist assumptions of employers.<sup>69</sup> Psychiatric and general hospitals employed some women who were registered in their own countries as nurse aides rather than as psychiatric nurses because their qualifications were not recognized in New Zealand.

Karl Pulotu-Endemann (known as Karl Endemann) was the first Pacific Island person to register as a psychiatric nurse in New Zealand. When he applied to train at Oakley in 1971, Pulotu-Endemann encountered stereotypical assumptions about his ability to succeed. Despite having done most of his schooling in New Zealand and having achieved School Certificate in five subjects, a number of people suggested that he should try community nursing instead of the three-year psychiatric programme. Before him, several Pacific Island nurses had started their training at Oakley but not completed it, largely because of language difficulties. Despite achieving high grades, Pulotu-

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<sup>65</sup> 25 June 1966, H-1, 32503, 30/35/51, ANZ, Wellington.

<sup>66</sup> 26 August 1963, H-1, 30779 30/35/51, ANZ, Wellington.

<sup>67</sup> The term, 'Pacific person' or 'Pacific people' is used to demote people of Pacific Island ethnicity. It is the term of choice used by the New Zealand Ministry of Pacific Island Affairs,

<sup>68</sup> Audrey Orbell to Mirams, with advice on a Samoan applicant, 3 December 1964, H-1, 30779 30/35/51, ANZ, Wellington.

<sup>69</sup> David Pearson, *A Dream Deferred: The Origins of Ethnic Conflict in New Zealand*, Wellington, 1990, pp.114-24.

Endemann encountered prejudice from some other staff throughout his training. He registered as a psychiatric nurse in 1974 and several years later completed general training at Auckland Hospital.<sup>70</sup>

### **‘Accidental nurses’: Patterns of recruitment**

Patterns of recruitment in some respects continued as they had in earlier decades. Men and women applied to work at psychiatric hospitals because of the good money, cheap accommodation and plentiful overtime.<sup>71</sup> There were, however, changes during the 1960s and early 1970s. Rather than primarily seeking job security, a number of applicants, both women and men, were looking for ways to improve their chances of education and social mobility. Earning money for university, gaining entry to a profession from a working-class background and having the opportunity to help people, were all reasons for training. Although psychiatric nursing continued to attract people from working-class backgrounds, it appeared to have gained the status of a profession or semi-profession. Few sought it out as a career, however. Most ‘fell’ into psychiatric nursing almost by chance.

Brian Craig emigrated from England by himself in the mid-1950s with very little money and saved to bring his wife and children over. During the next few years, he worked as a truck driver, a moulder in a foundry, and then qualified as a linesman with the Power Board. While in this last job, he struck up a conversation with a fellow spectator at a cricket match. On hearing how Craig’s work required him to be called out at night in all weathers, the man said, ‘I’m always warm and dry where I work. Have you ever thought of changing your job?’ The man was Morry Stitt, the Head Nurse at Lake Alice.<sup>72</sup> Craig visited the hospital the next weekend, made a decision, and started work in January 1961.<sup>73</sup>

Although money continued to be a major incentive for most men, some were also attracted by the ‘caring’ nature of the work. Peter Sanders gave up a motor engineering apprenticeship because he developed dermatitis. He made a deliberate choice to take up

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<sup>70</sup> Karl Pulotu-Endemann interview 7 April 2004.

<sup>71</sup> Reg Hyndman who started at Seaview in 1961 had done several other jobs and had studied at university. The ability to earn good money without having to do hard physical work attracted him to psychiatric nursing: Reg Hyndman interview 28 August 2004.

<sup>72</sup> H. Maurice Stitt was known as ‘Morry’.

<sup>73</sup> Brian Craig interview 29 June 2004.



nursing after seeing nurses at work when his wife was hospitalised after the birth of their first child. As well as offering an entrée into the nursing profession, psychiatric nursing also provided Sanders with steady work, good pay and plentiful vacations. Sanders recalled that he became aware during his training, which started in 1960, that, ‘I was one of the few who knew why I was there.’<sup>74</sup> Richard Rillstone was at 19 one of the youngest trainees at Seacliff Hospital in 1963. He had previously worked as a builder’s labourer but had seen an advertisement in the newspaper for psychiatric nurses. The work attracted him: ‘I was always interested in things like that. My mother reckons when I was six I hypnotised a local kid.’ Rillstone also had an idea that he could save money to go to university.<sup>75</sup>

For many women, psychiatric nursing offered a chance for a career when other doors were closed. Psychiatric hospitals were, for example, more flexible than general hospitals about employing married women and allowing trainees to live away. Barbara Milne had always wanted to be a general nurse, but when her marriage finished and she was left alone with two small children, that option was not available. Instead, she applied and was accepted to train at Oakley Hospital in 1960. Milne reflected, ‘I had no idea of what I was getting into’.<sup>76</sup> Barbara Milne is shown below as a newly qualified nursing sister in her starched uniform (Figure 21). Note the registered psychiatric nursing medal on her lapel.

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<sup>74</sup> Peter Sanders interview with Margaret Whineray, 13 July 1989, OHInt-0139/1, NERF -PNOHP, ATL, Wellington.

<sup>75</sup> Richard Rillstone interview 23 January 2004.

<sup>76</sup> Barbara Milne interview 7 September 2005.



**Figure 21 Barbara Milne, circa 1963.**  
**Source: Barbara Milne personal collection.**

Eight years later, Althea Hill had her heart set on being a policewoman. She was 21 years old and had been working first in the stock exchange and then for an insurance company. Hill interviewed for the police force, passed all the tests but failed to meet the stipulated height requirement. It was an ‘incredible disappointment’. She wanted a career of some sort but didn’t know what to do. When a friend asked if she had ever thought of psychiatric nursing, she retorted, ‘Good God. No!’ Despite her initial misgivings, Hill applied and was accepted at Oakley. She started as a nurse aide in April 1968 and joined the September training intake that year.<sup>77</sup>

For Tilly Lloyd, nursing offered ‘a road to freedom’. Brought up working-class in a small town in rural Otago, she felt her options were limited. She could not afford to go to university and was not sure she was ‘bright enough’. Lloyd took a summer job at Orokonui, and then applied to do general nurse training at Dunedin Hospital in 1972. For the first three months, the nursing class combined general and psychiatric nurse trainees. By the end of Preliminary School, having discovered that she identified most with the psychiatric students, Lloyd switched courses and moved out to Cherry Farm.<sup>78</sup>

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<sup>77</sup> Althea Hill interview 10 June 2004.

<sup>78</sup> Tilly Lloyd interview 9 April 2004.

Psychiatric nursing became a career of choice for a growing number of people who had other professional or semi-professional options. A buoyant economy encouraged occupational mobility for reasonably well-educated people. The new recruits' initial motivation was often financial, but their decision to stay was more complex. Bob Elliott had already qualified as a teacher when he started work at Tokanui in 1965. He had just returned from a three month trip to Japan and had gone home to spend time with his family in the Waikato. Needing some extra money, he phoned the hospital looking for casual work. The Head Nurse took the opportunity to invite him to join the training course that was about to start. Still committed to his teaching career, Elliott thought, 'if I learned things about mental health, perhaps I could use it with the kids'.<sup>79</sup> Forty years later, he is still working in mental health.

Margaret Harraway took a holiday job at Cherry Farm at the end of her first year at university. She was studying for a Bachelor of Arts, intending to go into law or journalism but a serious car accident changed her plans. Suffering from post-traumatic stress and worried about how to reimburse her friend whose car she crashed, she found herself unable to settle back at university. After a few months, and with some support and 'counselling' from a new acquaintance, the poet, James K Baxter, she decided to head back to Cherry Farm to make money.<sup>80</sup> Kitty Ellison, the dogmatic, 'no-nonsense' Matron told Harraway not to waste her time working as a nurse aide. Instead, she started in the next psychiatric nursing trainee intake in August 1967. Harraway was not the only one in her class with university experience. One held a degree and several had done university papers.<sup>81</sup>

Many psychiatric nurses started training almost by chance. Marney Ainsworth considers that she arrived in psychiatric nursing as an 'accidental nurse'. She started work as a vacation worker at Sunnyside in 1971, when the prospect of earning 60 cents an hour seemed a lot better than 30 cents for shop work. Ainsworth did go to university but continued working part-time as a nurse. When, for various reasons, university did not work out, she worked full-time at the hospital for a period before discovering that if she started her training, she would get an extra 30 cents an hour. Her application was not

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<sup>79</sup> Bob Elliott interview 2 June 2004.

<sup>80</sup> James K Baxter held a Robert Burns Fellowship in creative writing at the University of Otago from 1966-8. He took an active part in university life, engaged in political protest and was well-known for his concern and care for those in trouble: Paul Millar, *Baxter, James Keir 1926 - 1972*. 7 April 2006; available at: <http://www.dnzb.govt.nz/dnzb/> (5 May 2006)

<sup>81</sup> Margaret Harraway interview 25 August 2004.

straightforward because she had ‘attitude’ and refused to wear stockings. Once this had been resolved and she had passed the psychological test, Ainsworth started training in April 1973.<sup>82</sup>

### **Working and living on the fringe: the culture of psychiatric nursing**

Psychiatric hospitals and those who worked in them were, in many respects, on the fringe of society. Despite attempts to break down the barriers between mental health and the wider community, the hospitals remained physically isolated and socially marginalised because of their association with the stigma of mental illness. Insularity, gender and class norms, stigma and marginalisation shaped the culture of psychiatric nursing. Insularity created a lifestyle in which social networks were strong and the boundaries between work and ‘home’ were porous. Gender and class norms were sustained by the insularity and by structural divisions within the psychiatric hospital community. As these divisions began to dissipate, cultural differences were first exposed and then challenged. Stigma contributed to the perception of psychiatric nursing as ‘dirty work’, a perception that influenced the nurses’ responses to the incongruity they experienced in their everyday work. Finally, marginalisation created an environment in which difference could be both understood and accommodated. By choosing to work with people who were on the margins of society, psychiatric nurses made room for their own ‘queer folk’.

The culture of psychiatric nursing was in part a reflection of changes that were occurring in New Zealand society. The long period of relative stability and certainty since the end of the Second World War came to an abrupt end in the late 1960s as New Zealand entered a period of social, political and industrial unrest. These developments paralleled those in other western countries. Protests against the Vietnam War grew in size and vehemence. Other protest movements followed, including women’s liberation, gay rights and anti-racism. Anti-establishment thinking included challenges to the institution of psychiatry. International writers such as Thomas Szasz, R.D. Laing and

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<sup>82</sup> Marney Ainsworth interview 27 April 2004.

Michel Foucault, who were loosely identified as members of the 'anti-psychiatry movement', began to have influence on attitudes towards institutional psychiatric care.<sup>83</sup>

Lifestyles in New Zealand were changing in a very visible, and for some people, disturbing way. The introduction of oral contraceptives created a 'sexual revolution', in common understanding if not necessarily in practice.<sup>84</sup> Recreational drugs such as marijuana and LSD became more readily available and more widely used. Superficial changes, such as colourful clothes, the mini-skirt for women and long hair for men challenged accepted norms of behaviour and appearance. Some young people sought alternative or counter-culture lifestyles based on peaceful co-existence, ecological sustainability and communal living.<sup>85</sup> The culture of psychiatric nursing was influenced by these developments.

### ***Insularity, close-knit communities and porous boundaries between work and home***

Psychiatric hospitals tended to be close-knit communities. The insularity, particularly of the rural hospitals, maintained a 'village-type' atmosphere. Those who lived on site or in the nearby towns, not only worked together, but also shared their off duty lives. Long working hours and shift work contributed to the need for social self-containment. Working in a stigmatised occupation added to the tendency to 'stick with your own'. It was easier to socialise with others who understood the peculiar stresses of the work and the constraints of rostered duties.

One aspect of the close-knit hospital communities was the family connections. It was not unusual for a husband and wife to work at the same institution. Adult children often followed in their parents' footsteps. In some cases, family alliances among head nurses and matrons created a supportive environment for other staff. At Tokanui, for example, there were several marriage partners who both held positions of authority at the hospital. Mere Balzer recalls that these nurses tended to be sympathetic to nurses who were trying to balance work and home commitments. Sympathy extended to women who became pregnant during their training. Unlike the norm at general hospitals,

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<sup>83</sup> For example: R.D. Laing, *Sanity, Madness and the Family*, London, 1964; Foucault; Thomas S. Szasz, *The Myth of Mental Illness: Foundations of Theory and Personal Conduct*, New York, 1961.

<sup>84</sup> Danielle Moreau argues that the revolution was one of ideology rather than of behaviour: Danielle Moreau, "'Living with the Pill": Oral Contraceptive Use in New Zealand, 1960-1975', MA thesis, University of Auckland, 1997, pp.3-4.

<sup>85</sup> Michael King, *The Penguin History of New Zealand*, Auckland, 2003, pp.452-61.

women were accepted back to work and training after the baby's birth.<sup>86</sup> Family connections were, however, sometimes exclusionary and nepotistic. Nurses at Seacliff during the 1950s and early 1960s, for example, experienced the staff culture as 'political' and factionalised.<sup>87</sup> Nurses' progress in the hierarchy was enhanced or impeded on the basis of their religious affiliation. There were also instances of head nurses giving preferential treatment to their sons or nephews. Despite the ill-feeling caused by such favouritism, Seacliff nurses experienced the hospital and its nearby village as 'a friendly, family unit'.<sup>88</sup>

Some people who worked in psychiatric hospitals have reflected on how safe they felt with other staff, especially in rural hospitals. Margaret Roberts described Seaview as possessing a 'wonderful family atmosphere'.<sup>89</sup> Bob Elliott remembered that on night duty at Tokanui, 'I wandered all over the campus. Nothing bothered me – you felt safe – you knew everyone – none of 'them and us'.<sup>90</sup> Mere Balzer, who was also at Tokanui, recalled that, although the staff partied hard, the older staff looked after the younger ones. 'If you were drunk, you actually got put in a car and taken back to the hospital and put in your own bed and someone watched over you.'<sup>91</sup> This sense of safety contrasts with the stories from some other ex-nurses who recounted the pressure they felt to 'toe the line'. Although not physically threatened, nurses, particularly on the male side, were given the understanding that they should not break rank. This became an issue in the industrial unrest of 1971.<sup>92</sup>

The nature of socialising amongst staff changed during the 1960s and early 1970s. Until the mid-1960s, it was common for men and women to socialise separately. Barbara Milne remembers the 'very close community' of women at Oakley Hospital.

The [female] nurses were amazing, it was a great feeling. They worked hard. They worked long shifts, 12 hours a day a lot of the times and then played hard. There were lots of parties. I remember one of the nurses living-in had [a] whiskey still under her bed. We'd get phone calls at night time, "Do you want to come to a party?" It would be down at the boats or somewhere. And the nurses would all go

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<sup>86</sup> Mere Balzer interview 1 July 2006.

<sup>87</sup> Richard Rillstone interview 25 March 2004; Gordon and June Rapson interview 31 August 2004.

<sup>88</sup> Gordon and June Rapson interview 31 August 2004.

<sup>89</sup> Margaret Roberts interview 29 August 2004.

<sup>90</sup> Bob Elliott interview 2 June 2004.

<sup>91</sup> Mere Balzer interview 1 July 2004.

<sup>92</sup> The nurses' strike is discussed in Chapter VIII.

together and everybody would be safe because no-one would leave the others on their own. Everyone would look after everybody else. We used to have a wonderful time and we often came back in time to go to work the next morning.<sup>93</sup>

Partying took on a different shape from the late 1960s as hippy counter culture, drugs, and ‘free love’ became a part of the staff culture at some psychiatric hospitals. At Oakley Hospital, for example, despite the medical superintendent, Patrick Savage’s, abhorrence of recreational drugs, alcohol and drugs were commonly used, not just by nurses, but by other staff such as doctors and psychologists.<sup>94</sup> Pulotu-Endemann reflected that what was happening at Oakley could be understood as part of what was happening elsewhere in society, ‘That was the time ... There were lots of broken marriages, broken relationships, a lot of parties, lots of promiscuity’.<sup>95</sup> For some university students, vacation work as a psychiatric assistant at a psychiatric hospital was experienced as ‘one long party’.<sup>96</sup> For many student nurses, however, socialising and friendships counterbalanced the hard physical work of bathing, feeding, and dayroom supervision. Tilly Lloyd reflected on how important it was to be able to ‘pull your weight in good spirit during the day and party on at night’.<sup>97</sup>

For John Shennan, the social life at the Kingseat nurses’ home in the early 1970s was ‘unbelievable’. Most of the residents were young people. One wing was occupied by men; the women occupied the remainder. To the young men’s delight, a bus-load of female general nursing students would arrive every three months or so from Middlemore or Thames to gain several weeks’ experience on psychiatric wards. Their stay at Kingseat was enlivened by the ‘legendary’ parties. Shennan’s nursing class was directly affected by their social life. Towards the end of their first study block, police raided the nurses’ home for drugs. Overnight, as a result of arrests, his class was reduced from more than 25 students to four. Shennan, who had just moved into a batch at the beach with his girlfriend, was spared to continue his training.<sup>98</sup>

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<sup>93</sup> Barbara Milne interviewed 7 September 2005.

<sup>94</sup> Patrick Savage, who associated drug use with the general degeneracy of modern youth, was known to ask prospective employees about their attitudes to recreational drugs: Karl Pulotu-Endemann, interview 7 April 2004; Redmer Yska, *New Zealand Green: The Story of Marijuana in New Zealand*, Auckland, 1990, pp.94-5.

<sup>95</sup> Karl Pulotu-Endemann, interview 7 April 2004.

<sup>96</sup> Ken Jamieson interview with Jenny Robertson, 24 March 2004, TOHP.

<sup>97</sup> Tilly Lloyd interview 9 April 2004.

<sup>98</sup> John Shennan interview 10 March 2004.

Pilfering was another aspect of institutional life, also a product of the porous boundaries between work and home. Psychiatric hospitals were particularly vulnerable because they stocked goods such as linen, cooking utensils and food that could be of use at home. They also cared for people who were often too unwell or disempowered to report staff indiscretions. The network of long-term relationships among staff contributed to a culture of protection. Theft by staff has been noted as a problem in large psychiatric institutions in other countries.<sup>99</sup>

Although pilfering occurred on both the male and female sides, it seemed to be more common among the men. A number of women have commented that they knew that pilfering was rife but did not come across it until the wards were integrated. Male nurses have reflected on how difficult it was to stand up to this practice.

On the job, you had to be a bit careful about what you said and what you did. The charge nurses doled out the toothpaste – they always had heaps left over because they never gave the patients what they were entitled to, so every year, when they had to do the new requisitions and they wanted to get rid of it (the old stuff) – “Here you take that home”. I said, “No, I’m not taking anything home”. That immediately put you under suspicion. You had to be careful.<sup>100</sup>

Some men found less direct ways to resist the culture of pilfering. When, for example, one nurse noticed a charge nurse coming off night duty with his gabardine coat filled with eggs, the nurse ‘accidentally’ leant on him.<sup>101</sup> Food was the most commonly pilfered item. Some staff members were relieved when hospitals appointed full-time cooks because nurses no longer had free access to store cupboards.<sup>102</sup>

### ***Male and female differences and the challenge of integration***

A number of sub-cultures existed within psychiatric hospitals. The most prominent was that of the male and female sides. Each had established ways of working and socialising that were indicative of the influence of gender and class. While the differences reflected contemporary gender values, they were also influenced by employment patterns. As in the earlier decades, a large proportion of the men made a career out of psychiatric nursing, staying in the service for many years. Many were ‘family men’ with strong

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<sup>99</sup> Gittins, pp.92-3; Nolan, *A History of Mental Health Nursing*, pp.132-3.

<sup>100</sup> Male nurse interviewee.

<sup>101</sup> Bob Elliott interview 2 June 2004.

<sup>102</sup> *ibid*



networks of relationships underpinned by a sense of loyalty. Men worked together, met on the sports fields and socialised at each other's homes, in the staff quarters, or at the local pub. On the positive side, the relationships and sense of loyalty created an environment in which men worked as a team, knew their roles and backed each other up in times of trouble. More problematic for some, was the convention that men should stick together and therefore not expose one of their own to critique or censure.

Men have described a very 'blokey' culture in some hospitals.<sup>103</sup> Lake Alice, which was male-only until 1966, and the male wards at Seacliff and Oakley, appeared particularly to sustain 'masculinised' cultures. In an all-male environment, it did not seem unreasonable to dispel with niceties or to use swear language with each other and with the patients. One nurse who worked at Lake Alice commented that, 'Men seemed to have a method of communication, maybe a sort of roughness, getting on together, working as blokes – you could say it was the early stages of teamwork.'<sup>104</sup> The influence of ex-army personnel and the perceived need to contain potentially dangerous patients, no doubt contributed to this way of communicating. The male-only culture extended to the lunch breaks and staff quarters. Male nurses pursued such activities as card playing, smoking and playing pool without risking offending women's sensibilities.

Male nurses' identity as 'workers', rather than 'professionals', remained strong during the 1960s and early 1970s. Doing a fair day's work for fair pay was a priority. Union membership and activity was an important aspect of male nurses' collective working lives. Ideas of professionalism and association with a 'nursing' identity were, however, beginning to take hold. Individual nurses began to question institutional mores and to discuss issues of ethics and psychiatric practice among themselves.<sup>105</sup> The Division took deliberate steps to engage male nurses in professional activities. Men's inclusion in tutoring and in-service education drew them into the 'professional' arena. Under pressure from the Division and from the PSA, the nursing profession finally gave men access to organisational and educational opportunities from the mid-1960s. Men's exposure to such opportunities created a pathway for promotion and status that was associated more with 'professional' than 'worker' ideals. By 1972 men occupied more

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<sup>103</sup> Richard Rillstone, interview 25 March 2004.

<sup>104</sup> Brian Craig interview 29 June 2004.

<sup>105</sup> Adrian Moerenhout interview 11 April 2004.

than half the hospital tutors' positions, including six of the ten senior tutors' positions.<sup>106</sup>

The culture of the female side was also influenced by both gender norms and staffing patterns. Staff turnover was very high and the proportion of experienced, registered nurses was low. Many of the older nurses in positions of responsibility were single, 'career' nurses, but there was a growing number of married women who were charge sisters or matrons. A number were married to psychiatric nurses who also worked at the hospitals. Matrons, tutor sisters, and ward sisters were more likely than the men to identify with the broader nursing profession. A number, for example, were registered (general) nurses and some belonged to the New Zealand Registered Nurses Association (NZRNA). Until 1965, membership was restricted to women. Although few women made psychiatric nursing a career, one nurse commented that 'the ones that did, really did - there were some fabulous nurses who had been there for a long time and were really good women'.<sup>107</sup>

Although female nurses were, on the whole, from working-class backgrounds, they were less inclined than the men to identify strongly with the union. Many women belonged to the PSA, but it was the men who ran the meetings and held most of the committee positions. When industrial action drew the women into more active involvement with the union in the early 1970s, many struggled with the decision to withdraw their labour. The women felt caught between the need to gain improvements for themselves and their patients and their professional belief that going on strike was incompatible with nursing ideals.<sup>108</sup>

Integration of male and female staff exposed cultural differences and disrupted the relative comfort of single-sex environments. Both the men and women found the transition difficult but, in some hospitals, it seemed to be the men who were most reluctant to give up their male-only space. Integration occurred first in the lunchrooms and then in the wards. Male staff lost their separate dining areas in the mid-1960s. In most hospitals, they were required to dine at the nurses' home, an adjustment that was difficult for some. At Seaview, the men insisted for several years, on their right to use

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<sup>106</sup> New Zealand Public Service List, 1972.

<sup>107</sup> Barbara Milne interview 7 September 2005.

<sup>108</sup> Industrial issues are discussed more fully in Chapter VIII.

their own dining room.<sup>109</sup> Men at Seacliff were also reluctant to go to the nurses' home. It was observed, however, that they adjusted quite quickly when they discovered that the meals on the women's side were of superior quality.<sup>110</sup> Many men were also unhappy about the prospect of sharing their workspace with women. In 1966 the introduction of female nurses at Lake Alice was generally opposed by the male staff.<sup>111</sup> In other hospitals, women's presence on male wards was seen as an intrusion. Velda Kelly remembers the patronising attitudes she experienced from some older male nurses when first visiting the men's wards at Sunnyside as a supervisor. She commented, however, that others were welcoming and helped work towards the transition to integrated patient care.<sup>112</sup>

Integration, when it was fully introduced in the early 1970s, brought changes, not just in the wards but in the general culture of the hospitals. On the wards, women found they had to learn to be assertive to stand up to their male colleagues who were often many years their senior. The men had to prove themselves as 'nurses' in order to gain credibility with their female colleagues (practice changes are discussed further in Chapter VI).<sup>113</sup> Outside the wards, the male and female staff socialised together more. Bazley recalled that after integration at Sunnyside, they 'had some great times'. While integration may have given the men greater exposure to nursing ideals, it also exposed women to industrial militancy. As Bazley noted, the women became more outspoken.<sup>114</sup>

***'Dirty work': a culture shaped by association with the stigma of mental illness***

The term 'dirty work' was first used by Everett Hughes in 1951 and further developed in 1958 to refer to occupations that are considered as physically, socially, or morally degrading or disgusting.<sup>115</sup> These occupations are not intrinsically 'dirty' but carry the social construction of 'dirtiness'. The definition can usefully be applied to psychiatric hospital nursing. Physically, the nurses were intimately involved with the socially distasteful aspects of bodily function: toileting, washing and hand-feeding. Socially, they were tainted by their regular contact with stigmatised people; a process known as

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<sup>109</sup> 23 November 1965, H-1, 33794, 30/35/26, ANZ, Wellington.

<sup>110</sup> Richard Rillstone interview 28 April 2004.

<sup>111</sup> Brian Craig interview 29 June 2004.

<sup>112</sup> Velda Kelly interview 26 August 2004.

<sup>113</sup> For more discussion on the effects of integration on practice, see Chapter VI.

<sup>114</sup> Margaret Bazley interview 23 February 2004.

<sup>115</sup> Everett C. Hughes, *Men and their Work*, Glencoe, IL., 1958; Everett C. Hughes, 'Work and the Self,' in *Social Psychology at the Crossroads*, J. H. Rohrer and M. Sherif, eds, New York, 1951, pp.313-23.

‘courtesy stigma’.<sup>116</sup> Morally, psychiatric nurses were expected to control and contain others; tasks which society demanded but also regarded with ambivalence.<sup>117</sup>

Psychiatric nurses’ distinct culture can be understood as having developed, in part, as a response to the social construction of their work as ‘dirty’. Blake Ashforth and Glen Kreiner posit that group members who undertake ‘dirty work’ come to personify the work itself, and therefore become ‘dirty workers’.<sup>118</sup> They suggest that people involved in ‘dirty work’ employ a range of activities to construct a positive collective identity. One of the central strategies is that of social cohesion and the emergence of a strong occupational or work group culture. As discussed earlier, psychiatric nurses developed strong networks that traversed work, sport and social activities. These networks were strengthened by the social isolation engendered by physical distance and shift work.

Other aspects of psychiatric nursing culture can be seen as a product of the nurses’ collective response to their association with ‘dirty work’. For nurses to survive, they had to become resilient and view their work as normal. Orientation of new staff was often used by senior nurses as an opportunity to test a new recruit’s ability to make this transition. Nurses recount stories of how they were exposed to shocking sights or placed in impossible positions. On Althea Hill’s first day at Oakley, the Matron took her on a tour of the wards where the most severely disabled and physically dependent patients lived. Hill reflected that, ‘In retrospect, I think she wanted to shock me to see if I could cope.’<sup>119</sup> John Shennnon clearly remembers his first day at Kingseat. He was sent to a villa for people with severe intellectual disability and behavioural problems. The staff gave him a mop and bucket and asked him if he would mind going into the dayroom while they had handover from the night staff for ten to fifteen minutes. Shennan recalled, ‘Here I am in this big dayroom with no key to get out. I suppose there would have been maybe 40 or 50 people, mostly naked, or in ripped night-attire... There was a huge noise. The smell in the room was unbelievable; many with “shit” caked in their

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<sup>116</sup> The phrase ‘courtesy stigma’ was first coined by Erving Goffman and refers to the stigma experienced by families, friends and health professionals who closely associate with a person of a stigmatised group: Erving Goffman, *Stigma: Notes on the Management of Spoiled Identity*, Harmondsworth, 1963.

<sup>117</sup> In discussing the question of how ‘good people’ could have allowed others to perpetrate atrocities in Nazi Germany, Hughes has suggested that a social process was at play, in which society allowed its dirty work to be done by others but then denied responsibility, and in some cases, denied knowledge or memory of those acts; Everett C. Hughes, ‘Good People and Dirty Work’, *Social Problems*, 10, 1, 1962, pp.3-11.

<sup>118</sup> Blake E Ashforth and Glen E Kreiner, ‘“How can you do it?” Dirty work and the Challenge of Constructing a Positive Identity’, *Academy of Management Review*, 24, 3, 1999, pp.413-34.

<sup>119</sup> Althea Hill interview 10 June 2004.

hair – it was a scene of utter bedlam.’ If this wasn’t bad enough, as Shennan stood with his back to the wall, he noticed a small Maori ‘girl’ was hand-painting the fireplace with faeces and blood. When he went over to intervene, the young woman smiled and moved towards him trying to give him a hug. Shennan recalled that as he was ‘backing off... the staff in the office were “pissing themselves” with laughter. They knew what’s going on. Their ten minutes of smoko turned into three quarters of an hour.’<sup>120</sup>

Psychiatric nurses perceived that they were doing a job that others did not want to do. This appeared to engender a collective identity of being tough but kind. Barbara Milne reflected on her colleagues as a ‘real mixture of women, all different sorts, different backgrounds, usually with a good sense of humour; quite tough – but not in a nasty way... Those nurses cared an awful lot about the patients’.<sup>121</sup> Psychiatric nurses often felt that they were compared to general nurses and found wanting. Their defence was to highlight the things they did that were beyond the understanding or skill of a general-trained nurse. Not only did they feel that they dealt with social and emotional issues better than general nurses, but they also prided themselves in caring for physically-dependent patients more effectively. As Peter Sanders explained, ‘It was a challenge to show that we were better...than the general nurses because we were definitely second grade in those days’.<sup>122</sup>

Humour has been noted as an important coping mechanism amongst people working in harsh environments or where life and death are in balance. Carmen Moran and Margaret Massam, for example, identified humour as a mechanism by which emergency workers reframe their work, release tension and create emotional bonds within their teams.<sup>123</sup> ‘Black’ or ‘gallows humour’ is prevalent amongst groups who work in critical situations or where they experience incongruity. Thomas Kuhlman proposed that black humour is an ‘illogical, even psychotic, response to irresolvable dilemmas and offers a way of being sane in an insane place’.<sup>124</sup> Psychiatric nurses experienced incongruity on a daily basis. Not only were they confronted with unexpected and sometimes extreme situations, but they also experienced a gap between the rhetoric of therapeutic efficacy

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<sup>120</sup> John Shennan interview 10 March 2004.

<sup>121</sup> Barbara Milne interview 7 September 2005.

<sup>122</sup> Peter Sanders interviewed by Margaret Whineray, 13 July 1989 OHInt-0139/1, NERF-PNOHP.

<sup>123</sup> Carmen Moran and Margaret Massam, 'An Evaluation of Humour in Emergency Work', *The Australian Journal of Disaster and Trauma Studies: An Electronic Journal*, 3, 1997.

<sup>124</sup> T.L. Kuhlman, 'Gallows Humour for a Scaffold Setting: Managing Aggressive Patients on a Maximum-Security Forensic Ward', *Hospital and Community Psychiatry*, 39, 10, 1988, p.1085.

and the reality of crowded wards, shortages of staff and the burden of caring for chronically disabled patients.

Psychiatric nurses experienced stress in their daily work. The stresses included the physical demands and long working hours; exposure to some extraordinary sights, sounds, and smells and the emotional burden of working closely with people who were suffering severe psychological distress. The experience of incongruity was an added stressor. Nurses have reflected, for example, on the ‘madness’ of the acute wards in which people with a wide range of problems were thrown together. A person suffering from depression, schizophrenia, or mania could be alongside a transvestite struggling with identity problems, a remand patient awaiting assessment or an adolescent with behavioural issues. Attempting to create a ‘therapeutic environment’ in these conditions created a sense of incongruity.

Nurses found humour in situations that others may consider shocking or tragic. Nurses joked about their work and about each other. Jokes, as one nurse commented, kept them going, ‘without them, many of us would not have survived the journey’.<sup>125</sup> Another interviewee reflected that she considered a sense of humour was an essential part of psychiatric nursing.<sup>126</sup> On the men’s wards the level of humour was, at times, basic. Brian Craig explained that at Lake Alice, the men, ‘used to play jokes on each other, things you wouldn’t do if women were in the vicinity and from time to time, I suppose we were quite earthy, as blokes will be’.<sup>127</sup>

Almost everyone in psychiatric hospitals smoked cigarettes. Smoking was not just a release from stress, it was a way of life. Many people started smoking soon after joining the workforce. It provided a way to relax during the stress or the boredom of a long day and was also a meeting point with patients. Tobacco and cigarettes were also often used by nurses as bargaining tools. Pulutu-Endemann recalled the overpowering noise and smoke in some of the wards at Oakley. ‘That’s when I started smoking. I used to smoke Peter Stuyvesant, then no-one could say I had stolen smokes. I always carried them so I

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<sup>125</sup> *ibid.*

<sup>126</sup> Betty Dracevich interview 30 August 2003.

<sup>127</sup> Brian Craig interview 29 June 2004.

could give them to patients. I could use them to bargain with patients, for example to persuade someone not to take their clothes off.’<sup>128</sup>

Alcohol played a big part in the social lives of many psychiatric nurses and managing the restrictions of six o’clock closing was a surmountable challenge for nurses. Until 1967, pubs were not permitted to stay open past six in the evening. Richard Rillstone described how the Seacliff nurses circumvented the law. ‘You would go into a hotel called Branson’s Hotel in Dunedin. One staff member would book in, and he would be allowed guests. He would have something between 20-30 guests at any given time in the bar.’<sup>129</sup> Mere Balzer explained how Tokanui nurses managed the inconvenience of six o’clock closing. Those who finished work at 3pm would ‘shoot up to the nurses’ home, get changed, and shoot off to the hotel. For every drink they had, they would buy one for their friend who was knocking off at 5.30pm. They [the friends] would get in at about 5.55pm having showered and changed. Then they would knock them [the drinks] all back by the time 6.30pm came and you got kicked out.’<sup>130</sup>

### *A space on the margins and tolerance for difference*

Psychiatric hospitals, by virtue of their position on the fringes of ‘respectable society’ appeared to create a space in which staff members could experience relative freedom to be different. For some, the difference was a problem with alcohol or drugs. For others it was their sexual orientation or counter-cultural lifestyle. By choosing to take up psychiatric nursing, women and men placed themselves in close relationship with a stigmatised group of people. For those nurses who were themselves marginalised, this choice may not have been difficult. Psychiatric hospitals arguably attracted and provided a degree of refuge for people who were already marginalised. A similar phenomenon was noted by Gittins in her study of Severals Hospital in England where one nurse mused, ‘Where better to hide the stigma than in a stigmatised population?’<sup>131</sup>

For some women, the culture of marginality in psychiatric nursing appeared to provide a measure of safety and friendship. Relationships between ‘single’ female nurses had been an accepted, though in many ways hidden, part of psychiatric hospital life for many years. As in other areas of nursing, it was not unusual for unmarried ‘career

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<sup>128</sup> Karl Pulotu-Endemann interview 7 April 2004.

<sup>129</sup> Richard Rillstone interview 25 March 2004.

<sup>130</sup> Mere Balzer interview 1 July 2004.

<sup>131</sup> Gittins, pp.155-6.

nurses' to live together in long-term relationships. The term 'lesbian' was probably not applied either by the nurses themselves, or by others, since it was rarely used as a self-identifying label prior to 1970.<sup>132</sup> Historians of sexuality warn of the danger of imposing a modern construction of lesbian identity onto a previous period. However they note that by not doing so, there is a danger of perpetuating the invisibility of women who partner women.<sup>133</sup> In psychiatric hospitals, the nature of the relationships were often known by others, but not openly talked about. One nurse explained that as a young nurse in the early 1960s, it did not occur to her that the relationship of a matron and her housemate might be more than a friendship. It was not until some time later that she was told that they were partners.<sup>134</sup>

During the 1960s, lesbian sub-culture became a distinct though still not formally acknowledged part of the psychiatric nursing community. Margaret Harraway explained that, 'at Sunnyside, there were a lot of lesbian women. It was 'out' here more than anywhere I had ever been, but it was 'out' in a different way. It wasn't 'out' in the formal classroom, it wasn't 'out' in the curriculum, it wasn't 'out' in the formal social structure, but there was a big group of friends, and it was a big group, who were lesbian women. They did live together and they did socialise together and they were quite a strong force as a group.'<sup>135</sup> Women who identified as lesbian were tolerated by some, though mistrusted or despised by others. Before Mere Balzer transferred from Queen Elizabeth Hospital to Tokanui as a clerical worker, she was warned about the lesbians and homosexuals. Not knowing what the words meant, she consulted first her mother, then her grandmother. On arrival at Tokanui, she was once again warned, this time by the hospital secretary, not to fraternise with the nurses who he considered to be 'not a particularly nice type of people'.<sup>136</sup>

Gay men were not as visible as lesbian women in the psychiatric nursing community of the 1960s. The dominant culture of the male sides was not, on the whole, supportive of sexual difference. This culture in which toughness, sporting prowess, and loyal mateship were valued was also strongly heterosexual. Some hospital communities were

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<sup>132</sup> Alison J. Laurie, 'Lady-Husbands and Kamp Ladies. Pre-1970 Lesbian Life in Aotearoa/New Zealand', PhD thesis, Victoria University of Wellington, 2003.

<sup>133</sup> Alison Oram and Annmarie Turnbull, *The Lesbian History Sourcebook: Love and Sex between Women in Britain from 1780 to 1970*, London, 2001, p.237.

<sup>134</sup> Un-named interviewee.

<sup>135</sup> Margaret Harraway interview 25 August 2004.

<sup>136</sup> Mere Balzer interview 1 July 2004.



less accepting of difference than others. Rillstone recalled, for example, that in contrast to Cherry Farm, Seacliff was a very difficult environment for homosexual nurses. He could think of only one overtly homosexual psychiatric nurse. Two other homosexual (general) nurses who transferred to Seacliff had a very difficult time and did not stay long.<sup>137</sup>

Non-heterosexual nurses worked in professional environments in which their lifestyle was generally portrayed as pathologic. Although psychiatrists had been influenced by the normalising discourses of the Kinsey Report of 1948 that suggested that homosexuality was much more widespread than previously thought, the dominant psychiatric view was that people of homosexual or lesbian persuasion were ‘socially deviant’ and psychologically disturbed. Underpinning this belief was the Freudian view that homosexuality was a sign of arrested personality development.<sup>138</sup> Even those psychiatrists who argued that homosexuality in itself was not a sign of abnormality advocated psychiatric intervention to assist individuals either to change their direction of sexual preference or to learn to adapt better to life in general.<sup>139</sup> Both lesbian and gay nurses lived with the constant reminder that they could be considered psychiatrically unwell. Gay male nurses were, however, in a more tenuous position because homosexual acts were illegal.<sup>140</sup>

By the early 1970s the effects of the gay rights’ movement were being felt in the psychiatric nursing community. The movement had been gathering force in Western countries since the events at Stonewall in New York in 1969. Gay Liberation had its inaugural meeting in Auckland in 1972 and quickly snowballed to Wellington and Christchurch. The movement marked a distinct shift in the politics of homosexuality. By focusing on oppressive structures in society, lesbian and gay activists refused to accept the validity of labels of such as ‘deviance’ or ‘illness’.<sup>141</sup> Politicised psychiatric nursing students openly challenged their tutors on the subject of gay rights. Harraway recalled her experience as a new tutor at Sunnyside. ‘I had a group of students. They would have started round about late 1972-3. Two or three young women in that class

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<sup>137</sup> Richard Rillstone interview 25 March 2004.

<sup>138</sup> Laurence D Guy, *Worlds in Collision: The Gay Debate in New Zealand, 1960-1986*, Wellington, 2002, pp.39-44.

<sup>139</sup> H. Jenner Wily and Kenneth R. Stallworthy, *Mental Abnormality and the Law*, Christchurch, 1962, pp.239-48.

<sup>140</sup> Male homosexual acts remained illegal in New Zealand until 1986.

<sup>141</sup> For discussion on the rise of the gay rights movement in New Zealand, see: Guy, pp.90-104.

who were very outspoken, obviously political, and obviously good thinkers. They objected to things like homosexuality being a psychiatric disorder. They objected to being taught sexuality by a male tutor... At the time, I was the only young woman around so they came into my office and they laid out their feelings ... I was absolutely flummoxed!<sup>142</sup>

Psychiatric nursing in the late 1960s and early 1970s became a 'refuge' for people who had dropped out of university or were exploring a counter-cultural lifestyle. They were part of a generation that was testing the boundaries and questioning society's norms. Tilly Lloyd, for example, described many of her classmates as being 'drop-outs from varsity, counter-culture'. They were much older than her, and had had experiences such as being involved in producing *Mushroom Magazine*.<sup>143</sup> Lloyd remembers that she and her classmates lived 'on the edge' by doing such things as going mixed flatting when it was frowned on, taking drugs, and engaging in philosophical discussions about the meaning of life.<sup>144</sup>

In 1972, having dropped out of university John Shennan decided to apply for a casual job at Kingseat, while waiting for employment as a ship's hand. He and a friend took the bus out to the hospital after taking 'rather a large amount of speed'. By the time they got to the hospital, they were 'really quite high'. Shennan and his friend were flabbergasted by their tour of the male wards, especially by the sights and sounds of the people with severe intellectual and physical disabilities. His friend took one look at the 'bizarrely configured' people and took off, but Shennan was fascinated. He signed up immediately as a psychiatric assistant. He later reflected that, 'It was never a conscious decision to become a nurse. Once I got the job...when the next class came up, I thought, 'why not?' Several months later, when he was offered a place on a ship going to Canada, he decided that he was enjoying himself so much at Kingseat, he would stay.<sup>145</sup>

## Conclusion

Staffing patterns and the culture of psychiatric nursing began to change during the 1960s and early 1970s. Changes in the psychiatric nurses' role and identity attracted

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<sup>142</sup> Margaret Harraway interview 25 August, 2004.

<sup>143</sup> *Mushroom: A Magazine for Alternative Life Styles* was published in Christchurch between 1974 and 1985.

<sup>144</sup> Tilly Lloyd interview 9 April 2004.

<sup>145</sup> John Shennan interview 10 March 2004.

different types of recruits including increasing numbers of women interested in a professional career and fewer men from union and working-class backgrounds. The average age of recruits decreased. The stigma of mental disease and the marginalisation of those associated with care of the mentally-ill remained. To be a psychiatric nurse continued to be an 'accidental affair'. The culture of psychiatric nursing, with its close-knit communities and unusual tolerance of difference, retained its distinctive identity into the 1970s.

Staffing patterns and the culture of psychiatric nursing were associated with the professional and therapeutic developments of the period. Although most psychiatric care remained located in large public institutions, the focus of care moved from custody and containment to treatment and rehabilitation. The focus of nursing care moved from a reliance on physical strength and manual dexterity to development of listening skills and therapeutic interactions; from maintaining hospital farms to facilitating interpersonal relationships. Chapter VI explores these changes in psychiatric nursing practice.

## **Chapter VI**

### **Psychiatric Nursing Practice 1960 – 1972**

‘A nurse who has a specific responsibility for establishing and using therapeutically his relationship with a group of patients must be given every opportunity to get on with the job’.<sup>1</sup>

Between 1960 and 1972, psychiatric nursing practice became increasingly defined as an interactive therapeutic process with patients. Successful pharmaceutical treatments and changes to mental health policy and legislation created an environment in which a therapeutic role for nurses could be envisaged. In reality, nursing practice was slow to change. Hospital conditions, the nature of patient populations, and demands for basic physical work prevented wholesale adoption of therapeutic practices. It was not until the late 1960s that there were opportunities for substantial change. These included the nurses’ refusal to continue doing ‘non-nursing’ tasks, isolated instances of psychiatric hospital reform, the movement to general hospital and community care, and the amalgamation of male and female wards.

#### **Reconceptualising the psychiatric nurses’ role**

During the 1960s, the psychiatric nurses’ role was conceptually redefined as therapeutic rather than custodial. Influenced by international nursing literature, tutor sisters taught the concepts of interpersonal relationship as being fundamental to the nurses’ role.<sup>2</sup> Student nurses learned about the value of interpersonal skills and how to apply them with different types of patients and in various circumstances. Psychology was included as a subject in the curriculum as it was believed important for nurses to gain a better understanding of themselves and their patients. They learned the importance of treating people as individuals and that their duty was to assist patients to ‘regain self-confidence and self-respect’, develop ‘better relationships and tolerance of others’ and ‘face up to problems and demands of everyday life’.<sup>3</sup>

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<sup>1</sup> AJHR, 1969, H-31, p.80.

<sup>2</sup> Hildegard Peplau was particular influential in promoting interpersonal skills as the core attribute of psychiatric nursing practice: Peplau.

<sup>3</sup> Notes from psychiatric nursing class, 1959-1961, Peggy Edge personal papers.

The Division supported senior nurses' adoption of interpersonal skills. Communication skills and the nurse/patient relationship were a major focus of courses offered for matrons, head nurses, charge nurses and tutors.<sup>4</sup> By 1964, the concepts appeared to have been accepted, at least in principle, within the hospitals. A male journalist, who spent two weeks at Ngawhatu working as a nurse, reported that '...today's psychiatric nurse has a need for the exacting skills of personal relationship which is increasingly being identified and valued as an essential part of the job'.<sup>5</sup>

Anthony O'Brien, in his article on the historical development and significance of the therapeutic relationship in New Zealand, convincingly argues that psychiatric nurses' roles were redefined as therapeutic during the mid-twentieth century. His suggestion that this redefinition marked a break with custodial care in the 1960s, however, is not supported by the findings of this thesis.<sup>6</sup> Although the language changed, aspects of custodial care continued into the 1970s. Successful transition from custodial to therapeutic practice depended on a number of factors. While some changes in the psychiatric hospital environment, such as new treatment approaches, supported the nurses' adoption of therapeutic roles, other conditions, such as patient demographics and shortages of staff, were inhibitive.

### **Changing therapeutic approaches**

A therapeutic role envisioned for psychiatric nurses was compatible with broader developments occurring in psychiatry. New medications and the efficacy of somatic treatments gave the hope that hospitals could become places of treatment and rehabilitation rather than long-term custodial care. Hospitals attempted to alleviate the effects of institutional incarceration by allowing greater freedom and individualising care. Patients' rehabilitation, links with the outside community, and early discharge were also considered important.<sup>7</sup> Although, theoretically, these developments called for a more therapeutic role for nurses, in practice, this was not always the case.

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<sup>4</sup> For example, see the course programme for charge nurses and sisters, 15-19 July 1963, DAHI, Acc D266 357f, 6/26/4, ANZ, Dunedin. These latter courses are discussed further in Chapter VII.

<sup>5</sup> *Dominion*, 24 October, 1964, p.6.

<sup>6</sup> O'Brien, 'The Therapeutic Relationship', pp.133-4.

<sup>7</sup> This period of psychiatric hospital care has been described by Warwick Brunton as a form of deinstitutionalisation: Warwick Brunton, 'Deinstitutionalisation: A Romance for all Seasons', paper presented at *The Future of Mental Health Services in New Zealand conference*, Auckland 1986.

## *Medications*

By the 1960s, new psychiatric medications were having a significant impact on the clinical context in which nurses practised.<sup>8</sup> Chlorpromazine and other phenothiazine derivatives were extensively used as antipsychotic tranquilizers for a wide range of patients. Their effects on individual behaviour and the general tone of the more ‘disturbed’ wards were profound. Many patients lost their most disturbing symptoms and became more amenable to interaction and efforts of rehabilitation. Others became less impulsive and violent. A nurse, who worked at Porirua during the 1950s and 1960s, described the transformation of one particular woman as a ‘miracle cure’. The patient had previously worked in the hospital kitchens where she would ‘talk to the pots and throw them around’. On the new medication she improved sufficiently to leave hospital and hold down a job in the community.<sup>9</sup> For nurses working with potentially violent patients, chlorpromazine was seen as a ‘godsend’.<sup>10</sup>

Anti-depressant medications also came into common use in both psychiatric hospitals and in the community. Imipramine and Nardil were some of the first to be used in New Zealand. Both brought some relief of symptoms but also had serious side effects. They were soon followed by Amitriptyline which was found to be somewhat less problematic in terms of side-effects and toxicity.<sup>11</sup> Although they gradually reduced the use of electro-convulsive therapy (ECT) in psychiatric hospitals, anti-depressants were not considered as effective, particularly for people with serious depressions.<sup>12</sup> Side effects and possible toxicity from overdose were also considered reasons for caution against over prescribing.<sup>13</sup>

The proliferation of new medications was by no means experienced as an entirely positive phenomenon for patients, nurses or medical practitioners. The phenothiazines,

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<sup>8</sup> A wide range of drugs were trialled during the early 1960s. Five drug trials, for example, were undertaken at Porirua in 1960 and several were undertaken at Seaview Hospital in the early 1960s: AJHR, 1961, H-31, p.68 and 1964, H-31, p.66.

<sup>9</sup> Williams, p.215.

<sup>10</sup> Brian Craig interview 29 June 2004.

<sup>11</sup> AJHR, 1960, H-31, p.66. For overview of development of anti-depressants, see: Joseph A Lieberman III, 'A History of the Use of Anti-depressants in Primary Care', *Primary Care Companion to Journal of Clinical Psychiatry*, 5, Supplement 7, 2003.

<sup>12</sup> Following a trial of Amitriptyline at Kingseat in 1962, for example, the researchers concluded that ECT was still the treatment of choice for those admitted to hospital: NZMJ, 363, 1962, pp. 548-50.

<sup>13</sup> General practitioners were warned against taking ‘undue risks’ with prescribing anti-depressants rather than referring their patients to psychiatrists for ‘the most effective form of therapy’: NZMJ, 373, 1963, pp.407-9.

in particular caused worrying side effects. Patients were often heavily sedated, and many found that their skin became very sensitive to sunlight. Nurses soon discovered that they had to take care that their patients were kept out of the sun. Other more serious side-effects included agranulocytosis (reduction in white blood cells) and dystonia (facial stiffness and grimacing). Some psychiatrists and nurses were not convinced about the merits of wholesale use of tranquilizers. There was concern that over-reliance on the use of sedation might simply mask symptoms and result in patients being discharged before they were ready.<sup>14</sup>

A shortage of psychiatrists and other doctors meant that the standard of prescribing and monitoring of medications was variable. There was often only one doctor for several wards.<sup>15</sup> Those who were available were not necessarily qualified for the specialist work. In the early days of the new medications, it was not uncommon for a ward charge or matron to prescribe drugs without medical approval. Both doctors and nurses at times overused the medications. Nurses recall their concern about patients being unnecessarily sedated or suffering from the combined effects of multiple medications.<sup>16</sup> Others remember the occasional ward charge creating their own cocktail of medications for new patients.

### ***ECT and other somatic treatments.***

Electro-convulsive treatment (ECT) introduced in the 1940s, continued to be in common use, particularly for severely depressed patients and for the seriously disturbed. Its use, however, diminished as anti-depressants came on stream. Medical staff began to view ECT as an adjunctive treatment to medications, occupational therapy, recreation and talking therapies, rather than as a primary treatment in its own right.<sup>17</sup> Most hospitals, however, continued to provide ECT at least three times a week. Administration protocols for ECT were tightened, at least on some admission wards. At Tokanui, for example, rather than treating everyone in the dormitory by moving between screened beds with the ECT trolley, a separate treatment room was set up and

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<sup>14</sup> AJHR, 1960, H-31, p.77.

<sup>15</sup> Several interviewees talked about the difficulties of medication prescribing because of the shortage of doctors. For example: Mere Hammond interview 16 April 2004; Barbara Milne interview 7 September 2005.

<sup>16</sup> Peter Sanders interviewed by Margaret Whineray, 13 July 1989, OHInt-0139/1, NERF-PNOHP.

<sup>17</sup> Oakley Hospital Annual Report, 1964, p.3, YCAA, 1081, 22c, ANZ, Auckland.

patients taken for treatment one by one.<sup>18</sup> Many nurses, reflecting on this period, expressed the opinion that ECT was an effective treatment for severe depression and recalled instances when patients experienced dramatic improvement after a course of treatments.

Many nurses, who worked at this time, however, believed that ECT was overused and in some cases used inappropriately. Althea Hill recalled that on the disturbed wards at Oakley Hospital, it seemed that ‘too many patients were given ECT including people with long-term schizophrenia’.<sup>19</sup> Nurses expressed discomfort about the ‘mass-produced’ manner in which it was administered on these wards.

The trolley would come out - we administered the shots as a second-year nurse. A doctor, not a trained psychiatrist - there were very few of them - ... gave the IV anaesthetic and muscle-relaxant. And we would come along and just ‘bang’ in one room, then the next room, ‘bang’.... At least 10 one after the other... We would roll them [the patient] on their side and leave someone with them.<sup>20</sup>

Modified insulin therapy, also introduced during the 1940s, continued to be used in some hospitals, as was abreaction therapy.<sup>21</sup> From the mid-1960s, some psychiatrists also experimented with deep narcosis and some with Lysergic Acid (LSD) which was used to enhance psychotherapy. Since LSD was associated with illegal drug-taking in the community, its use in psychiatry was controversial.<sup>22</sup> These therapies, however, do not figure prominently in accounts from nurses who worked in psychiatric hospitals during this period.<sup>23</sup>

### ***Psychotherapy***

Psychotherapy was offered to a narrow range of patients in particular settings. Voluntary patients suffering from neuroses or ‘life stress’ were sometimes treated in admission wards and receiving homes with individual and group psychotherapy. These approaches were also applied in day hospitals as they became established.

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<sup>18</sup> Bob Elliott interview 2 June 2004.

<sup>19</sup> Althea Hill interview 10 June 2004.

<sup>20</sup> *ibid.*

<sup>21</sup> 24 November 1966, memo to Medical Superintendent, Tokanui Hospital, YCBG, 5929, 16b, ANZ, Auckland.

<sup>22</sup> Distribution of LSD was legally restricted to members of the Australian and New Zealand College of Psychiatrists: David Livingstone, ‘Some General Observations on the Usefulness of Lysergic Acid in Psychiatry’, *NZMJ*, 65, 410, October, 1966, p.659.

<sup>23</sup> One interviewee reported having seen sleep therapy at Ngawhatu. Another understood that LSD was used but did not witness it.



Psychotherapeutic techniques were more commonly applied at Ashburn Hall, which was still the only private psychiatric hospital in New Zealand, and Queen Mary Hospital at Hanmer Springs, which treated people with neurotic disorders and addictions. From the late-1960s, psychiatric units attached to general hospitals offered a wide range of therapies, including psychotherapy.

Nurses' involvement with psychotherapy was more the exception rather than the rule in the early 1960s. It was largely considered to be in the practice domain of psychiatrists and psychologists. Both professions, however, were too thinly spread in public psychiatric hospitals to do in-depth therapy with many patients. Edwin Hall, the medical superintendent of Sunnyside Hospital, however, proffered the opinion that 'the part played by nursing staff in this form of treatment is of great importance and not given the recognition it deserves'.<sup>24</sup> He probably referred to the nurses' daily contact with patients, rather than a formal role.

### *Therapeutic use of the hospital environment*

In the early 1960s, psychiatric hospital medical superintendents placed great store in the therapeutic value of the hospital environment.<sup>25</sup> They attempted to achieve greater freedom, encourage patients to be self-reliant, and provide more recreational and rehabilitative activities. Hospitals generally followed an 'open door' policy, where they considered it was safe.<sup>26</sup>

Hospitals prided themselves on providing recreational, occupational and social activities.<sup>27</sup> Greater connection with the outside community was encouraged. Recreation officers were employed to organise sports, outings and film evenings. Concerts were a popular item at some hospitals. Oakley, for example, prided itself on their annual concerts like the one featured in Figure 22 below. Consideration was given to patients' spiritual needs. Chaplains were appointed at most hospitals and chapels built with the assistance of local funding. Nurses helped organise social events, accompanied patients to dances and outings and often ran sporting activities. Male nurses, in particular, took

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<sup>24</sup> AJHR, 1965, H-31, p.63.

<sup>25</sup> The term, 'therapeutic community' was used to describe the type of environment they were trying to achieve. This did not bear much relationship to the therapeutic communities established in British hospitals during the 1940s and 1950s: AJHR, 1961, H-31, p.58.

<sup>26</sup> In 1960, for example, 14 of the 18 wards at Tokanui were completely open during the day: AJHR, 1960, H-31, p.82.

<sup>27</sup> For example, see: Oakley Hospital Annual Report, 1964, p.5, YCAA, 1081, ANZ, Auckland.

an active role in organising sports events with external clubs. Winston Maniapoto, for example, organised an activity programme for male patients at Tokanui in the early 1960s. He taught the patients ball-handling skills and arranged for one of his relations to bring a rugby team to play against them. When the men's skills had improved, the new players challenged a team from Waikeria Prison. Matches were played at both the hospital and the prison.<sup>28</sup>



**Figure 22 Patients' concert, Oakley Hospital, 1960s.**  
Source: Personal collection.

Introduction of television in the early 1960s was arguably the recreational innovation most appreciated by patients and nursing staff, particularly on the closed wards. Oakley installed TV sets in six wards in 1961 and other hospitals followed suit over the next few years. B.D. Hart, the medical superintendent of Porirua Hospital, commented that, 'Over the years I know of no amenity which has been added to this hospital which has been more appreciated by the residents. Its therapeutic value is also not to be ignored.'<sup>29</sup> Nurses noticed TV had a soothing affect on patients. The number of fights between patients reduced substantially and people had something to do rather than 'just walk round and round'.<sup>30</sup>

Despite restrictions on central funding, attempts were made to modernise buildings and to provide new therapeutic and recreational facilities. Hospitals undertook their own repainting, carpeting and curtain-making. Senior nurses were sometimes able to make

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<sup>28</sup> Winston Maniapoto interview 10 August 2004.

<sup>29</sup> AJHR, 1964, H-31, p.65.

<sup>30</sup> Peter Sanders interviewed by Margaret Whineray, 13 July 1989, OHInt-0139/1, NERF-PNOHP; Mere Hammond interview 16 April 2004.

improvements at a ward level. Miss Allison, the Matron of the Seacliff Hospital Group, was known for her staunch insistence of standards of physical care and occupation. She insisted that all (female) patients were provided with their own clothing, wards were furnished with new carpets and drapes, and patients were kept occupied – oftentimes with playing bowls, which was a favourite game of hers.<sup>31</sup> Some male charge nurses also had reputations for doing what they could to maintain the physical appearance of their wards. Charge Nurse Todd at Porirua was remembered not only because he modelled tolerance for ‘people as people’ but also for doing everyday maintenance, such as sewing the torn curtains when they were not able to be replaced.<sup>32</sup>

Changing views on the ‘proper function’ of psychiatric hospitals were reflected in the 1963 edition of the Ethics and Rules of Conduct for Staff.<sup>33</sup> The Division suggested that patients should be given greater liberty, individual care and opportunities for self-determination. Concerns for safety had not, however, been discarded. Nurses were reminded that some psychiatric patients were unable to protect themselves from natural hazards and others would ‘actively seek danger’.<sup>34</sup>

### *Therapeutic use of work*

Occupation of one sort or another was still highly valued in the early 1960s. For those patients who were able-bodied, work was considered the ideal. Hospitals reported annually on the numbers of patients actively engaged in work or some other occupation. In 1964 at Oakley Hospital, for example, more than a third of male patients and approximately a quarter of female patients worked around the hospital.<sup>35</sup>

A considerable portion of the psychiatric nurses’ time was taken with work supervision or with the work itself. For the women, this largely entailed hours of domestic work. Male nurses continued to take work gangs out to the farms and gardens. In 1964 at Tokanui, for example, eleven male nurses supervised work gangs each day. Some did gardening, some farm work; others were on the excavator gang or on special projects.<sup>36</sup>

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<sup>31</sup> Margaret Bazley interview 29 January, 2004.

<sup>32</sup> Peter Sanders interviewed by Margaret Whineray, 13 July 1989, OHInt-0139/1, NERF- PNOHP.

<sup>33</sup> Health Department Division of Mental Health, *Ethics and Rules of Conduct for Staff*, Wellington, 1963.

<sup>34</sup> *ibid.*, p.3.

<sup>35</sup> Oakley Hospital Annual Report, 1964, p.8, YCAA, 1081, 22c, ANZ, Auckland.

<sup>36</sup> Medical Superintendent Tokanui Hospital to Director of Mental Health, 15 May 1964, YCGB, 5929, 16b, ANZ, Auckland. At Oakley, 13 patients were employed daily on the farm and 60 - 70 patients worked in the gardens supervised by seven nurses: Oakley Hospital Annual Report, 1964, p.14, YCAA, 1081, 22c, ANZ, Auckland.

As late as 1968, when Wi Keelan started his nursing training at Porirua Hospital, he experienced a pattern of work on the ‘refractory’ ward that had not changed for many years.

Every morning, one of the head nurses would come down and stand outside the gate and yell out, “Work Gang”. There was a huge bullring where everyone used to congregate.... He and the charge nurse would call out the staff member who was in charge of each gang. That staff member would come out with his list and would read his list out. Then, one by one, the patients would go out.<sup>37</sup>

The number of patients who were able-bodied and available for hospital work reduced considerably during the 1960s. This was largely the result of the efficacy of treatments and changing patterns of admissions and discharge. Hospital work also became less acceptable as a therapeutic approach. As a result, hospitals experienced difficulties sustaining some indoor and outdoor maintenance tasks; the burden of work fell to nurses to pick up.<sup>38</sup>

### ***Rehabilitation***

Efforts to support patient rehabilitation and discharge intensified during the 1960s.<sup>39</sup> It was no longer considered acceptable, for example, for occupational therapists to merely ‘occupy’ patients in craft sessions. They were instead to engage patients in activities ‘more closely related to the demands of the workaday world’.<sup>40</sup> Oakley Hospital led the way with establishing an industrial unit to teach work skills and a domestic unit to retrain women in home-making skills.<sup>41</sup>

Industrial therapy units were established in most hospitals.<sup>42</sup> These were usually supervised by occupational therapists. Patients were able to earn a small allowance in return for simple, usually repetitive, work on manufacturing or packaging contracts. One unexpected outcome of the establishment of industrial therapy units was that long-term patients chose to do this work rather than continue working unpaid on the

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<sup>37</sup> Wi Keelan interview 26 July 2004.

<sup>38</sup> See, for example: Oakley Hospital Annual Report, 1964, p.14, YCAA, 1081, 22c, ANZ, Auckland.

<sup>39</sup> AJHR, 1964, H-31, p.62.

<sup>40</sup> AJHR, 1963, H-31, p.65.

<sup>41</sup> Oakley Hospital Annual Report, 1961, p.3, YCAA, 1081, 22c, ANZ, Auckland.

<sup>42</sup> AJHR, 1968, H-31, p.71.

household tasks or outdoor maintenance. The pool of available workers was thus further reduced.<sup>43</sup>

Occupational and industrial therapy contributed to a shift in the nurses' role. Their role in the occupational or industrial therapy units was often little more than a minder; they were there to keep the therapist safe. Nurses often felt that they carried the brunt of basic patient care without the opportunity to contribute to more therapeutic activities. As one nurse reflected, 'They [the occupational therapists] were a specialised unit ... We always thought of ourselves as the ones who did the work and if any dirty work had to be done, it would come back to us'.<sup>44</sup>

Social workers were increasingly employed to assist with the processes involved in discharge. Numbers employed in mental hospitals grew from seven in 1959/60 to 35 in 1972. Social workers assessed patient's support networks, provided the links between hospital and families, and organised work trials in the community for patients prior to discharge. At many hospitals, they also established clubs for patients.<sup>45</sup> At Oakley Hospital, for example, the social workers hosted the Adelphi Club for ex-patients, the Philadelphia Club for adult inpatients, and the Friendship Club for inpatients over sixty-five.<sup>46</sup>

Follow-up of patients on trial leave or discharge became a priority of psychiatric rehabilitation. During the early to mid-1960s, this did not generally involve psychiatric nurses. Social workers or public health nurses visited those living too far away to attend outpatient clinics.<sup>47</sup> Tokanui Hospital provided training for public health nurses for this purpose. Seaview Hospital which had difficulty recruiting a social worker had to rely on general practitioners and district nurses to report on the progress of ex-patients.<sup>48</sup>

By the mid-1960s, it was clear that more intensive strategies were required to support long-term patients who were being moved out of hospital. Many suffered from the effects of institutionalisation and needed substantial support to regain confidence and living skills. One solution was to establish supported accommodation. The first hostel

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<sup>43</sup> Report on Staffing at Kingseat Hospital, 27 July 1969, H-1, 45588, 39/5/9, ANZ, Wellington.

<sup>44</sup> Barbara Milne interview 7 September 2005.

<sup>45</sup> For description of the work of one psychiatric social worker, see: KT, 40, 8, 1962, pp.7-9.

<sup>46</sup> Oakley Hospital Annual Report, 1964, p.15, YCAA, 1081, 22c, ANZ, Auckland.

<sup>47</sup> AJHR, 1962, H-31, p.70.

<sup>48</sup> AJHR, 1964, H-31, p.65-6.

for people with psychiatric illness had been established in Tinakori Rd in Wellington in 1961. ‘Connor House’ for women was named after Rose Connor, the Matron of Porirua. Over the next few years two men’s hostels were established close to Porirua Hospital.<sup>49</sup> Hostels were also established by other psychiatric hospitals.

### ***Outpatient care***

During the 1960s, the Division increased its efforts to provide outpatient care. This was facilitated by the 1961 Amendment to the *Mental Health Act* which allowed mental hospitals to use their facilities for non-residential care. Most hospitals quickly opened outpatient clinics for voluntary patients, these supplementing clinics already being offered at general hospitals and other sites. Attendances at outpatient clinics grew rapidly over the next few years.<sup>50</sup>

Sunnyside opened a day hospital in 1963.<sup>51</sup> It was staffed by one registered nurse, two assistant nurses, one occupational therapist, a cook and a domestic. Patients attended from 9am till 5pm. The day started with ECT treatments and then continued with group discussions, crafts, exercises and outings. Individual therapy depended on the availability of a senior psychiatrist. The programme offered a very different approach from most inpatient care which presumably allowed for a more flexible role for the registered nurse.<sup>52</sup>

Although day programmes were offered at a number of hospitals, they were considered ‘expensive’ in terms of staff time because they ideally offered intensive therapeutic programmes. It was assumed that therapeutic input would come from ‘senior staff’, that is, psychiatrists and psychologists. For this reason, and because of lack of accommodation, other hospitals were slow to develop comprehensive day hospital programmes.<sup>53</sup>

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<sup>49</sup> Williams, pp.258-9.

<sup>50</sup> AJHR, 1964, H-31, p.58.

<sup>51</sup> *ibid.*, p. 57.

<sup>52</sup> Nurse Inspector, Hospital Inspection Report, November 1963, p.9, H-1, 41804, ANZ, Wellington.

<sup>53</sup> AJHR, H-31, 1963, p.60, 1965, H-31, p.58.

## Effect of hospital demographics on nurses' practice

### *Demographics: hopeful change but continuing challenges*

Changing demographic trends created a sense of hope for hospital administrators and clinical staff. Between 1960 and 1972, the number of people in psychiatric hospitals fell from 418.9 to 322.2 per 100,000 population (see Appendix G).<sup>54</sup> Admission and re-admission rates increased and from 1959, voluntary admissions outnumbered those under committal.<sup>55</sup> Average lengths of stay, particularly for first admissions, declined.<sup>56</sup> This trend was accelerated by changes to the Mental Health Act. From 1962, voluntary patients were only required to give 24 hours notice of their intention to leave hospital instead of the previous seven day's notice.<sup>57</sup>

The proportion of middle-aged and elderly patients decreased as did the number of people with schizophrenia, 'psychoneuroses' and senility.<sup>58</sup> For those diagnosed with the disorders in the 'schizophrenia group', the reduction appeared to be related to the efficacy of medications and more active rehabilitation (see Figure 23 for chart showing changes in diagnostic categories). In the case of the elderly, the reduction related to legislative changes and admission procedures. The 1961 amendment to the *Mental Health Act* allowed for informal admission of mentally infirm (senile) people. Initially, this resulted in higher numbers of elderly patients but mental hospital administrators soon realised that they were no longer obliged to take every elderly referral. They limited numbers of admissions and established waiting lists. Between 1961 and 1971, the proportion of patients with a diagnosis of senile or pre-senile dementia dropped from eight percent to five percent of the psychiatric hospital population.<sup>59</sup> The changes reflected the Department of Health's policy of accommodating senile patients in rest homes rather than psychiatric hospitals.<sup>60</sup>

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<sup>54</sup> National Health Statistics Centre (NZ), *Mental Health Data 1973*, Wellington, 1973, p.5.

<sup>55</sup> AJHR, 1960, H-31, p.77.

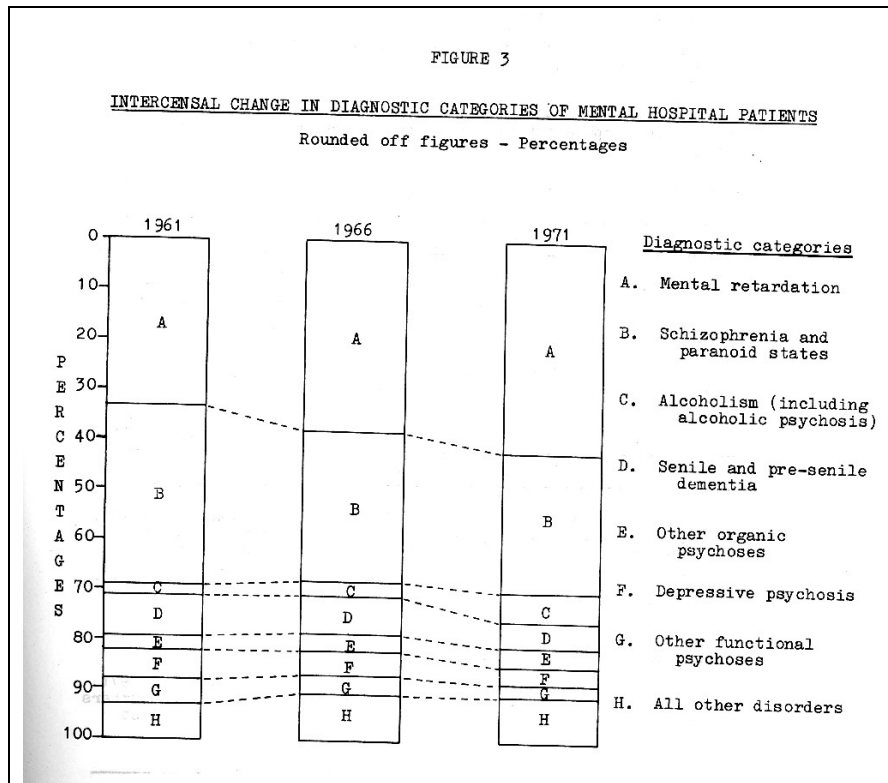
<sup>56</sup> By 1969, three out of every four new admissions were discharged within three months: National Health Statistics Centre, *Mental Health Data 1969*, Wellington, 1969, p.2.

<sup>57</sup> AJHR, 1963, H-31, p.58. Between 1961 and 1966, the proportion of patients who stayed in hospital for less than one year doubled from 11 percent to 23 percent: AJHR, 1967, H-31, p.73.

<sup>58</sup> National Health Statistics Centre (NZ), p.3.

<sup>59</sup> Department of Health National Health Statistics Centre, *Census of Mental Hospital Patients 1971*, Wellington, 1971, p.10.

<sup>60</sup> *ibid.*, pp.12-4.



**Figure 23 Diagnostic categories of mental hospital patients, 1961, 1966, 1971.**  
Source: National Health Statistics Centre, Department of Health, Census of Mental Hospital Patients, 1971, p.11.

Although rates of admission decreased, overall patient numbers continued to increase until 1965 (see Appendix G). Overcrowding remained a problem in some hospitals. In 1967 the Division estimated that its hospitals were overcrowded by approximately 800 patients. Certain types of patients became more commonly represented in psychiatric hospitals. Numbers of mentally retarded, adolescents, people referred from the courts and alcoholics all rose during the 1960s. Elderly people still comprised a significant proportion of the hospital population. Insufficient specialised accommodation or prior screening and classification sometimes resulted in patients being thrown together in less than ideal situations. The specialist needs of particular patient groups often clashed with the overall therapeutic direction of wards or hospitals.

### *Intellectual disability and elderly infirm*

Numbers of mentally retarded people in the division's institutions grew substantially during the 1960s. This was largely as a result of the implementation of policies



recommended in the 1953 Aitken Report.<sup>61</sup> Despite strong criticism from the New Zealand Branch of the British Medical Association, the Division pursued Aitken's recommendation that mentally subnormal children should be accommodated in large, separate institutions.<sup>62</sup> Mental deficiency colonies were renamed 'psychopaedic hospitals' and, at a local level, separated administratively from psychiatric hospitals. Templeton was separated from Sunnyside in 1960 and Nelson Mental Hospital was renamed 'Braemar Hospital and Training School' in 1962 and separated from Ngawhatu Hospital.<sup>63</sup>

Despite the growth in psychopaedic institutions, a large number of mentally retarded children and adults remained in psychiatric hospitals. Many were profoundly disabled or had concomitant psychiatric or behavioural problems that were considered difficult to manage in environments designed for children.<sup>64</sup> In some regions growth in demand for psychopaedic beds far outstripped the building programmes. Delays commissioning a facility in the Auckland area created particular challenges; the first villas at Mangere Hospital and Training school were not opened until 1966.<sup>65</sup> In the meantime Kingseat and Tokanui Hospitals took most of the admissions from the Auckland region. By 1971 there were 2,170 mentally disabled people in psychiatric hospitals. This was more than a quarter (27.86%) of the total psychiatric hospital population.<sup>66</sup>

What remained a significant issue in relation to nursing practice was the large number of physically dependent patients. The elderly, for example, still comprised a significant proportion of the mental hospitals' population. In 1971 one-fifth (2,076) of the patients in psychiatric hospitals were over the age of 65. Senility and pre-senility, at just over five percent, was the third leading diagnostic group in psychiatric hospitals. Although their numbers were reducing, this group of patients still required intensive physical and supervisory care. 'Custodial' care was still very much needed.

Intellectually disabled and elderly patients required intensive physical care. Nurses recall the interminable bathing, toileting, and feeding. Urinary and faecal incontinence

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<sup>61</sup> Consultative Committee to the Minister of Education, *Intellectually Handicapped Children Report*, Wellington, 1953.

<sup>62</sup> NZMJ, 58, 323, 1959, pp.83-108.

<sup>63</sup> AJHR, 1960, p.79, 1963, H31, p. 64.

<sup>64</sup> NZMJ, 58, 1959, pp.571-7.

<sup>65</sup> AJHR, 1967, H-31, p.74.

<sup>66</sup> Calculated from 1971 statistics: National Health Statistics Centre, *Census of Mental Hospital Patients 1971*, p.25.

were a major challenge in many of the long-term wards. Nurses never forgot the sights, smells and noises. Peter Sanders described how he avoided walking through a particular ward after he had been on a month's holiday. Having become unaccustomed to the smell, it made him dry-wretch as it hit him again.<sup>67</sup> Althea Hill, who started work at Oakley Hospital in 1968, has vivid memories of struggling to manage severely psychotic, faecally-incontinent women at Park House at Oakley Hospital. 'I washed my hands all day long. We also wore gowns that we took off when we went over to have meals, but sometimes I used to go home and bath in Dettol and I never wore my shoes inside.'<sup>68</sup>

Managing the physical care of large numbers of dependent patients was challenging. Hill recalled conditions in the geriatric ward.

They (the women) sat in their wheelchairs in two rows ...don't get me wrong, they were kept clean, but the toileting regime wasn't rigid enough and they would just wet themselves sitting in their chairs all the time...You would just look for the next puddle of urine under them and clean them up until the next puddle of urine – you were going flat out the whole day. Then the meals came and you would line the meals up and one nurse would feed about eight mouths, one mouthful after another, then back...<sup>69</sup>

### ***Court referrals, alcohol and drug addicts, adolescents***

Psychiatric hospitals began to admit certain types of patients who had previously not been represented in the hospital population, or had only been present in very small numbers. This included people referred through the justice system, patients for whom addiction was their primary diagnosis, and adolescents with emotional and behavioural problems. Each group posed unique challenges in terms of nursing care.

Increasing numbers of people were remanded to psychiatric hospitals from the courts for assessment. Admissions of remandees grew from 14 (13 men and one woman) in 1955, to 595 (518 men and 77 women) in 1966.<sup>70</sup> Because these patients were not primarily hospitalised for treatment purposes and did not necessarily suffer from mental

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<sup>67</sup> Peter Sanders interviewed by Margaret Whineray, 13 July 1989, OHInt-0139/1, NERF-PNOHP.

<sup>68</sup> Althea Hill interview 10 June 2004.

<sup>69</sup> Althea Hill interview 10 June 2004.

<sup>70</sup> National Health Statistics Centre, *Mental Health Data*, 1960, p.7 and 1966, p.14.

illnesses, they created particular challenges for medical and nursing staff.<sup>71</sup> Nurses complained about problems with remandees such as the risk of violence, potential influence on other patients and possibilities for absconding. Remand patients were not usually treated so nurses were not able to manage symptoms or behaviours with medication.<sup>72</sup>

Under Section IV of the Mental Health Act, a person found ‘not guilty on the grounds of insanity’ could be committed to a psychiatric hospital, as could someone who was unable to plead because of insanity. Prisoners who developed certifiable mental disorders could also be transferred to mental hospital.<sup>73</sup> Between 1964 and 1966, Section IV admissions rose from 341 to 642 per annum.<sup>74</sup> Most ‘security patients’ were managed in locked wards in urban hospitals; the majority were sent to Auckland Mental Hospital in the North Island or Seacliff Hospital in the South.<sup>75</sup> The presence of security patients in these hospitals undermined attempts to introduce open door policies and therapeutic community principles.

Following the lead of the United Kingdom, a decision was made by the government to establish a national security facility; Lake Alice Hospital was chosen for the site. Work on the new buildings commenced in 1962, but despite reassurances from head office, were not completed until mid-1965.<sup>76</sup> Staff and patients began to be transferred to the new National Security Unit in early 1966.

Nursing practice on security wards, particularly on the male sides, tended to focus on control and safety rather than therapeutic activity and rehabilitation. Nurses were valued in these wards for their strength and their ability to back their colleagues up under pressure. When Winston Maniapoto transferred from Tokanui to Oakley Hospital during his training, he spent most of his time in M3, the security ward. ‘I had just turned 20. I’m six feet tall, fit as anything (I used to run all over the place). They needed the

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<sup>71</sup> Approximately two-thirds of remand patients each year were not considered certifiable under the Mental Health Act: National Health Statistics Centre, *Mental Health Data*, 1966, p.14.

<sup>72</sup> A large proportion of remandees were discharged without committal (66.4% in 1966): Department of Health National Health Statistics Centre, *Census of Mental Hospital Patients 1966*, Wellington, 1966, p.14.

<sup>73</sup> *New Zealand Statutes*, 1908-31, vol.5, pp.756-8.

<sup>74</sup> AJHR, 1965, H-31, p.57, 1967, H-31, p.72.

<sup>75</sup> Section IV patients was relatively small (1.9% of resident patients in 1964): National Health Statistics Centre, *Mental Health Data*, 1964, p.5.

<sup>76</sup> AJHR, 1963, H-31, 64, 1966, H-31, pp.78-9.

young, fit, strong fellows in M3...'<sup>77</sup> At the National Security Unit at Lake Alice, staff cohesion was again highly valued. Maniapoto was part of the new team when it opened in January 1966. He recalls that during their one-month training, the nurses were cognisant of the fact that the unit was expected to fill with 'forty-eight of the most violent, dangerous psychiatric patients in Australasia – some dastardly deeds in their histories...' He remembered that, above all, the nurses felt they needed 'unity and trust'.<sup>78</sup> Maniapoto is shown here with the other new staff at Lake Alice in 1960.



**Figure 24 Inaugural nursing staff, Maximum Security Unit, Lake Alice Hospital, 1960.**

**Source: Winston Maniapoto personal collection**

**Winston Maniapoto, back row, second from left. See Appendix N for other names.**

The number of people admitted with alcohol-related disorders also grew during the 1960s and early 1970s. With the passing of the *Alcohol and Drug Addiction (A&DA) Act* in 1966, provision was made for committal of alcoholics and drug addicts for a period of up to two years.<sup>79</sup> When the *A&DA Act* came into force in 1969, six psychiatric hospitals were certified for admission of alcoholics and one, Oakley, for drug addicts.<sup>80</sup> Treatment of addictions was beginning to be seen as a specialty within psychiatry. Medical staff experimented with group therapy, aversion techniques and Alcoholics Anonymous meetings. Although working with alcoholics and drug addicts

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<sup>77</sup> Winston Maniapoto interview 10 August 2004.

<sup>78</sup> Winston Maniapoto interview 10 August 2004.

<sup>79</sup> AJHR, 1967, H-31, pp.75-6.

<sup>80</sup> AJHR, 1970, H-31, p.68

was a relatively small part of most psychiatric nurses' practice, it did draw some nurses into more specialist practice based on individual and group therapy skills.

Adolescents comprised a small, but growing part of the psychiatric hospital population.<sup>81</sup> Most were boys. Between 1966 and 1971 the total number of male adolescents grew from 87 to 142 but the number of female adolescents fell.<sup>82</sup> The most prominent diagnoses among the male adolescents were schizophrenia and 'paranoid states'.<sup>83</sup> The growth in numbers of male adolescents coincided with a rapid increase of young people in residential welfare institutions. The Child Welfare Division was struggling to manage their residents, who were increasingly exhibiting disturbed, violent or otherwise problematic behaviour.<sup>84</sup> Many adolescents in psychiatric hospitals were admitted from welfare institutions or directly from the courts.

Special activation and rehabilitation programmes were gradually instigated for adolescents. Department of Education schools had been established at Cherry Farm and Porirua. Hospitals also made use of the National Correspondence School.<sup>85</sup> During the mid to late 1960s, wards were established for adolescents. These initially catered for boys and were staffed by male nurses. In 1965, for example, Russell Flahive became charge nurse of a boys' ward at Porirua. The boys' ages ranged from eight to eighteen years.<sup>86</sup>

By the late 1960s, Maori youth were relatively over-represented in psychiatric hospital units.<sup>87</sup> The rate of Maori first admissions more than doubled between 1961 and 1972 with a particularly large increase in 1967.<sup>88</sup> The presence of these patients posed questions and challenges for Maori nurses. As a student nurse at Porirua, Wi Keelan noticed that a growing number of young Maori men were being admitted to the refractory ward.

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<sup>81</sup> This section refers to adolescents with diagnoses other than mental retardation.

<sup>82</sup> An estimate based on total numbers per age group minus patients per age group with diagnosis of mental deficiency; National Health Statistics Centre, *Census of Mental Hospital Patients 1966*, pp.20-4; National Health Statistics Centre, *Census of Mental Hospital Patients 1971*, p.35.

<sup>83</sup> National Health Statistics Centre, *Census of Mental Hospital Patients 1971*, p.3.

<sup>84</sup> Bronwyn Dalley, *Family Matters. Child Welfare in Twentieth-Century New Zealand*, Auckland, 1998, pp.204-5.

<sup>85</sup> AJHR, 1968, H-31, p.71.

<sup>86</sup> Russell Flahive interview 1 June 2004.

<sup>87</sup> Numbers of Maori youth in welfare institutions was also growing during this period: Dalley, pp.204-5.

<sup>88</sup> The 1967 increase can partially be explained by the inclusion of figures from psychiatric units at public hospital. This, however, only accounts for 43 of the extra 100 first admissions that year; National Health Statistics Centre, *Mental Health Data 1972*, Wellington, 1972, p.101.

Some were younger than me, some the same age. I was absolutely surprised and fascinated as to why they were there as patients and why I was there as a nurse. As far as I was concerned they were no different to what I was.... I didn't see them as having a psychiatric diagnosis.<sup>89</sup>

Keelan's experience with this group of patients caused him to start a process of re-examination of some of his basic assumptions, for example, that 'New Zealand is a place of opportunity, if you worked hard enough, you could do whatever you wanted to do'. It was the plight of Maori youth that attracted Keelan to continue in psychiatric nursing. 'That is the reason I stayed and began working towards trying to find solutions.'<sup>90</sup>

Treatment approaches for adolescents varied across psychiatric hospitals. In the mid-1960s at Porirua, the electroencephalogram (EEG) department played a significant role in diagnosing temporal lobe epilepsy in adolescent boys.<sup>91</sup> This provided at the time, an explanation and basis for treatment of problem behaviour. One of the first integrated wards at Tokanui was for adolescents. It was run along the lines of a therapeutic community. Again at Porirua, in the early 1970s, Keelan and another staff nurse, Monica Molsen were given the task of developing the 'Adolescent Training Programme'. The programme was designed to provide a balance of school, sports, and recreational activities.<sup>92</sup> A Child and Adolescent Unit, opened at Lake Alice in 1972, worked on behavioural therapy principles. The unit, which within a few years had attracted negative publicity, appeared to have relied heavily on aversion therapy to control unwanted behaviour.<sup>93</sup>

Although the number of adolescents in psychiatric hospitals was small, they posed a unique challenge in an environment that was not generally attuned to their needs. Many adolescents exhibited behavioural problems and were considered unable to be treated in an open ward.<sup>94</sup> Attempts were made to cater for the needs of children and adolescents, but it would seem that from the patients' point of view, these often fell short of the mark. In recent years, ex-patients have lodged complaints about their treatment as

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<sup>89</sup> Wi Keelan interview 26 July 2004.

<sup>90</sup> *ibid.*

<sup>91</sup> Russell Flahive interview 1 June 2004.

<sup>92</sup> Wi Keelan interview 26 July 2004.

<sup>93</sup> *"The Case of a Nuiean Boy": Report of the Commission of Inquiry into the Case of a Nuiean Boy*, Wellington, 1977.

<sup>94</sup> AJHR, 1966, H-31, p.78.

adolescents in psychiatric hospitals. Some of these have led to compensation payouts by the Government and others are currently before the courts. In 2001, compensation payments were made to 95 people who had been patients at Lake Alice Hospital Child and Adolescent Unit between 1972 and 1977. Another 88 received compensation in 2004.<sup>95</sup>

### **Influence of hospital conditions**

Physical conditions affected the nurses' ability to create therapeutic environments. Frustration mounted over delays in relieving overcrowding in some hospitals.<sup>96</sup> Urgent renovations of kitchens, bathrooms and heating systems were delayed in several hospitals.<sup>97</sup> Oakley, Porirua and Sunnyside all had wards and bathrooms that were considered sub-standard. The physical conditions at Seacliff Hospital continued to deteriorate as staff and patients awaited the completion of Cherry Farm; the acute wards were finally transferred in 1964. At Porirua, the physical conditions became the focus of industrial protest by the nurses in 1966. The nurses, through the PSA, published a series of photos highlighting overcrowding and the state of disrepair in some wards.<sup>98</sup> They followed this action with an invitation to the local Health Inspector to visit the hospital. His report proved to be an embarrassment to the Government.<sup>99</sup> Physical conditions in psychiatric hospitals continued to be the focus of political debate and industrial unrest into the 1970s.

Conditions on male and female wards were different. On the whole, the women's wards were more comfortable and homely. One retired male nurse reflected that, 'I was sufficiently aware that the female side was different. Oakley [the male side] was very clean but the female side had a more 'nurse-caring attitude'.<sup>100</sup> Another commented that the women's wards seemed 'more comfortable, cleaner, brighter', and were often envied by the men.<sup>101</sup>

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<sup>95</sup> *New Zealand Herald* (NZH), 31 July 2004, p.A5.

<sup>96</sup> AJHR, 1964, H-31, p.60-1.

<sup>97</sup> AJHR, 1963, H-31, p.64.

<sup>98</sup> *PSJ*, 53, 4, 1966, p.6 & 53, 5, 1966, p.7.

<sup>99</sup> Porirua 98 12/44 City Health Inspector's Report 10 June 1966 cited in Wendy Hunter Williams, *Out of Mind Out of Sight, The Story of Porirua Hospital*, Porirua, 1987, p.236. Discussed further in Chapter VIII.

<sup>100</sup> Adrian Moerenhout interview 11 April 2004.

<sup>101</sup> Peter Sanders interviewed by Margaret Whineray, 13 July 1989, OHInt-0139/1, NERF- PNOHP.

Although male charge nurses usually insisted on high standards of cleanliness, there was less attention to patient comfort and dignity or on beautifying the environment. It was not unusual, for example, for male wards to have no curtains in the windows. Some of the ‘back wards’ on the male sides were particularly Spartan; others were unkempt. A nurse inspector, who visited Sunnyside Hospital in 1963, was dismayed at the condition of some of the male wards. She commented on one long-stay ward which she felt had particular problems because of the well established ‘legend of chronicity’ that permeated staff attitudes. She noted,

This ward presented a very depressing picture. Many of the problems are a direct result of overcrowding and structural obstacles. ... The general impression, however, was one of neglect and the ward was dirty and untidy. Linen and store rooms were poorly kept... Many buckets of coal were standing around the ward and a long handled garden shovel was in use as a fire shovel. The ablution and toilet blocks were in such a state of disrepair and substandard hygiene that one was under the impression that they were being demolished. Unfortunately this was not so.<sup>102</sup>

### ***Demands for domestic and outdoor labour***

Psychiatric nurses continued to provide much of the hospitals’ domestic and outdoor manual labour. As one female nurse commented, ‘For years, [the introduction of medications] didn’t make a difference to the work we did. We still had to cook, we still had to clean.’<sup>103</sup> Both male and female nurses’ domestic duties included bed-making, washing windows, and mopping and polishing floors. Hill reflected,

It was hard, hard work. .... ‘You had finished your days nursing, made sure that everyone was in bed ... then you started mopping the dayrooms. And the dayrooms at Park house were like the size of a tennis court. They had to be wet-mopped, and they had to be dried and they had to be buffed. You were lucky if you finished at quarter to eight, and if you hadn’t finished you carried on until you had.’<sup>104</sup>

Male nurses continued to occupy a different ‘space’ in the work life of the hospitals. In the early 1960s men undertook a wide range of duties. Adrian Moerenhout recalled that not only did he go out on working parties on the farm and gardens, but there were also

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<sup>102</sup> Hospital Inspection Report to the Director, Division of Nursing, November 1963, H- 1, 41804, ANZ, Wellington.

<sup>103</sup> Joy Collins interview 27 January 2004.

<sup>104</sup> Althea Hill interview 10 June 2004.



times when he was in charge of the laundry or pharmacy.<sup>105</sup> Fire patrol on night duty, moving bodies to the mortuary and assisting with post-mortems were tasks almost always reserved for men. In 1961 the PSA claimed that the staff attendant's duties included an 'unlimited variation of outside and other duties, eg. car driving, film screening, tree felling, butchering, cooking etc ad infinitum'.<sup>106</sup>

Winston Maniapoto had been working at Tokanui for just a few months when he was put on 'sexton duties'. He was told to take a group of patients, dig a grave and bury a patient who had died with no relatives near enough to claim his body. As a young Maori man from a deeply religious family, Winston found the task extremely difficult,

There was no family, no priest – so at nineteen and a half years of age (I had been to tangi) - these six patients and I stood around the grave. We sang a hymn and I said a prayer and then we buried him. I went back to the boss man and complained bitterly. That night I went home to Mum and Dad almost crying. They said, "You are not a minister, you're too young". We went to see my grandparents – sat practically all night – they said prayers for me. Dad went into town, picked up Father McGrath, he sat with me, had prayers with me well into the night, then I hopped onto my bike and went back to Tokanui where I was living.<sup>107</sup>

During the 1960s views about nurses performing domestic duties changed. Professional leaders advocated for general and psychiatric nurses to be relieved of domestic tasks so they could focus on patient care. Rita McEwan, for example, in her role as a nurse inspector, criticised Oakley Hospital for their reliance on nurses for domestic work and recommended that the hospital considered creating a domestic staff establishment. She claimed that, 'When cooking, cleaning, polishing etc outweigh participation in nursing activities and patients are sitting around unoccupied or uninterested then it is time to consider how the situation might be improved.'<sup>108</sup> The Oakley head attendant did not subscribe to McEwan's views. He defended the use of 'spit and polish' as a nursing practice that had stood the test of time.<sup>109</sup>

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<sup>105</sup> Adrian Moerenhout interview 11 April 2004.

<sup>106</sup> PSA submission, 4 April 1961, H-1, 31000, 30/7/6, ANZ, Wellington.

<sup>107</sup> Winston Maniapoto interview 10 August 2004.

<sup>108</sup> Rita McEwan, Nurse Inspector, Report on Oakley Hospital, April 1965, YCAA, 1081, 29d, ANZ, Auckland.

<sup>109</sup> C. Vollmer, Head Attendant, Oakley Hospital comments on the Nurse Inspector's report, 5 April 1965, YCAA, 1081, 29d, ANZ, Auckland.

Nurses also became less tolerant about doing tasks that were not related to patient care. Their frustrations were triggered by a growing sense of themselves as nurses and by the fact that they were being asked to do tasks that had previously been done by ‘worker patients’. Nurses were further frustrated by the Division’s reluctance to employ sufficient domestic and maintenance workers. As Reg Hyndman recalled ‘you were given these ideals to live up to but when you looked at what you were actually doing, much of it was menial work which was not in the nursing profession at all’.<sup>110</sup>

In the late 1960s, the issue of non-nursing duties became a focus of industrial action. The nurses drew the line between what was, and what was not, psychiatric nursing. Cleaning, cooking, driving, stoking boilers and answering the hospital telephones were not, they considered, ‘nursing’; they refused to continue doing these tasks. In taking a stand, the nurses’ were laying claim to a new identity as mental health professionals whose primary role was therapeutic.

It was closure of hospital farms that marked a turning point in psychiatric practice and the role of psychiatric nurses. Hospitals were now being seen as places of treatment and rehabilitation rather than as places of asylum. Medications, occupational therapy, industrial therapy and social work were replacing daily structure and supervision as the mainstays of patient care. The assumption that farming was inherently therapeutic was officially dismissed as an outdated but cherished ‘piece of folklore’.<sup>111</sup> Farming activities were gradually wound down during the 1960s. Initially the estates were whittled away and agricultural activities stopped as they became uneconomic or inconvenient.<sup>112</sup> In 1967 all the remaining farm land was handed over to the Department of Lands and Survey. Don McKay, the Minister of Health, assured Parliament that ‘hospitals were for curing patients, not for farming operations’.<sup>113</sup>

### **Opportunities for new roles**

The site, context and ideology of psychiatric nursing began to change in the late 1960s and early 1970s. These changes were influenced by international movements that challenged the very basis of institutional care. Social psychiatry and milieu therapy

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<sup>110</sup> Reg Hyndman interview 28 August 2004.

<sup>111</sup> AJHR, 1967, H-31, p.77.

<sup>112</sup> The piggeries at Porirua, for example, were closed in 1964 because the effluent was discharged into the Kenepuru Stream which passed by a new maternity hospital: Williams, p.137.

<sup>113</sup> NZPD, 1967, p.2823.

were beginning to have an impact on the approach to psychiatric care in some hospitals. Criticisms of the anti-psychiatry movement spurred on the calls for hospital reform, community care and deinstitutionalisation. Changes in the United Kingdom and the United States challenged New Zealand psychiatrists to consider a closer liaison with general hospital services. New services and hospital reforms produced opportunities for psychiatric nurses to explore new practice roles. These innovations included domiciliary care, therapeutic community, psychiatric units in general hospitals, and the integration of male and female wards. Changes to the composition of the mental hospital workforce arguably created the greatest opportunities for nurses to shift from custodial care to a therapeutic role.

### *Domiciliary nursing*

Psychiatric nursing home visiting was established in response to the need to assist long-stay patients return to the community. In 1966 Oakley Hospital was the first to experiment with sending psychiatric nurses into people's homes. Patrick Savage, the medical superintendent, decided that with the recent introduction of long-acting anti-psychotic medications, it was safe to discharge people with chronic schizophrenia. Savage, who tended to be risk-averse, chose to commence the trial with male patients visited by male nurses who could deal with potential violence. He recalled asking the head nurse to 'find me a good fellow who is reliable, who won't flap, won't get angry and upset'. The head nurse chose Doug Cantley, a nurse who Savage considered had a 'good manner with patients and everybody else'.<sup>114</sup> Six months later, a female nurse, Shona Finchum, was added to the team. Most patients were placed on twelve months' trial leave from hospital. The nurses' duties included administration of medication, therapeutic support, education of the community and information conduit between patient and doctors.<sup>115</sup> Adrian Moerenhout, who was another of the early psychiatric home visitors, remembers that they had very few instructions for the role. He believed that they succeeded in their new role by choosing the patients very carefully, matching them with suitable accommodation and providing 24 hour back-up. The nurses had large caseloads and often worked long hours.<sup>116</sup>

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<sup>114</sup> Patrick Savage interview January 2001.

<sup>115</sup> NZMJ, 75, 476, 1972, pp.15-9.

<sup>116</sup> Adrian Moerenhout interview 11 April 2004.

Sunnyside and Porirua started domiciliary nursing in 1967 and 1969 respectively. At Sunnyside, the service was an extension of the therapeutic programme at Ferguson Clinic, the female acute unit. A ward sister visited patients in their homes, and with the social worker, ran outpatient discussion groups.<sup>117</sup> Two other nurses were appointed to domiciliary work in 1970.<sup>118</sup> Like the first nurses, they spent a portion of their day in the wards running groups.<sup>119</sup> Porirua started a domiciliary nursing service with only one (female) nurse. Mrs R. Ball is shown below with her hospital car (Figure 25). With no processes of referral, the service took some months to get going, but once its value was recognised by the hospital staff, it grew rapidly. The nurse worked with the social workers to establish ex-patients in supportive housing and re-introduce them to the workforce.<sup>120</sup>



**Figure 25 Mrs R. Ball, Domiciliary Nurse, Porirua Hospital.**  
**Source: KT, 63, 9, 1970, p.10.**

Home visiting gave psychiatric nurses opportunities to practice in a new way. Nurses took responsibility for individual patients rather than being allocated tasks and worked much more autonomously than had been possible on the wards. Organising patient discharge and follow-up required them to liaise with the medical staff, social workers and other health professionals. The nurses' success in maintaining patients in the community depended on the availability of suitable supported accommodation. This was much easier in places such as Christchurch, where the hospital established its own

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<sup>117</sup> Peter Sanders to Director of Nursing, Report on Observation Visit to Sunnyside Hospital, February-March 1969, H,1, 41804, ANZ, Wellington.

<sup>118</sup> One man and one woman were appointed.

<sup>119</sup> J.A. Begg, Acting Medical-Superintendent, Sunnyside Hospital to Director-General of Health, 23 October 1970, H1, 41804, ANZ, Wellington.

<sup>120</sup> Williams, pp.259-62.

half-way houses.<sup>121</sup> Nurses in Auckland often had to rely on boarding houses or rest homes supervised by people with no experience in mental illness.<sup>122</sup>

### ***Therapeutic community, group work and individualised care***

Therapeutic community concepts were implemented in a number of settings from the late 1960s. Group processes, democratic ward structures and team work were central to this approach. Radical reforms at Sunnyside Hospital, for example, provided unique opportunities for nurses to shift the focus of their practice.

Under the leadership of Edwin Hall and Margaret Bazley, principles of therapeutic community and intensive rehabilitation were implemented at Sunnyside. These innovations started in Ferguson Clinic, the acute and convalescent unit. Group therapy, team work and patient participation replaced the reliance on medical treatment protocols. Each morning, patients and staff attended medically-led group psychotherapy sessions. These were followed by small group, nurse-facilitated discussions. Patients were expected to participate in committees that took responsibility for organising the ward duties, arranging social events and giving feedback to the team about other patients' behaviour. Weekly meetings of all staff and patients gave everyone an opportunity to comment on aspects of the ward management.<sup>123</sup>

Sunnyside gradually implemented reforms in other wards. In the long-term wards, the emphasis was on activation programmes and preparation for discharge. Wards were refurbished and patients were equipped with their own clothes. Work and occupation around the hospital continued to be an important part of the treatment programmes. Patients were assisted to move out of hospital gradually. As in the acute wards, nurses worked as part of the therapeutic team. They were expected assist with the development of individual patient plans and to implement rehabilitation strategies.<sup>124</sup> Nurses developed programmes that included a range of activities such as the keep-fit class shown in the photograph below.

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<sup>121</sup> Margaret Bazley interview 23 February 2004.

<sup>122</sup> NZMJ, 79, 516, 1974, p.18.

<sup>123</sup> KT, 63, 5, 1970, pp.9-11.

<sup>124</sup> KT, 61, 12, 1968, pp.15-6.



**Figure 26 Nurses take a keep-fit class for patients at Sunnyside Hospital.**  
Source: KT, 61, 12, 1968, p.15.

Implementation of therapeutic community at Sunnyside gave nurses, for the first time, access to comprehensive patient information and formal opportunities to contribute to clinical decision-making. Daily staff meetings were attended by doctors, nurses, occupational therapists and social workers. Everyone, no matter their seniority was expected to contribute. Recently admitted patients were discussed in length, the whole team becoming familiar with the person's reason for admission, physical state and socio-economic background. These changes offered nurses a greater say in treatment decisions and patient management, but they also exposed them to critique from both patients and team members.<sup>125</sup>

Aspects of therapeutic community were introduced in a few wards at other hospitals. As mentioned earlier, two psychiatrists established an adolescent unit at Tokanui based on therapeutic community principles. This foreshadowed a more radical experiment in therapeutic community initiated by Dr John Saxby at Tokanui. Patients were encouraged to establish their own treatment plans, contribute to the ward rules and participate fully in ward meetings. Group psychotherapy based on psychodrama methods formed the basis of treatment. Because of its somewhat radical approach, and the intense relationships formed within the staff group, the ward initially attracted

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<sup>125</sup> KT, 63, 5, 1970, pp. 9-11.

criticism from other parts of the hospital. It is remembered, however, for its contribution to training nurses and others in therapeutic techniques.<sup>126</sup>

### ***General hospital psychiatric units***

Three new psychiatric units opened at general hospitals between 1970 and 1971: Manawaroa in Palmerston North, Kew in Invercargill and Wakari in Dunedin. The 40-bed wards were the result of seven years' planning by the Department of Health and the hospital boards. They were designed to fill geographical gaps in psychiatric services and to provide comprehensive inpatient and day patient programmes.<sup>127</sup> It was hoped that the closer association with general health would break down stigma against mental illness and facilitate easier access for patients and their families.

Psychiatric units at general hospitals were able to develop a different therapeutic culture from that of most of the large psychiatric hospitals. They had the advantage of not being saddled with large numbers of patients with chronic illness or disability. They were also not obliged to admit people with a primary diagnosis of intellectual disability, alcoholism, or drug addiction. They also did not appear to have a problem with large numbers of admissions of patients with senile dementia. Until 1970, general hospitals were not able to admit legally committed patients. Although this changed with the passing of the 1969 Mental Health Act, these units were still sometimes accused of only admitting the 'cream of cases' and leaving psychiatric hospitals to 'deal with the dregs', an accusation denied by general hospital psychiatrists.<sup>128</sup>

General hospital units, unconstrained by the traditions and the institutional demands of the large psychiatric hospitals, were able to attract a wider range of well-qualified staff and experiment with a different treatment approaches. Within a short time, the new units were commended for their 'different patterns of operation and in some respects different underlying philosophies of clinical approach...'<sup>129</sup> Nurses' staffing patterns contributed to this greater freedom. The new units were relatively well staffed. Senior nurses were seconded from the psychiatric hospitals and other general and psychiatric nurses employed directly by the hospital boards. The units were not initially obliged to

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<sup>126</sup> Bob Elliott interview 2 June 2004; Tony Moran interviewed by Cathy Coleborne, 10 March 2004, Tokanui Oral History Project (TOHP), Te Awamutu Museum.

<sup>127</sup> AJHR, H-31, 1964, p.59.

<sup>128</sup> NZMJ, 76, 321, pp.321-6.

<sup>129</sup> AJHR, 1972, H-31, p.77.

employ student nurses. Instead, they hired community nurses to undertake the less skilled work and offered general hospital students clinical experience on a supernumerary basis.<sup>130</sup>

Nurses employed at general hospital units discovered that they had opportunities to participate within a therapeutic team in a way that had not been possible in most psychiatric hospitals. In an article in *Kai Tiaki*, K. Dasler, the Charge Nurse at the Department of Psychological Medicine at Auckland Hospital, described the ‘therapeutic milieu’ in that unit. She claimed that nurses were able to step back from the ‘old authoritarian approach’ and encourage patients in ‘the emergence of independent and responsible functioning’.<sup>131</sup> Short stays and intensive use of day-patient programmes contributed to an approach that discouraged patient dependency. Nurses of all seniorities contributed to team meetings, in which patient treatment and progress were discussed.<sup>132</sup> Although this approach was being used at Sunnyside, it was not as common in other psychiatric hospitals.

### ***Integrated wards***

During the 1960s, the mixing of male and female patients began to be viewed as beneficial to patients’ recovery. Seaview Hospital was one of the first to experiment with a mixed reception unit in 1962. Patients came together for meals, activities and recreation.<sup>133</sup> Although initially deemed a success, by the second year, the matron noted that newly-admitted women tended to feel uncomfortable having their meals in a mixed dining-room.<sup>134</sup> Early experiments at Sunnyside Hospital also had teething problems. The medical superintendent commented that greater freedom for the sexes to mix had given rise to, ‘unrestrained behaviour on the part of some of the younger patients until a fixed code of behaviour was laid down’.<sup>135</sup> Despite the initial hiccoughs, the Division increasingly promoted a policy of sex integration within the hospitals and wards. Most hospitals gradually integrated one or two wards, as it seemed desirable and possible.

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<sup>130</sup> Palmerston North Hospital: Psychiatric Unit, Nursing Staff Establishment (proposed), 1969, H, W2678, 39/19/12/2, 35687, Box 27, ANZ, Wellington.

KT, 66, 6, 1973, p.16.

<sup>132</sup> KT, 66, 6, 1973, pp.16-7 & 20.

<sup>133</sup> AJHR, 1963, H-31, p.69.

<sup>134</sup> AJHR, 1964, H-31, p.66.

<sup>135</sup> AJHR, 1965, H-31, p.63.



Full-scale integration of the sexes was not implemented until the early 1970s. The process caused anxiety for some nurses. Many of the men were uncomfortable with the prospect of working with female patients. Karl Polotu-Endemann who started work at Oakley Hospital in 1971, believed that men were worried about sexual tension and about their own abilities as nurses. He recalled that ‘a lot of men did not want to work with women, often because of their inadequacies. They were taught not to be nurses, taught to be tough, rough ... underneath it was really about a lack of confidence’.<sup>136</sup> In some situations, the men’s fears were reinforced by their initial experiences in mixed or women’s wards. Francis Gugich who, as a staff nurse, was transferred to a women’s ward at Seaview Hospital remembers that the female nurses did not at first trust the men to do more than menial jobs. They were not allowed to touch the medications.<sup>137</sup>

Some men welcomed the opportunity to be involved in a different sort of therapeutic environment on integrated wards. Bob Elliott’s move to the mixed, adolescent ward at Tokanui was a positive experience.<sup>138</sup> Polotu-Endemann, unlike most of his colleagues, wanted to work with women. He perceived the female nurses as more fastidious and the standards as generally better. Karl’s identity as a Samoan fa’afafine, no doubt situated him uniquely in relation to women. ‘I was one of the ones who wanted to go onto integrated wards’.<sup>139</sup>

Many female nurses also found the transition to mixed wards difficult. They feared that their standards would drop and that their female patients could be at risk. The women struggled to come to terms with different standards of cleanliness, attitudes to work and styles of communication.<sup>140</sup> Some thought the men lazy. For others, working with men was quite a shock. When Althea Hill returned to Oakley Hospital in 1973, she discovered that, for the first time, she was expected to work in integrated wards.

I didn’t really relate professionally to the men very well as I didn’t find their standards very high and was worried that they might drag us down because they did quite a lot of scoffing at our standards. I felt very concerned about the female patients.... I saw women being frightened of having psychotic men around them... and women

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<sup>136</sup> Karl Polotu-Endemann interview 7 April 2004.

<sup>137</sup> Francis Gugich interview 29 August 2004.

<sup>138</sup> Bob Elliott interview 2 June 2004.

<sup>139</sup> Karl Polotu-Endemann interview 7 April 2004.

<sup>140</sup> Most of the women interviewed for this study mentioned the difficulties adjusting to working with male nurses. All spoke of the different standards. For example; Jamesina Kett interview 2 June 2004; Joy Collins, interview 27 January 2004, Mere Balzer interview 1 July 2004.

suffering from mania can be sexually vulnerable ... Those were the things I disapproved of about integration...<sup>141</sup>

Integration appeared to have been a mixed success. There was a general understanding that integration had improved conditions on the wards. One nurse commented, on reflection, that ‘integration was good for the men because of the civilising affect but not so good for the women because of their vulnerability’.<sup>142</sup>

### *Changing shape of the mental hospital workforce*

Relinquishing domestic and outdoor maintenance work was arguably the most significant shift in the psychiatric nurses’ role during the 1960s and early 1970s. This was made possible, in part by the increase in numbers of other workers. In 1969, the government succumbed to the nurses’ demands and gave approval for the employment of substantial numbers of domestics, cooks and nurse aids.<sup>143</sup> The new positions were established over the next few years. Although nurses were not entirely relieved of domestic duties, the decision to employ auxiliary staff reflected a shift in understanding of psychiatric nursing practice. It was now being seen as a therapeutic endeavour rather than custodial and manual work.

The creation of more domestic and nurse aid positions contributed to a trend that had been happening for a number of years; the proportion of nurses to other mental hospital staff dropped. Not only had the number of manual workers increased, but so had that of other healthcare disciplines such as psychology, social work and doctors (see Table 9).

	1959/60	1972
Nurses	1,539	2,858
Medical officers	33	96
Occupational therapists	88	81
Social workers	7	36
Psychologists	2	24
Dispensers	4	14
Physiotherapists	-	7
Training officers	5	64

**Table 9 Treatment staff 1959/60 and 1972.**  
**Source: NZPSL, 1959/60; National Health Statistics Centre, Mental Health Data, 1973, Wellington, 1973, p.76**

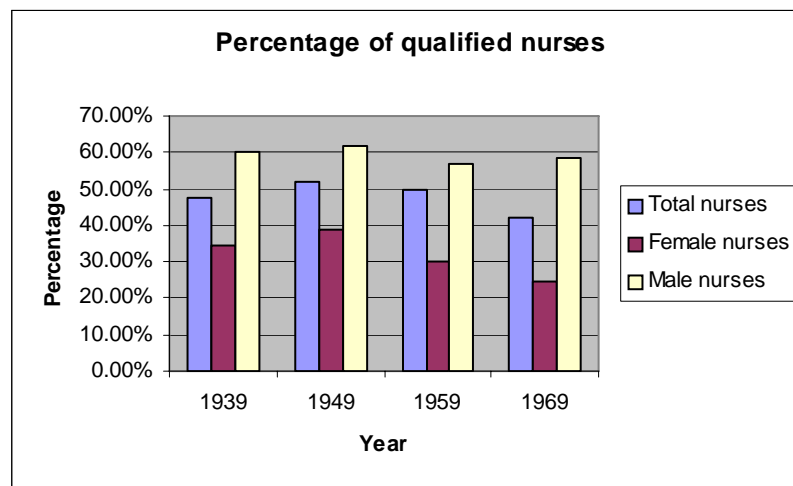
<sup>141</sup> Althea Hill interview 10 June 2004.

<sup>142</sup> Marney Ainsworth interview 27 April 2004.

<sup>143</sup> AJHR, 1970, H-31, pp.69-70.

Psychiatric nurses' shift to a more therapeutic role was occurring alongside the growth of other mental health disciplines. As nurses relinquished their domestic and manual duties, they were challenged to define their therapeutic roles within newly-formed multi-disciplinary teams. In the early 1970s, it was yet unclear what functions they would perform within broader treatment teams.

Not only were nurses relieved of non-nursing duties, but the overall number of nurses increased at a time when patient numbers were beginning to decrease. Between 1959 and 1972, the ratio of nurses to patients decreased from 1:6.5 to 1:4.1. The change had been most pronounced in the previous few years. This more favourable ratio, along with the extra domestic workers, potentially allowed nurses to focus on therapeutic patient care. These changes, however, were offset by the fact that most of the new nurses were unskilled nurse aids (see Appendix P for staffing numbers). The proportion of qualified nurses in the nursing workforce was the lowest it had been since 1939. The proportion of qualified female nurses was particularly low (see Figure 27 below). With a largely unqualified workforce to supervise, registered female psychiatric nurses continued to experience constraints in their freedom to engage in therapeutic programmes.



**Figure 27 Percentage of qualified nurses in mental hospital nursing workforce.**

**Source: NZPSL, 1939, 1949, 1959-60 & 1969.**

### **Complaints, poor practice and abuse**

A large number of ex-patients have complained in recent years about ill-treatment in psychiatric hospitals during the 1960s and 1970s. Initially, these allegations were focused on Lake Alice and Porirua, but most other hospitals have now been implicated.

Most of the complainants were between eight and sixteen when hospitalised.<sup>144</sup> Many of the complaints include reference to ill-treatment at the hands of nurses. A class action lawsuit is currently in process involving over 300 former patients.<sup>145</sup>

Recent events have highlighted the difficulties of uncovering or portraying a single story of psychiatric nursing practice. Reliance on documentary evidence provides a view with a strongly official flavour. Nurses' oral history accounts, while allowing for variation, are still constrained by the inevitable restrictions of a 'top-down' approach. Consumers' accounts provide a different angle. Their stories have at times been dismissed as unreliable, or in the current climate, framed to attract compensation.<sup>146</sup> Accusations of unreliability are arguably no more valid than the suggestions that official accounts are designed to protect the established order and those who work for it.

It would appear that there were instances of patient ill-treatment by nurses in this period. Whether these are understood as instances of out-of-line behaviour by the occasional 'bad apple' or a more endemic sign of an institutional culture of abuse depends on the perspective of the narrator. There were two responses to accusations of abuse at the time. One, put forward by hospital administrators, was that instances of abuse were perpetuated by inexperienced and obviously unsuitable staff members. From the administrators' accounts, their behaviour was dealt with swiftly, and the abusive person dismissed if necessary. The limiting of bad behaviour to inexperienced staff members, however, is disputed by many psychiatric nurses and past patients. It seems that some senior nurses may have behaved in bullying or abusive ways. A second contemporary view was that hospital conditions were such that poor practice was sometimes inevitable. The PSA argued that shortages of staff, overcrowding and poor physical conditions were the main causes of patient discomfort; occasional poor practice could be expected when nurses had to work in such conditions. Again, this position is challenged. Nurses who worked in psychiatric hospitals acknowledge the difficulties of poor conditions but recognise that individuals had choices about how they behaved towards the patients.

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<sup>144</sup> NZH, 21 June 2004, p.A4.

<sup>145</sup> Press, 15 July 2004, p.A9.

<sup>146</sup> Roger Chapman, one of the lawyers representing the class action on behalf of ex-patients felt compelled to defend his clients' reliability on the basis that 'a lot of them aren't crazy and never were': Press, 23 June 2004, p.A3.

Two inquiries at the time highlighted problems within psychiatric hospitals. The first was held at Porirua in 1969 after an ex-nurse had gone to the *Truth* newspaper with stories of ill-treatment of patients and staff drunkenness. A twelve-day hearing was held before a hospital inspector, E Eaton Hurley.<sup>147</sup> Sixty-three witnesses were called including patients, staff, and family members. Allegations included specific incidences of physical abuse such as hair-pulling, beating, or rough handling in seclusion. Occurrences of patient neglect and reported sightings of nurses being drunk on duty were also raised. None of the forty-two allegations were upheld. Some because the witnesses were considered unreliable; one nurse had left the hospital under a cloud and another was making allegations about an ex-friend after a very ‘disappointing’ break-up.<sup>148</sup> Patients’ allegations were either found to be of a general nature about hospital conditions, or could not be substantiated as abuse.

The second inquiry was held at Oakley Hospital in 1971. It was undertaken on the request of psychiatric nurses as part of a settlement after a national strike.<sup>149</sup> Nurses at Oakley had been concerned for some time about hospital conditions. A three-person team, chaired by Charles Hutchinson, QC, inspected the hospital and took public submissions for three weeks, followed by a further nine days for private submissions. Rather than addressing individual instances of nursing or psychiatric care, the team was charged with investigating the hospital’s overall administration and in particular, psychiatric services and staffing.<sup>150</sup>

The Oakley Inquiry Report painted a picture of a hospital under considerable strain. Not only was it overcrowded, under staffed, and burdened with old buildings, but there was also little evidence of implementation of modern psychiatric practices. Outpatient and day patient facilities were almost non-existent and there was very little in the way of psychological or psychotherapeutic services. One of the major problems was a critical shortage of trained psychiatrists, made worse by the fact that the medical staff worked largely in isolation. The absence of teamwork limited the hospital’s ability to make use of the skills of nurses, social workers, occupational therapists, and psychologists. At a

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<sup>147</sup> A. Eaton Huntly, *Report on Investigation, In the Matter of the Mental Health Act 1911, Section 72 and In the Matter of Allegations as to Ill-treatment of Patients and Drunkenness of Staff while on Duty at Porirua Hospital*, Wellington, 1969.

<sup>148</sup> *ibid.*, p.33., p.33.

<sup>149</sup> See Chapter VIII for discussion of industrial issues.

<sup>150</sup> Charles P Hutchinson, *Psychiatric Services at Oakley Hospital: Report of Commission of Inquiry*, Auckland, 1971.

time when most hospitals were striving for greater patient freedom, contact with the outside community and integration of the sexes, Oakley, under the leadership of Patrick Savage, appeared to be doing the opposite. Recreational and social activities were declining, male and female patients and staff were almost entirely segregated and a high number of patients were contained in locked wards. It seemed that the whole culture at Oakley was coloured by the need for security measures for patients referred from the courts. Staff shortages were also thought to contribute to the restrictions on patients' freedom.<sup>151</sup>

A number of factors contributed to an environment in which instances of patient neglect or ill-treatment were possible. The 1960s and early 1970s was a period in which changing expectations of psychiatric care were not matched by the reality of conditions in hospitals. A system that had been established to provide custodial care for a largely stable patient group was being called on to treat, rehabilitate and discharge patients in a mostly open environment. Certain patients were arguably misplaced in psychiatric hospitals and added to the problems of an already overburdened system. Adolescents, most of who were admitted for behavioural rather than psychiatric problems, and people admitted from the courts, provided particular challenges. Staff shortages, overcrowding and a lack of resources added to the problems.

Tight staff networks, while providing social support, could also protect nurses from facing the consequences of abusive behaviour. People who worked during this period have spoken of the difficulties of trying to challenge poor practice, particularly on the men's wards. Speaking out could lead to a nurse being ostracised or silenced. The PSA, while providing essential support for its members in employment conflicts, was also accused from time to time of being over-protective. Reluctance to 'rock the boat' was not just at the ward or hospital level. Success of the unified national system of administration of psychiatric hospitals depended on maintaining relationships without undue conflict.

### **International context**

New Zealand psychiatric nurses adopted the language of therapeutic relationship during the 1960s. Their opportunities to engage in practice based on principles of therapeutic

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<sup>151</sup> *ibid.*, p.31.

relationship, however, were constrained by the conditions in which they worked. Residual asylum-type conditions, shortages of staff, and large numbers of physically dependant patients hampered attempts to create therapeutic roles for nurses. In certain settings, however, opportunities were made available for the development of therapeutic roles, either through innovative leadership or by the development of new services such as general hospital units or domiciliary nursing.

This uneven adoption of therapeutic roles was a phenomenon noted among psychiatric nurses in other Western countries during this period. In the United States where the idea of 'therapeutic relationship' had originated, graduate-prepared psychiatric nurses expanded their practice in the newly-developed Community Mental Health Centres (CMHCs). They developed skills in psychotherapy and family therapy.<sup>152</sup> Hildegard Peplau built on her earlier work on interpersonal skills by offering summer workshops to state hospital nurses and nurse educators. The intensive, practice-based programmes taught nurses how to use group and individual skills with patients diagnosed as psychotic.<sup>153</sup> Despite these developments, it would appear that conditions in most large state mental hospitals prevented a general change in nursing practice. Constrained by budget imperatives, administrators were reluctant to employ large numbers of registered nurses. The nurses' role was therefore limited to administration, supervision of attendants and administration of medical treatments.<sup>154</sup>

In the United Kingdom, adoption of new therapeutic roles was the exception rather than the norm. Peter Nolan refers to a 'glaring contradiction' between what nurses were taught and how they practised. He suggests that most care was 'patronising and disabling'.<sup>155</sup> John Hopton's account of life at Prestwich Hospital supports Nolan's assertions. He describes nurses' practice on back wards as involving little more than observation and mass-produced care.<sup>156</sup> In contrast to these examples, nurses in some other hospitals in the United Kingdom were involved in new initiatives, such as

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<sup>152</sup> Rhetaugh G Dumas, 'Psychiatric Nursing in an Era of Change', *Journal of Psychosocial Nursing*, 32, 1, 1994, p.12.

<sup>153</sup> Shirley Smoyak, 'Peplau History Project', *Journal of Psychosocial Nursing*, 35, 5, 1997, pp.12-4.

<sup>154</sup> Gerald Grob, *From Asylum to Community: Mental Health Policy in Modern America*, New Jersey, 1991, pp.119-20.

<sup>155</sup> Nolan, *A History of Mental Health Nursing*, p.131.

<sup>156</sup> John Hopton, 'Daily life in a 20th Century Psychiatric Hospital: An Oral History of Prestwich Hospital', *International History of Nursing Journal*, 2, 3, 1997, pp.27-39.

therapeutic communities, integrated wards and community nursing.<sup>157</sup> Active rehabilitation and discharge of long-term patients were also being pursued.<sup>158</sup> Scottish psychiatric hospitals were particularly progressive and the therapeutic aspects of a psychiatric nurses' role was well developed.<sup>159</sup>

Philip Maude's account of psychiatric services in Western Australia suggests that changes in psychiatric nurses' roles were similar to those happening in New Zealand. Maude describes how for much of the 1960s, nurses' practice was dominated by the need to manage large groups of physically dependent patients and to maintain a spotlessly clean physical environment. While medications, ECT and occupational therapy created some changes, he argued that it was the introduction of therapeutic community in the late 1960s that gave nurses opportunities for a 'totally different way of interacting with patients'.<sup>160</sup> Maude describes how nurses learned to run groups and eventually became comfortable working in unlocked wards. Opportunities also started to become available for nurses to follow patients up in the community.<sup>161</sup>

## Conclusion

In 1973 Margaret Bazley claimed in an international nursing journal that, 'The emphasis in psychiatric nursing has shifted from physical care to skill in interpersonal relationships. Today the basic skill of psychiatric nursing is considered to be the relationship between the nurse and the patient – the therapeutic relationship.'<sup>162</sup> Bazley was laying claim to a shift in practice for New Zealand psychiatric nurses. Her assertions, while no doubt true for psychiatric nursing at Sunnyside Hospital, were founded more on a theoretical ideal than the reality. Although the concept of interpersonal relationship had been generally accepted as the theoretical basis of psychiatric nursing, New Zealand psychiatry was still struggling to shake off the remnants of asylum-type care. Psychiatric nurses were constrained by the contexts in which they practiced. In places where new therapeutic models were established and the

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<sup>157</sup> T.M. Caine and D.J. Smail, 'Attitudes of Psychiatric Nurses to their Role in Treatment', *British Journal of Medical Psychology*, 41, 1968, pp.193-7.

<sup>158</sup> See, for example; Gittins, pp.67-88.

<sup>159</sup> Margaret Bazley, Report of British Commonwealth Nurses War Memorial Fund Scholarship, 1970, Margaret Bazley personal papers.

<sup>160</sup> Philip Maude, 'From Lunatic to Client: A History/nursing Oral History of the Treatment of Western Australians who Experienced a Mental Illness', PhD thesis, University of Melbourne, 2001, p.318.

<sup>161</sup> *ibid.*, pp.299-323.

<sup>162</sup> Bazley, 'Psychiatric Nursing', pp.103-9.



burden of care for physically dependent patients was reduced, psychiatric nurses were able to develop practice based on 'therapeutic relationship'. In other areas where institutional conditions persisted and therapeutic innovations were rare, psychiatric nursing retained many of the aspects of custodial care.

The next chapter discusses how educational reform was increasingly perceived to be the means by which a change of practice could be achieved. Proposals for reform exposed differences in opinion about whether psychiatric nursing should be incorporated within general nursing education.

## **Chapter VII**

### **Educational and Professional Developments 1960 – 1972**

Enough to ‘make the blood of a good psychiatric nurse rise to the bait’.<sup>1</sup>

Two distinct reform movements affected psychiatric nursing education during the 1960s and early 1970s. One was the movement to prepare psychiatric nurses for a specialised role in active therapeutic, rather than purely custodial, care. The other was a call from professional nursing leaders to reform basic general nursing education. Nursing leaders questioned the apprenticeship model and sought to broaden the general nursing curriculum, a task that included integration of psychiatric nursing concepts. Psychiatric nursing was caught between these two movements. The former would potentially enhance the distinct nature of the specialty, but could distance it from nursing. The other offered the benefits of educational reform but carried with it the potential loss of specialist focus and identity.

#### **Psychiatric nursing education: early 1960s**

By the 1960s, therapeutic changes in psychiatric hospital practice and international writing on the therapeutic role of the mental health nurse were driving the direction of psychiatric nursing education. Developments such as ECT, neuroleptic medications and open door policies required psychiatric nurses to work in new ways. The concept of the hospital as a ‘therapeutic community’ invited nurses to think of themselves as part of the patients’ social environment which could, in itself, be therapeutic. Dr Geoffrey Blake-Palmer, Director of Mental Health from 1960 to 1964, explained that the ‘duties, training and routine of the psychiatric nurse have undergone and are still passing through a most interesting period of development and change to meet the different demands and emphases for the forms of mental disorder and methods of their increasingly effective control’.<sup>2</sup>

Calls for improvements in psychiatric nursing education were supported by international changes. In 1956 a World Health Organisation (WHO) Expert Committee on Psychiatric Nursing had warned that psychiatric nurses needed to acquire new

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<sup>1</sup> A comment by Rita McEwan during a panel discussion on psychiatric nursing in the basic curriculum: KT, 56, 5, 1963, pp.11-2.

<sup>2</sup> AJHR, 1963, H-31, p.62.

knowledge and skills in order to keep pace with the rapidly changing ideas and practice in psychiatry. If this did not happen, there was a danger that the nurses' practice would remain custodial; either the patients' interpersonal needs would be ignored or other disciplines would take up the more therapeutic functions. The report predicted that as mental hospitals became more 'community-like', there would be a marked shift in the nurses' role. This needed to be reflected in psychiatric nursing education with a shift from didactic teaching to group interaction and the inclusion of theories on human behaviour, sociology, personality development and group skills.<sup>3</sup>

### ***Gradual improvements***

Improvements in psychiatric nursing education were gradually implemented. The new curriculum, introduced in 1958, acted as a catalyst for changes, but these did not happen quickly.<sup>4</sup> Hospitals struggled to allow their junior nurses time to study rather than always prioritising their work roles. Major obstacles included difficulties in releasing nurses from ward and outdoor duties and problems fitting lectures around individual nurse's bi-annual leave and rosters. It was not unusual for nurses to miss up to 25 percent of their classes over the three-year training period.<sup>5</sup> Shortages of qualified tutorial staff and senior nurses' minimal understanding of the concepts underpinning the new syllabus were also a problem.

Tutor sisters were able to introduce some reforms at a local level. When Betty Dandy, for example, left Oakley to take up the position of senior tutor at Porirua Hospital in 1962, she took the opportunity to instigate changes. Dandy created a roster in which pupil nurses could take their bi-annual leave and days off in class groups rather than as individuals; this greatly reduced the absentee rate. She also requested that classes be taught in whole days rather than two-hour periods and that each class be given a 'block course' to enable them to complete the whole curriculum. Dandy's successes were not duplicated in all hospitals. Oakley Hospital administrators, for example, had still not

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<sup>3</sup> World Health Organisation, Expert Committee on Psychiatric Nursing, *First Report*, Geneva, 1956.

<sup>4</sup> See Chapter IV.

<sup>5</sup> See for example: Report on Inspection of Seaview Hospital by Rita McEwan, 14 May 1963, H-1, 34234, ANZ, Wellington.

implemented a block system of training by 1964.<sup>6</sup> Their classes continued to be interrupted by the leave and roster requirements of individual nurses.<sup>7</sup>



**Figure 28 Tutor Sister Dandy teaching at Oakley, circa 1960.**  
**Source: Oakley Hospital photographs collection, ANZ, Auckland.**

Tutor sisters lobbied for fixed starting dates for classes. Bi-annual intakes gradually replaced what Dandy called, the “willy-nilly, silly-dilly, straggle-in” policy of trainee recruitment’.<sup>8</sup> Hospital administrators, however, remained reluctant to ask applicants to wait to take up employment.<sup>9</sup> A compromise was reached by which hospitals were encouraged to appoint new staff as attendants or assistant nurses until the next training block was available. The new policy was largely in place by 1964 but continued to be challenged by the Public Service Association (PSA). The union accused the employers of constructing a way of employing cheap labour and demanded trainee status and pay for all intending student nurses.<sup>10</sup>

The new curriculum’s longer teaching hours created a demand for more tutors; at least two were required for each hospital. Since there were not enough double-qualified (psychiatric and general) female nurses to fill these positions, the Division of Mental Health decided to allow men to apply for teaching positions and to encourage them to undertake training as registered male (general) nurses.<sup>11</sup> Prior to this, men had assisted

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<sup>6</sup> Williams, p.246.

<sup>7</sup> Nurse Inspector’s Report, 26 March 1965, YCAA 1081, 29d, ANZ, Auckland.

<sup>8</sup> Williams, p.247.

<sup>9</sup> Blake-Palmer circular, 14 September 1960, DAHI, Acc D266 357e, 6/26/4, ANZ, Dunedin.

<sup>10</sup> 24 March 1964 Dan Long to Mirams, H-1, 31000, 30/7/6, ANZ, Wellington.

<sup>11</sup> AJHR, 1961, H-31,p.61.

with teaching but had not been formerly appointed as tutors. Sunnyside Hospital was one of the first to advertise specifically for male tutors.<sup>12</sup> W.G.C. Thompson was appointed (see Figure 28 below of Thompson with the graduating class of psychiatric nurses in 1960). Seaview Hospital advertised for a male tutor soon afterwards<sup>13</sup> Although men took up tutoring positions, few undertook general (male nursing) training, largely because of the economic implications of reverting to trainee status in the general hospital system. By 1965, five of the twelve tutorial positions across the Division were occupied by men, only one of whom was a registered male nurse. In contrast, all but one of the seven tutor sisters held dual registration.<sup>14</sup>



**Figure 29 Sunnyside Hospital state finalists with male tutor, W.G.C. Thompson (front left), November 1960.**  
**Source: Sunnyside Hospital photograph collection, Canterbury District Health Board.**  
**For other names, see Appendix N.**

### ***Refresher courses for psychiatric nurses***

It became apparent that if there were to be changes in nursing practice, educational updates were also required for senior nurses. Stanley Mirams, the Deputy-Director of Mental Health, believed that if changes in psychiatric hospitals were to be achieved, nurses would need the skills and opportunities to ‘think critically and constructively about the future of their own profession’.<sup>15</sup> Largely at his instigation, the Division

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<sup>12</sup> KT, 53, 8, 1960, p.32.

<sup>13</sup> Medical-Superintendent, Auckland Mental Hospital to Director of Mental Hygiene, re applications for male tutor position at Seaview Hospital, 17 July, 1961, YCAA, 1081, 33d, ANZ, Auckland.

<sup>14</sup> New Zealand Public Service List, 1965. YCAA, 1083, 4a, ANZ, Auckland.

<sup>15</sup> KT, 56, 9, 1963, p.20.

established a training programme for senior nurses and tutors. Planning commenced in 1960 when Mirams enlisted the support of the Divisions' two clinical psychologists and the Department of Health's Staff Training Officer to assist in planning and implementing a series of workshops. They were joined by Rita McEwan, who had recently returned from a three-year WHO appointment teaching mental health in Singapore. She was now a nurse inspector with the Department of Health's Division of Nursing.<sup>16</sup>

The first training programme was a week-long residential course for tutor sisters held at the Postgraduate Nursing School in Wellington in August/September 1961.<sup>17</sup> The School was still the only facility offering 'postgraduate' education for nurses. Its main programme was the year-long Diploma in Nursing for senior registered nurses but short courses were also offered for registered nurses.<sup>18</sup> In this first course, 14 psychiatric tutor sisters undertook classes on teaching and learning methods such as discussion techniques and exam skills. They also learned about current psychiatric developments including community care, social work and mental deficiency services. They were briefed about Divisional policy and met the Director, Blake-Palmer, to air their concerns. It was evident from the discussions that most tutors felt limited in their ability to influence clinical teaching and standards. It seems that their access to the wards was constrained by the degree of welcome afforded by charge nurses and ward sisters. The wards, and the nursing care practised within them, were considered the domain of those in charge. Although Blake-Palmer acknowledged their requests for better access to the wards, it does not appear that he did much more to make this happen.<sup>19</sup>

Over the next few years, the Division held over 15 refresher courses for senior nurses. These week-long residential courses were held at one of the psychiatric or psychopaedic hospitals. Some were for matrons and assistant matrons, some for head (male) nurses and others for male charge nurses and female ward sisters. Refresher courses were also provided for tutors.<sup>20</sup> Although the focus differed for each course, the overall

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<sup>16</sup> KT, 50, 1, 1957, p.3.

<sup>17</sup> Programme circulated, 22 August 1960, DAHI, Acc D266 357e, 6/26/4, ANZ, Dunedin.

<sup>18</sup> In 1970, the name of the Postgraduate Nursing School was changed to the School of Advanced Nursing Studies. The School closed in 1978 after the introduction of nursing studies at Massey University: Marie E. Burgess, *Nursing in New Zealand Society*, Auckland, 1984, pp.72-6.

<sup>19</sup> Blake-Palmer to medical-superintendents, 14 September 1960, DAHI, Acc D266 357e, 6/26/4, ANZ, Dunedin.

<sup>20</sup> 'In-service Education on a National Scale', KT, 56, 9, 1963, pp.20-4.

programme contained consistent themes. Senior nurses were introduced to new ideas about mental health and the role of the psychiatric nurse including the need for communication skills and the importance of the nurse/patient relationship. They were also taught about the nurses' role in relation to rehabilitation and community liaison. Pre-reading included texts on community mental health and clinical teaching.<sup>21</sup> Mirams, who believed that nurses should have an understanding of the patients' experience of hospitalisation, introduced them to passages from Janet Frame's autobiographical novel, *Faces in the Water*.<sup>22</sup>

The refresher courses appeared to be successful in introducing nurses to new ideas in psychiatry. Margaret Bazley recalls that the course was enlightening and useful. She attended the first course for ward sisters in 1963. She had, by this time, left Oakley Hospital, completed her general and obstetric nursing training in Thames, and was in charge of a female ward at Tokanui. Bazley clearly remembers Mirams reading aloud extracts from *Faces in the Water*. She was also introduced to the concept of therapeutic community, which she immediately attempted to apply in her ward. Several years later, these principles became central to the reforms she spearheaded with Edwin Hall at Sunnyside Hospital.<sup>23</sup>

For most of the nurses, the courses provided a rare opportunity to be exposed to people and ideas outside their own institutions. They learned, for example about the broader nursing profession. Flora Cameron, the Director of Nursing, talked to the matrons about their role as administrators and Elizabeth Orbell, Principal of the Postgraduate Nursing School, discussed 'modern hospital administration'.<sup>24</sup> It was Miram's intention that such addresses would assist the matrons to discover that they 'need not be isolated from other types of nursing service'.<sup>25</sup>

### ***Separating out psychopaedic nursing***

From 1963, nurses in mental deficiency hospitals undertook a separate training from psychiatric nurses.<sup>26</sup> The three-year 'psychopaedic' nursing programme and registration

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<sup>21</sup> For example, see the course programme for charge nurses and sisters, 15-19 July 1963, DAHI, Acc D266 357f, 6/26/4, ANZ, Dunedin.

<sup>22</sup> Janet Frame, *Faces in the Water*, London, 1980 (first published 1961).

<sup>23</sup> Margaret Bazley interview 29 January 2004.

<sup>24</sup> Programme distributed to matrons, 13 June 1961, H-MHD-30, 43932, 30/7/3, ANZ, Wellington.

<sup>25</sup> Mirams to Cameron, 12 May 1961, H-MHD-30, 43932, 30/7/3, ANZ, Wellington.

<sup>26</sup> AJHR, H- 31, 1963, p. 89 and 1964, p.59.

were introduced as a result of an amendment to the *Nurses and Midwives Act* in 1960. The term ‘psychopaedic’ was coined in an attempt to avoid the stigmatising effect of words such as ‘mental deficiency’ and ‘mentally subnormal’, both terms used interchangeably in the early 1960s.<sup>27</sup> ‘Psychopaedic’ was also thought to best describe the core functions of the nurses’ work, ‘the upbringing and training of the young subnormal child’.<sup>28</sup>

The instigation of psychopaedic training and registration was recognition of the specialist nature of the work in mental deficiency hospitals and training schools. This paralleled developments in Britain where there had been substantial growth of separate institutions for mentally handicapped children and adults staffed by specialist nurses. Psychopaedic registration was also seen as a necessary step in attracting and retaining staff for this growing area. Registered psychiatric nurses with experience in mental deficiency nursing were given opportunities to ‘bridge’ to the new qualification. Some were credited with the new psychopaedic registration and others undertook a course of instruction and sat a special ‘bridging’ examination.<sup>29</sup>

### ***Greater control by the Nurses and Midwives Board***

Although the N&MB had been nominally responsible for psychiatric nursing education since 1945, the process of handing over control from psychiatry to nursing had been slow. Psychiatrists had a substantial role in planning and delivering the educational programme. This was partly due to an assumption, common to all areas of nursing, that nursing knowledge was a subsidiary of medical knowledge. In the psychiatric field this reliance on medicine was exaggerated because of the relative insularity and the well-established traditions of the mental hospital network. Medical superintendents, who held paramount control of their hospitals, were not always willing to make space for the N&MB and its representatives.

The matron was legally responsible under the *Nurses and Midwives Act* for her hospital’s nursing school. She was expected to set and monitor the standards of classroom and clinical teaching and communicate directly with the Board. Her influence in psychiatric hospitals, however, was limited by the overall authority of medical

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<sup>27</sup> The term, ‘intellectual handicap’ began to be used from the mid-1960s.

<sup>28</sup> AJHR, 1961, H-31, p.61.

<sup>29</sup> AJHR, 1964, H-31, p.59.



superintendent, the power of the hospital secretary, and the administrative structure of the male sides. Head nurses (previously known as ‘head attendants’) made decisions on staff allocation, clinical experience for trainees, and nursing practice on the male wards.<sup>30</sup> A matron relied on her relationship with the male head and charge nurses to gain access to the male wards and staff. She also depended on the goodwill of the medical superintendent and hospital secretaries for access to correspondence in and out of the hospitals. Matrons’ difficulties in this regard were illustrated in 1961, when they complained at the Matrons’ Conference, that they often had to wait for information, even to the extent of missing out on reading Divisional circulars, because they were not sent individual copies.<sup>31</sup>

When Mirams became Director of Mental Health in 1964, he acted to strengthen the matron’s position in the hospitals’ hierarchy and endorse the authority of the N&MB.<sup>32</sup> He informed the hospital medical superintendents that it was the N&MB, not the Division, that was responsible for training schools. He reminded them that the matron was accountable for the training of both female and male pupils; she was ultimately responsible for attesting to a pupil nurse’s suitability and experience.<sup>33</sup> This latter question had been a source of friction between matrons and head nurses because of the practice of appointing staff weeks or months before classes began. Trainees sometimes argued for the right to sit the State Examination early because of their previous nursing experience. Mirams also reinforced the matron’s right to uninterrupted communication with the N&MB. In future, he instructed, all correspondence from the N&MB Registrar ‘should be passed to the Matron immediately and unopened’.<sup>34</sup>

Until the mid-1960s, the N&MB had relied heavily on Rita McEwan to set and mark State Examination questions. Few other tutor sisters had had opportunities to gain higher qualifications or to network within national nursing circles. McEwan and Rose Connor were still the only psychiatric nurses to have attended the Postgraduate Nursing School.<sup>35</sup> In 1965, when McEwan accepted a WHO posting to Iran, her sudden absence

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<sup>30</sup> The term, ‘attendant’ was replaced by ‘nurse’ in the early 1960s.

<sup>31</sup> Matrons’ Conference, 7-8 November 1960, H-MHD-30, 34932 (30/7/3), ANZ, Wellington.

<sup>32</sup> Williams, p.234.

<sup>33</sup> Mirams to medical superintendents, 15 May 1964, DAHI, Acc D266, 357f, 6/26/4, ANZ, Dunedin.

<sup>34</sup> *ibid.*

<sup>35</sup> Rose Connor was Matron of Porirua Hospital.

left a gap that was hard to fill.<sup>36</sup> Elizabeth Orbell, the Chairman of the Board's Examination Committee, and Elsie Boyd, neither of whom were psychiatric nurses, had to write the psychiatric questions for that November's State Examination. Orbell insisted that this solution 'cannot be repeated as our knowledge of the subjects is totally inadequate'.<sup>37</sup>

McEwan's absence also exposed the lack of co-ordination between the Division of Mental Health and the N&MB. When Orbell invited psychiatric tutors to forward questions, she discovered that they had no experience of setting examinations. Until mid-1965, the Hospital (internal) Final Examinations had been set by Divisional Head Office.<sup>38</sup> They were in essay format rather than the short answer structure of the State Examinations. Not only were the tutors unfamiliar with setting questions, they were unable to prepare students adequately for the unfamiliar short-answer questions in the State Examination. Orbell surmised that this probably explained the poor pass rate.<sup>39</sup>

The N&MB resolved to take full control of the psychiatric examination process. Mirams agreed that, in the future, the Examination Committee of the N&MB would be responsible for collecting questions, setting and approving papers, arranging examiners, marking, and evaluation. The Division of Mental Health had previously undertaken much of this work. In order to facilitate these changes, a psychiatric nurse, Miss Nicholls of Sunnyside Hospital, was appointed to the Education Committee. It was also decided that a psychiatrist would be appointed to the Board's Examination Committee.<sup>40</sup> Although medical officers continued to have input, the decision represented a substantial shift of control from psychiatry to nursing. After almost fifty years, the Division was relinquishing its primary role in managing its nurses' examination processes.

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<sup>36</sup> Rita McEwan was sent to Iran to provide advice on psychiatric nursing education and services: KT,58, 3, 1965, p.21.

<sup>37</sup> Elizabeth Orbell to Audrey Orbell, Registrar, N&MB, 27 August 1965, H-1, 32893, 1/9, ANZ, Wellington.

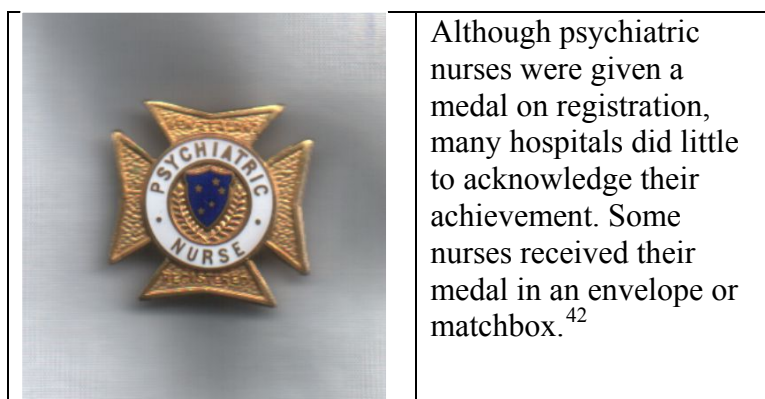
<sup>38</sup> After 1965, Hospital Final Examinations were to be set by one of the medical superintendents and marked by the medical superintendent of each hospital.

<sup>39</sup> Elizabeth Orbell to Audrey Orbell, Registrar, N&MB, 27 August 1965, H-1, 32893, 1/9, ANZ, Wellington.

<sup>40</sup> Minutes of Discussion between Director, Division of Mental Health, Registrar, N&MB, and Chairman, Board's Education Committee, 20 May 1966, H-1, 3340, 1/11/77, ANZ, Wellington.

### *Stirrings of professional interest*

Educational changes were accompanied by an emerging interest in professional issues among some psychiatric nurses. Dawn Price, a tutor sister at Seacliff Hospital, was one such nurse. In November 1959, supported by J.D. Joynt, the hospital psychologist, Price sought permission to establish a professional body for psychiatric nurses. Seacliff nurses wanted an organisation that was open to both men and women and focused on their concerns. They noted that both the New Zealand Registered Nurses' Association (NZRNA) and the Registered Male Nurses' Association focused mainly on general nursing issues and both were single-sex organisations. In the absence of their own professional organisation, psychiatric nurses had been forced to use their union, the PSA as an organ of professional concern. This situation was Price and Joynt believed, not 'desirable or ethical'.<sup>41</sup>



**Figure 30 Registered Psychiatric Nurse medal**

The Seacliff nurses were motivated by a desire to protect their professional standards. They strongly objected to proposed legislation that would grant registration to mental hospital nurses and attendants who had not passed the State Examination but had passed the Institutional Final Examination prior to June 1960. Current students, they claimed, would view the proposed legislation with a 'feeling of dismay that the registration for which they are studying so diligently, is contemplated as a gift to a favoured and quite undeserving section'.<sup>43</sup> The nurses were also concerned about poor morale and 'inertia', particularly among male nurses. Their proposal included the creation of a second-level workforce of assistant nurses or attendants, who could undertake the 'more

<sup>41</sup> Dawn R. Price and J.D. Joynt to Director of Mental Hygiene, 10 November 1959, DAHI, Acc D266 357e, 6/26/4, ANZ, Dunedin.

<sup>42</sup> Gordon Rapson interview 31 August 2004; Peter Sanders interviewed by Margaret Whineray, 13 July 1989, OHInt-0139/1, NERF-PNOHP, ATL.

<sup>43</sup> Draft letter of Seacliff Registered Psychiatric Nurses' Institute, November 1960, DAHI, Acc D266, 358n, 6/32/0, ANZ, Dunedin.

unskilled jobs, such as cleaning and truck driving' and thus release male and female nurses to focus on patient care.<sup>44</sup>

The Seacliff Registered Psychiatric Nurses' Institute was established in 1960. It aimed to 'raise the standard of psychiatric nursing to the highest possible professional level, and give, by example and instruction, the dignity and meaning to psychiatric nursing that the calling needs and deserves'.<sup>45</sup> Meetings, which were open to all members of staff, were addressed by invited speakers on various topics related to mental health. The institute showed its support of students by offering prizes for top Seacliff graduates. An attempt was made to transform the organisation into a national body, but the initiative had to be abandoned due to lack of interest.<sup>46</sup> The institute lasted less than two years. In that time its organisers had written a constitution, appointed a patron, officers and committee members, and held monthly meetings. There were no further initiatives to establish a separate professional body for psychiatric nurses during the 1960s.

A few psychiatric nurses, mostly matrons and tutor sisters, were active in the NZRNA. Branches were established at or close to psychiatric hospitals. Rose Connor, Matron of Porirua Hospital, had founded a branch in 1956.<sup>47</sup> Membership grew steadily during the 1960s, though, like many other NZRNA branches, a great proportion were non-practising registered nurses drawn from the surrounding district.<sup>48</sup> An active branch at Te Awamutu had close links to Tokanui Hospital. M. Stallworthy, wife of Kenneth Stallworthy, the Medical Superintendent, was President for a time in the early 1960s.<sup>49</sup> Other branches invited speakers on mental health from time to time, and occasionally held their meetings at the local psychiatric hospitals. When the Otago Branch held its meeting at Seacliff Hospital in October 1962, it was heralded as '... a step of great importance, as it will help to further the understanding between the psychiatric and general branches of the nursing profession'.<sup>50</sup> Despite these links, the numbers of

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<sup>44</sup> Dawn R. Price and J.D. Joynt to Director of Mental Hygiene, 10 November 1959, DAHI, Acc D266 357e, 6/26/4, ANZ, Dunedin.

<sup>45</sup> Constitution of the Seacliff Registered Psychiatric Nurses' Institute, 1960, DAHI, Acc D266, 358n, 6/32/0, ANZ, Dunedin.

<sup>46</sup> H.G. Roberts, Hon. Secretary, Seacliff Registered Psychiatric Nurses' Institute to Medical Superintendent, Avondale Hospital, 11 July 1961, YCAA, 1081/43e, ANZ, Auckland.

<sup>47</sup> KT, 54, 4, 1961, p.26.

<sup>48</sup> KT, 62, 10, 1969, p.12.

<sup>49</sup> KT, 54, 1, 1961, p.8.

<sup>50</sup> KT, 55, 1 1, 1962, p.20.

psychiatric nurse members remained low. The exclusion of men severely limited its appeal in the Division's hospitals.

NZRNA continued to hold the sole right to nominate a psychiatric nurse to the N&MB. The issue remained a bone of contention between the NZRNA and the psychiatric nurses' union, the PSA. The union raised the issue repeatedly with the successive Ministers of Health and Prime Ministers and, in 1963, used legal means to try to stop the appointment.<sup>51</sup> They were unsuccessful, largely because of the lobbying power of the NZRNA and the lack of support from the Division. The PSA's relentless lobbying did, however, finally wear down the Nurses' Association's resolve about male membership. In 1965, the Association's constitution was amended to allow full membership for male registered psychiatric and psychopaedic nurses. The NZRNA acknowledged that the decision was made with 'a view to protecting the right of the Association to nominate the Psychiatric Member of the Nurses and Midwives' Board'.<sup>52</sup>

Although psychiatric nurses did not join the NZRNA in large numbers, interest in the organisation increased in the late 1960s. Branches of the affiliated Student Nurses' Association (SNA) were established in a number of mental hospitals. In 1968/9, Sunnyside Hospital hosted the annual SNA conference.<sup>53</sup> By 1971 there was sufficient interest in the annual SNA conference that the Division of Mental Health agreed to grant paid leave and travel allowance for two delegates per hospital and any Executive members.<sup>54</sup> It appears that this increased interest was not purely because of raised awareness of professional issues, but was also a by-product of industrial unrest. Student nurses used the SNA as a vehicle for expressing views both in support of and against the union. During a strike by psychiatric nurses in 1971, several SNA branches were suddenly formed in psychiatric hospitals, presumably to provide another voice for the strikers (see Chapter VIII for further discussion of the strike).<sup>55</sup>

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<sup>51</sup> Telegram from Macalister, Mazengarb & Co. to Don McKay, Minister of Health, 17 May 1963, H, 1, 33374, 2/1/2, ANZ, Wellington.

<sup>52</sup> Female registered psychopaedic nurses also gained full membership: KT, 58, 6, 1965, p.25.

<sup>53</sup> Folder of information for student nurses attending Student Nurses' Association Conference at Sunnyside Hospital, 1968/9, CAJV, CH303/20h, ANZ, Christchurch.

<sup>54</sup> Department of Health circular to medical superintendents, 8 October 1971, DAHI, Acc266, 351d, 6/16/1, ANZ, Dunedin.

<sup>55</sup> Margaret Bazley interview 23 February 2004. For further discussion on the nurses' industrial action, see Chapter VIII.

### *Residual problems in psychiatric nursing education*

A number of problems continued to plague psychiatric nursing education. Service requirements, such as domestic duties and shift work, interfered with the learning programme. Staffing shortages limited the hospitals' ability to select people with solid educational backgrounds and the conditions in psychiatric hospitals contributed to a high student dropout rate. Although students were introduced to modern psychiatric concepts in class, there were limited opportunities to apply them in the wards. Recruitment to tutor positions remained difficult and very few had training for the job. These problems were not unique to the psychiatric hospitals, but they tended to be worse than in general hospitals.

Although educational standards of nursing applicants were generally improving, psychiatric hospitals lagged behind general nursing. It was common practice for the Division of Mental Health to accept recruits without School Certificate. All that was required was post-primary schooling, a medical examination, a chest x-ray and a satisfactory interview.<sup>56</sup> At times, psychiatric hospitals even offered training to people without secondary schooling if they had proved their worth as attendants or assistant nurses. Mature men with work experience were particularly valued.

'Wastage' during psychiatric nurse training was very high. In 1963, only 51 psychiatric nurses qualified for state registration across the whole country. The next year was better, but still only 79 sat the Final Examination.<sup>57</sup> Classes often started with 20 to 30 trainees but reduced to five or six by the end of three years. When Barbara Milne started training at Oakley Hospital in 1960, for example, she was in a class of well over 30 students, but she recalls only four passed the State Final Examination.<sup>58</sup> Peter Sanders started work the same year at Porirua. Many of his classmates dropped out at the end of 'Prelim'. Of his remaining class of nine, only three sat State Finals. Four others continued 'on the job' as psychiatric assistants.<sup>59</sup> The dropout rate was higher than that of general nursing, although that rate was also considered to be problematic.

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<sup>56</sup> See letters of inquiry, H-1, 30779, 30/35/51 and H-1, 32503, 30/35/51, ANZ, Wellington

<sup>57</sup> AJHR, 1964, H-31, p.84.

<sup>58</sup> Barbara Milne interview 7 September 2005.

<sup>59</sup> Peter Sanders interviewed by Margaret Whineray, 13 July 1989, OHInt-0139/1, NERF-PNOHP), ATL, Wellington.

## **Nursing education reform**

During the 1960s, nursing leaders called for significant changes in general nursing education. Initially, this focused on the need to broaden the content of the curriculum by adding more social sciences and psychiatric nursing concepts. Later, they lobbied successfully to raise the minimum entry qualification, introduce a second-level nursing programme (community nursing) and increase the hours in the basic nursing programme. As the decade progressed, they became overtly critical of the hospital-based, apprenticeship model of nursing education. Nursing leaders looked towards North America for guidance in their search for a better model; the ideal was generalist programmes in which trainee nurses could have student status. They also advocated for the opportunities for university education for some nurses. Because of the focus on general nursing as the normative 'professional' qualification, it was not always clear what the emerging proposals might mean for psychiatric nursing.

### ***Psychiatric concepts in the general curriculum***

Broadening the basic (general) nursing curriculum was the major focus of nursing education reform in the early 1960s. The NZRNA, in particular, lobbied for the inclusion of a variety of subjects, including psychiatric nursing concepts. The Association's actions were largely motivated by a fear that New Zealand, represented by the NZRNA, would lose its membership with the International Council of Nurses (ICN) if it did not comply with that organisation's directives.

In 1961 ICN issued a new draft constitution which caused debate and consternation among some of its member countries. The constitution included a definition of a professional nurse as 'one who has completed a comprehensive nursing preparation in an approved School of Nursing and is authorised to practise nursing in her country [my emphasis]'.<sup>60</sup> ICN's position was that nurses should be given a broad general education as a foundation for the acquisition of specialty nursing skills. General nursing training would no longer be considered adequate preparation unless it included a range of subjects including psychiatric nursing concepts. ICN's new definition potentially caused problems for member associations whose countries that did not offer generic, basic-level programmes. Their membership of ICN was jeopardised. Because New Zealand

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<sup>60</sup> Bridges, p.213.

offered specialty basic-level programmes such as psychiatric and psychopaedic nursing rather than a single, broad-based programme, the NZRNA's membership of ICN was threatened.

ICN's policies had always reflected an assumption of the primacy of general nursing. The organisation considered other types of nursing to be specialties, rather than 'professional nursing' in their own right. In the 1940s, the Council had attempted to limit membership to nurses who held a general nursing qualification but this had become impossible to sustain because several member associations, including the NZRNA, allowed membership of single-specialty registered nurses.<sup>61</sup> From 1947 ICN had followed a compromise position. Associations that accepted membership of single-specialty registered nurses were allowed to belong but only nurses holding a general registration could serve on ICN's Board of Directors, Grand Council, or committees.<sup>62</sup> Another proposal to create stringent membership criteria based on general training failed in 1959.<sup>63</sup>

ICN's position on nursing education was influenced by North America, where a model of nursing education, based on generic undergraduate and specialised postgraduate programmes, was being promoted. During the 1950s, federal funding in the US had been made available for 'integration projects' in which psychiatric nursing concepts were introduced into undergraduate general nursing programmes. Some US nurse educationalists went so far as to suggest that the teaching psychiatric nursing as a distinct specialty at undergraduate level was divisive to nursing. The skills, they argued, should be so thoroughly integrated that the specialty would be no longer identifiable.<sup>64</sup>

Generic undergraduate nursing programmes were predicated on the belief that nursing is a single, unified entity. ICN's support of this premise was affirmed in 1959 when the organisation approved publication of Virginia Henderson's *Basic Principles of Nursing Care*. Henderson, an American nurse-theorist, claimed that basic nursing care was 'the

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<sup>61</sup> NZRNA had granted full membership to female registered psychiatric nurses in 1945: KT, 38, 3, 1945, p.61.

<sup>62</sup> Bridges, pp.133-4.

<sup>63</sup> Barbara Brush, et al., eds, *Nurses of All Nations: A History of the International Council of Nurses, 1899-1999*, Philadelphia, 1999, p.214, pp.133-4.

<sup>64</sup> Church, 'That Noble Reform', pp.215-8.



same whether the person is physically or mentally ill'. Her definition of the unique function of nursing became foundational for nursing education in many countries.<sup>65</sup>

Because of potential problems with membership issues, ICN deferred its decision on the new constitution.<sup>66</sup> Instead, it undertook an extensive consultation process on their proposed definition of 'professional nurse' during 1962.<sup>67</sup> New Zealand nurses participated through workshops and discussion groups organised by the NZRNA. Nursing leaders predominantly agreed that the basic nursing curriculum should be broadened to include social sciences and psychiatric concepts. These, they argued, would allow nurses to have a better understanding of the world and of human behaviour, including their own. Psychiatric concepts were considered necessary to prepare general nurses for a more extensive future role. It was predicted, that as barriers between general and psychiatric services began to break down, general nurses would take a greater role in caring for people with mental illness. Nurses would be needed to staff psychiatric wards at general hospitals and to care for patients on leave or discharged from psychiatric hospitals. Public health nurses were already working with ex-patients, and with families and children in the prevention of mental illness.<sup>68</sup>

Proposals to introduce psychiatric concepts into the basic (general) curriculum met with some opposition. Rita McEwan challenged the suggestion that a nurse prepared in a three-year generalist programme could work as a specialist in psychiatry. She clashed with other nurse leaders over the issue during a panel discussion at the NZRNA's annual conference.<sup>69</sup> Nancy Kinross, who had studied psychiatric nursing as a post-graduate student in the United States, was of the opinion that nurses should be taught principles, rather than specific subjects. These principles could be applied in any setting, whether it was obstetric, medical, surgical, or psychiatric. Flora Cameron, the former Director of Nursing, was inclined to agree that the curriculum should not be fragmented into different types of nursing, but should be fully integrated. McEwan reacted strongly. Their comments, she suggested, would 'make the blood of a good psychiatric nurse rise

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<sup>65</sup> Brush, et al., eds, pp.135-6.

<sup>66</sup> Bridges, pp.213-4. KT, 55, 1, 1962, p.23.

<sup>67</sup> KT, 55, 12, 1962, p.7.

<sup>68</sup> KT, 56, 2, 1963, pp.8-10.

<sup>69</sup> KT, 56, 5, 1963, pp.8-17, 20.

to the bait'. She objected to the implication that the 'vast body of knowledge and skill lying behind the psychiatric nurse could be passed on in six easy lessons'.<sup>70</sup>

In isolated incidences, moves were begun to teach psychiatric nursing concepts to general nurses. A few general hospital schools had begun to experiment with including psychiatric content in the basic curriculum.<sup>71</sup> In 1962 Tokanui and Porirua Hospitals also began to offer short courses in psychiatric assessment and management for public health nurses.<sup>72</sup>

Over the next few years the N&MB investigated ways to include psychiatric concepts in the general curriculum. Despite her reservations, McEwan contributed to the discussions as a member of the Board's Curriculum Planning Committee. In 1964 the committee formulated a Plan for Nursing in New Zealand. Its central goal was that by 1970 nursing education should be in three main streams: a degree programme, a general three-year programme and a community (shortened course) nurse programme. The basic curriculum should include psychiatric concepts.<sup>73</sup> The plan became a point of reference for advocates of nursing education reform over the next eight years.<sup>74</sup>

The Curriculum Planning Committee realised that integration of psychiatric concepts depended on general nursing tutors gaining extra knowledge and skills. Two courses were suggested; a short course to be offered three times each year for general tutors and a longer, six-month 'post-certificate' programme for general nurses with an interest in psychiatry. It was hoped that the post-certificate programme could lead to registration in psychiatric nursing for those who completed a further six months training.<sup>75</sup>

Short courses in psychiatric nursing concepts were provided for general nursing tutors from August 1965. North Island tutors attended courses at Kingseat Hospital and those from the South went to courses at Templeton Hospital. Peter Simmonds, who had replaced McEwan on the renamed Education Committee, took a lead in facilitating the

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<sup>70</sup> KT, 56, 5, 1963, pp.11-2.

<sup>71</sup> Minutes of N&MB, 15 November 1962, H, 1, 28503, ANZ, Wellington.

<sup>72</sup> KT, 60, 6, 1967, pp.19-23.

<sup>73</sup> See, Workforce Development Group, Department of Health, *Nursing Education in Transition. The Transfer of Nursing Education to the General System of Education*, Wellington, 1988, p.5.

<sup>74</sup> In 1969, the *Plan for Nursing in New Zealand* was being used as a benchmark for reviewing the Psychiatric and Psychopaedic curricula: 16 January 1969, ABYO, 7888, Acc. W5148, Box 20, Record 20, ANZ, Wellington. It has been considered as a significant step in the movement towards comprehensive education: *ibid*.

<sup>75</sup> Minutes of N&MB Curriculum Planning Committee, 26 November 1964, ABYO, 7888, AccW5148, Box 20, Record 20, ANZ, Wellington.

courses on both sites. Simmonds, who was registered in both Psychiatric and Male Nursing, was the Senior Tutor at Kingseat Hospital.<sup>76</sup> The four-week courses provided a brief introduction to psychiatric nursing approaches, interpersonal relationships, basic psychology and group process.

Nursing tutors were surprised by the informality of the workshops and the relatively relaxed atmosphere that pervaded relationships within psychiatric hospitals. One participant commented on the 'environment of controlled relaxation'.<sup>77</sup> Another noted how the lectures had 'awakened in us a much deeper awareness of the psychology of life... we began to realize that by understanding ourselves and our students better, we would be reaching a milestone towards better patient care'.<sup>78</sup> Despite enthusiastic reports from participants, many tutors experienced difficulty implementing the concepts in their own nursing programmes.<sup>79</sup>

Two six-month, post-certificate courses in psychiatric nursing were proposed, one in the North Island at Kingseat and the other, in the South Island, at Sunnyside. Simmonds was given the task of developing the course outline with help from the principal tutor of Auckland Hospital Board.<sup>80</sup> This plan, however, was soon superseded. The Education Committee of the N&MB took an opportunity to use the planning skills of two psychiatric nurses who were attending the Postgraduate School in Wellington in 1965. One was Bazley, who was now an assistant matron at Seacliff Hospital. The other was Betty Higgins of Nelson.<sup>81</sup> It was decided that Bazley had the skills to run the programme. She was duly instructed by Elizabeth Orbell, the Postgraduate School principal, to shift from the Administration Stream to the Education Stream of the Postgraduate Programme. Orbell informed her that she would not be returning to Seacliff, but would stay in Wellington to run the post-certificate course at Porirua Hospital.<sup>82</sup>

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<sup>76</sup> Minutes of N&MB Curriculum Planning Committee, 27 April 1965, ABYO, 7888, AccW5148, Box 20, Record 20, ANZ, Wellington.

<sup>77</sup> KT, 58, 10, 1965, p.15.

<sup>78</sup> KT, 59, 5, 1966, pp.13-4.

<sup>79</sup> Minutes of N&MB Curriculum Planning Committee, 2 August 1966, ABYO, 7888, AccW5148, Box 20, Record 20, ANZ, Wellington.

<sup>80</sup> Minutes of N&MB Curriculum Planning Committee, 27 April 1965, ABYO, 7888, AccW5148, Box 20, Record 20, ANZ, Wellington.

<sup>81</sup> Betty Higgins was a registered (general) nurse who had also trained as a psychiatric nurse. She was a tutor sister at Nelson (General) Hospital: Margaret Bazley personal communication.

<sup>82</sup> Margaret Bazley interview 29 January and 23 February 2004

Later in 1965 Bazley was again given new directives. She was called to the head office of the Division of Mental Health where Mirams told her that she would now be going to Sunnyside Hospital in Christchurch. Edwin Hall, the Medical Superintendent, was threatening to return to England unless the Division could find a young matron who was willing to work with his progressive ideas. Mirams' solution was to move Bazley and the post-certificate course to Sunnyside. Promotion was still largely based on seniority, so the only way to ensure that she got the position was for the Division to advertise for someone holding the Postgraduate Diploma. As soon as her results were available, Bazley was given the word, and moved to Christchurch to take the position as Matron of Sunnyside Hospital. At 27 years, she was the youngest matron in the Division.<sup>83</sup> Bazley is shown below with the Sunnyside sisters, some of whom were many years her senior.



**Figure 31 Matron Margaret Bazley (4<sup>th</sup> from left, front row) with ward sisters at Sunnyside, 1967.**

**Source: Sunnyside Hospital photograph collection, Canterbury District Health Board.**

Mirams, who was keen to have the post-certificate course up and running by April 1966, worked with Bazley to finalise the curriculum. The State Services Commission initially approved funding for the Division to employ ten students and an extra tutor. This was to be reviewed for each course, with an understanding that hospital boards would take over support for their own employees.<sup>84</sup> In what was either an oversight or

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<sup>83</sup> Margaret Bazley interview 29 January and 23 February 2004.

<sup>84</sup> Memo from SSC to Department of Health, 8 March 1966, H-MHD, 30, 34932, 30/7/3, ANZ, Wellington.

possibly Mirams' sense of ownership, the programme began before it had been signed off by the N&MB. Students commenced on 27 April 1966.<sup>85</sup>

Most of the general nurses attending the post-certificate course had a special interest in working with people with mental illness. They included nursing tutors, people running psychiatric wards in general hospitals and public health nurses working with psychiatric patients in the community.<sup>86</sup> Supernumerary status enabled the tutors to plan ward experiences around the student's learning needs. Most clinical experience was undertaken at the acute unit, Fergusson Clinic, though the students also spent some time on the chronic, long-stay wards. Students also visited community agencies, clinics and other hospitals. Such opportunities were considered a luxury for nursing students on basic programmes.<sup>87</sup>

The post-certificate programme, like the psychiatric short courses, emphasised relationship skills, self-knowledge, and group process. The course purported to teach students the importance of a nurse's 'awareness of how she feels about herself and others, how she copes with her own problems, and her ability to relate to members of various types of groups'.<sup>88</sup> In this respect, the programme was underpinned by the interpersonal relations theories that were prevalent in psychiatric nursing literature at the time. Unlike the short courses, the six-month programme introduced general nurses to the workings of a psychiatric hospital and the treatment and care of psychiatric patients. The tutors endeavoured to portray hospitalisation as just one part of the patient's experience. Sessions focused on the patient's relationship to family, community, hospital, and hospital staff.<sup>89</sup>

Graduates of the post-certificate courses were not given any credit towards psychiatric training. This may have contributed to the fact that the course was not fully subscribed. In the first year, six graduated in May and eight in November.<sup>90</sup> The State Services Commission's reluctance to guarantee ongoing funding of the supernumerary positions

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<sup>85</sup> W. Horgan, Secretary, N&MB to Shirley Lowe, Registrar, N&MB, 26 August 1966, H-1, 33330, 1/11/38, ANZ, Wellington.

<sup>86</sup> Margaret Bazley interview 23 February 2004.

<sup>87</sup> KT, 59, 12, pp.16-7.

<sup>88</sup> KT, 59, 12, p.17.

<sup>89</sup> Programme outline of Post Certificate Course in Psychiatric Nursing, 1966, H-1, 33330, 1/11/38, ANZ, Wellington.

<sup>90</sup> Six students graduated in May 1967 and eight in November 1967, memos from Bazley, 24 May and 30 November 1967, H-1, 33330, 1/11/38, ANZ, Wellington.

may also have been a factor. The programme continued to be offered until 1972. After this, it was replaced by 40-week programmes leading to registration.<sup>91</sup>

In 1965, ICN finally adopted a new constitution. Its definition of a 'professional nurse' was much more inclusive than that of the earlier draft. A nurse was defined as a person who had 'completed a programme of Basic Nursing Education' and was 'qualified and authorized in her country' to provide nursing service and health promotion. Although ICN expected that a basic programme should provide a 'broad and sound foundation', there was no mention of a comprehensive requirement.<sup>92</sup> These definitions allowed individual countries freedom to decide how they wished to structure their nursing programmes. By this time, however, New Zealand nursing authorities were well on the path of incorporating psychiatric concepts in the basic general curriculum. Over the next seven years, this would develop into a concerted effort to introduce generalist or comprehensive programmes based in educational institutions.

### *Entry standards and second-level nurses*

During the early 1960s the N&MB, supported by the NZRNA, sought to improve the standard of nursing by raising the entry criteria for the three-year general nursing programme. It was anticipated that any shortfall of registered nurses could be filled by second-level nurses prepared in shorter, less academically taxing courses. Pilot programmes for a twelve-month, 'community nurse' training commenced in 1963.<sup>93</sup> These courses were originally instigated by the Department of Health with the aim of providing nursing care for patients in their own homes. They were, however, soon viewed as a solution to workforce problems in general hospitals. The N&MB sought legislative changes to establish an 18-month educational programme leading to community nurse registration. At the same time, they called for School Certificate to become the mandatory minimum qualification for entry to the general nurse training.<sup>94</sup>

Proposals to raise the level of entry to general nursing met with resistance from a number of groups. Hospital boards complained about the probable dire effects on

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<sup>91</sup> Harraway, p.46.

<sup>92</sup> KT, 59, 6, 1966, p.7.

<sup>93</sup> AJHR, H-31, p.53.

<sup>94</sup> KT, 58, 11, 1965, p.4. School Certificate was a national qualification available to school students in their third year of secondary education.

recruitment.<sup>95</sup> Members of the public and some nurses questioned whether academic ability was a necessary attribute for a nurse. Questions were raised in Parliament. Rona Stevenson, Member for Taupo, suggested that, 'The qualification for nursing should be the desire to nurse. If a girl really wants to nurse she will succeed in passing her nursing examinations'.<sup>96</sup> When, the Nurses and Midwives Amendment Bill was tabled in Parliament, NZRNA was dismayed to discover that the minimum qualification section had not been included.

Raising the level of entry was only achieved through intense lobbying by the NZRNA. Nurses wrote to their Members of Parliament and sent telegrams to the Prime Minister. Their efforts were successful. When the *Nurses and Midwives Amendment Act* was passed in late 1965, it not only provided for eighteen-month Community Nursing programmes but also for School Certificate to be introduced as the minimum entry qualification for general nursing. Both were implemented in 1966.<sup>97</sup>

The new minimum qualification did not extend to psychiatric nursing. Annual reports of the Nursing Division suggest that there was little or no consideration of the possibility. School Certificate as a minimum qualification was probably considered too difficult to implement in psychiatric nursing because of the severe recruitment difficulties. It was possibly also thought unnecessary for the psychiatric nursing course since it was assumed by some nurses not to be at the same level as the general programme. In the years leading up to the change the Nursing Division annual reports had regularly commented on the improving standard of general nursing applicants. By 1965 the percentage of general nursing entrants with School Certificate reached 61 percent, double those of 1958.<sup>98</sup> The Nursing Division made no equivalent comment on psychiatric nursing. By 1969 less than a quarter of all trainee psychiatric and psychopaedic nurses held School Certificate.<sup>99</sup>

Introduction of School Certificate as a minimum qualification for general nursing created an extra hurdle for psychiatric nurses wishing to further their careers. Those

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<sup>95</sup> KT, 57, 5, 1964, p.7.

<sup>96</sup> NZPD, 1964, 338, p.63.

<sup>97</sup> KT, 59, 6, 1966, p.11.

<sup>98</sup> AJHR, H-31, p.84.

<sup>99</sup> In 1969, the Department of Health employed 766 trainee psychiatric and psychopaedic nurses. Of these, 56 held University Entrance and 96 held School Certificate: New Zealand Public Service List, 1969.

without School Certificate now had to pass an aptitude test before gaining entry to general or male nurse training. Two psychiatric nurses from Ngawhatu were caught out by the regulations within days of them coming into effect. The nurses had been accepted to train as male nurses at Nelson Hospital and had been approved unpaid leave but just prior to commencing the course, were denied entry. Both men decided to forgo the training rather than sit the test.<sup>100</sup> They returned to Ngawhatu and one was supported by his medical-superintendent to apply for a tutor's position.<sup>101</sup> The regulations continued to be a source of irritation for psychiatric and psychopaedic nurses. Nurses considered that their psychiatric nursing qualification should be sufficient proof of competence to train for another field of nursing.

### *Call for university courses*

Nursing leaders had, for many years, lobbied for the establishment of nursing studies in a university. A programme, commenced at Otago University in 1925, had fallen through after two years because the university withdrew its financial support. Since then, the Postgraduate School in Wellington, established in 1928, had filled a gap by providing advanced nursing studies.<sup>102</sup> By the mid-1960s, however, this was no longer considered sufficient. The NZRNA advocated for the establishment of university-based, generalist undergraduate and postgraduate programmes for the preparation of 'top level' nurse educators, researchers, clinicians and administrators.<sup>103</sup> Alma Reid, the Director of Nursing at McMaster University in Hamilton, Ontario, was invited to New Zealand to investigate and report to the University Grants Committee on the 'desirability and feasibility' of developing university based nursing education.

Reid's 1965 report addressed a range of issues. She observed that nursing in New Zealand was beset by problems, many of which related to the educational system. Hospitals' service needs frequently interfered with educational goals. Student nurses provided a considerable proportion of patient care in a routine, task-orientated manner. Standards across schools of nursing varied considerably but overarching problems included the short supply and poor preparation of tutors and a tendency of schools to

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<sup>100</sup> Dan Long, General Secretary, PSA to Mirams, 13 December 1966, H-1, 33920, 30/7/6, ANZ, Wellington.

<sup>101</sup> Medical-Superintendent, Ngawhatu to Mirams, 14 December 1966,

<sup>102</sup> 'The History of the New Zealand School of Advanced Nursing Studies (Formerly the Post-Graduate School for Nurses)', KT, 71,11, 1978, pp.16-7.

<sup>103</sup> KT, 57, 12, 1964, p.20.



focus on preparing nurses for state examinations rather than providing a rounded education. Nursing curricula offered little challenge for brighter students, but instead tended to be geared ‘to the lowest common denominator’. While not providing any detailed solutions, Reid concluded that there were firm grounds for introducing university education.<sup>104</sup>

Other reports endorsed the view that nursing education should be separated from hospital service. In 1966, the Fifth Report of the WHO’s Expert Committee on Nursing recommended that, ‘the education of the nurse at the basic as well as post-basic level be incorporated into the system of higher education of [each] country as rapidly as conditions permit’.<sup>105</sup> The next year, Elsie Boyd, a New Zealand nurse, reported on her four-month study tour of the United States. Boyd was impressed by the manner in which nursing programmes were gradually being moved from hospital to educational settings. She recommended that New Zealand should investigate the cost and efficiency of existing hospital-based courses and consider options for transferring nursing programmes to educational institutions.<sup>106</sup>

### **Psychiatric nursing education: developments from mid-1960s**

Changes were occurring, albeit unevenly, in psychiatric nursing education in the mid to late-1960s. The most substantial reforms were made at Sunnyside Hospital under Bazley’s leadership. Bazley believed that psychiatric nursing would be more attractive if students could focus on learning relevant theory and practical skills rather than spending most of their time providing basic physical care.<sup>107</sup> She substantially enlarged the content of the psychiatric nursing curriculum, increasing the preliminary block to two months and incorporating a module on sociology and an expanded course in human growth and development.<sup>108</sup>

These changes corresponded with reforms in the clinical area at Sunnyside. As therapeutic groups and intensive rehabilitation were introduced to the wards, students demanded more focus on psychiatric skills and less on medical/surgical techniques. In

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<sup>104</sup> Alma E. Reid, *Report on Nursing Education in New Zealand*, Wellington, 1965.

<sup>105</sup> KT, 61, 1, 1968, pp.11-13.

<sup>106</sup> KT, 60, 11, 1967, pp.13- 16, 27.

<sup>107</sup> Margaret Bazley interview 23 February 2004.

<sup>108</sup> Peter Sanders, Nurse Advisor, Department of Health, Report on Observation Visit Sunnyside Hospital, 2 July 1969, H-1, 41804, ANZ, Wellington.

response, the tutors introduced courses in group dynamics and gained support from the Nursing Division to limit the time students spent on ‘basic (physical) nursing skills’ during their training.<sup>109</sup> Nursing practice and education were directed towards concepts of interpersonal relations and therapeutic community.

In a move that caused some controversy with both the nursing profession and the PSA, Bazley introduced registered general nurses and community (shortened course) nurses to the psycho-geriatric wards. Her aim was to release psychiatric nurses for the more active therapeutic work in other wards. In 1967 she gained approval to run a community nurse training programme at Sunnyside.<sup>110</sup> In 1969 she also gained permission, in principle, to offer psychiatric endorsements to community nurses.<sup>111</sup> It seems, however, that this training may never have been offered at Sunnyside during Bazley’s time as matron.<sup>112</sup>

Bazley was convinced that the way to attract recruits to psychiatric nursing was to raise the entry standard rather than pander to the fears about recruitment. She invited applications for the nursing programme from people with University Entrance, a standard above that of the local general hospital school. Although this proved to be too high for many applicants, the advertisements did succeed in attracting a high number of people with School Certificate. Over the next few years, a significant number of university students and graduates also applied for training at Sunnyside.

Educational developments at Sunnyside were successful, largely because they were applied within the context of co-ordinated hospital reform. Bazley also had the advantage of her connections with national nursing bodies. She appeared to understand the need not only to introduce nursing reforms, but also to promote them to the profession and the public. Articles on the changes at Sunnyside appeared in both *Kai Tiaki* and in regional newspapers throughout New Zealand.<sup>113</sup> Headlines such as,

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<sup>109</sup> Peter Sanders, Nurse Advisor, Department of Health, Report on Observation Visit Sunnyside Hospital, 2 July 1969, H-1, 4180, ANZ, Wellington.

<sup>110</sup> 20 July 1967, Minutes of N&MB Education Committee, ABYO, 7888, W5148, Box 20, Record 20, ANZ, Wellington.

<sup>111</sup> 16 January 1969, Minutes of N&MB Education Committee, ABYO, 7888, W5148, Box 20, Record 20, ANZ, Wellington.

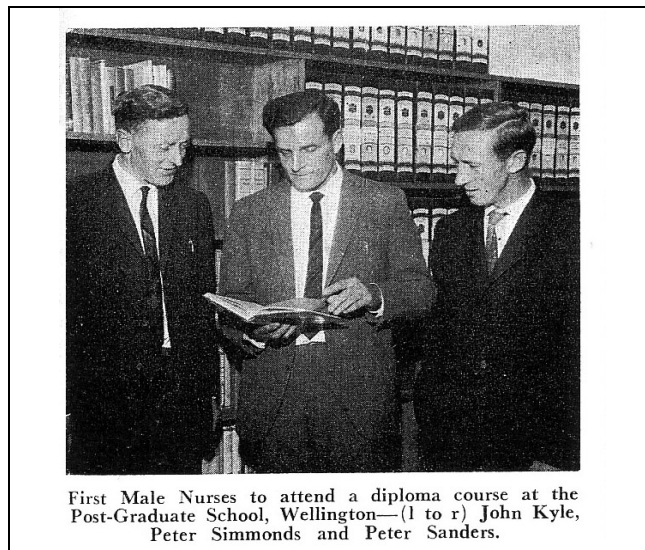
<sup>112</sup> Margaret Baxley personal communication.

<sup>113</sup> See, for example, J.L. Riley, ‘Sunnyside has Changed’, *KT*, 64, 2, 1970, p.13.

‘Scope of Psychiatric Nursing ever on the upgrade’ and ‘New Ideas in Psychiatric Nursing’ portrayed psychiatric nursing as an exciting, innovative profession.<sup>114</sup>

Educational innovations were occurring at other psychiatric hospitals, but these were isolated. Tutors tried out new techniques such as class discussions, presentations and case histories. There were also attempts to improve the links between classroom and clinical learning. Peter Sanders recalled his time teaching at Porirua with Betty Dandy and Billy Ames in the mid-1960s as a period of experimentation. He was able to use his connections with staff to take students onto wards to observe assessments of interesting patients. His position as a male nurse facilitated these interactions since the hospital was still divided into male and female sides. Sanders recalled that he received a great deal of appreciation from male nurses because he was the first male tutor.<sup>115</sup>

Male psychiatric tutors were beginning to find a place, not only in their hospitals, but also in the wider nursing profession. Kevin Schroder from Seaview Hospital was the first man to receive a certificate from the Postgraduate School of Nursing. He had attended an eight-week tutors’ course in 1966.<sup>116</sup> The next year John Kyle from Sunnyside, Peter Simmonds from Kingseat and Peter Sanders were the first men to attend the year-long Postgraduate Diploma programme (see Figure 31 below).<sup>117</sup>



**Figure 32 First male nurses at Post-Graduate School.**  
Source: KT, 60, 4, 1967, p.13.

<sup>114</sup> *Dominion*, 1 October 1968; Northern Advocate, 16 August 1968,

<sup>115</sup> Peter Sanders interviewed by Margaret Whineray, 13 July 1989, OHInt-0139/1, Psychiatric Nurses Oral History Project, NERF, ATL, Wellington.

<sup>116</sup> KT, 59, 5, 1966, p.15.

<sup>117</sup> ‘Another Year Underway’, KT, 60, 4, 1967, p.13.

These three nurses' acceptance into the programme was an indication of the profession's softening attitude toward men. Their presence also challenged the prevailing discourse about what constituted a professional nurse. Kyle and Sanders were the first nurses to be accepted without general registration. This concession highlighted some contradictions within the nursing profession. On the one hand, nurse leaders advocated for a generic qualification, but on the other, they were willing to recognise psychiatric registration as a professional qualification in its own right in order to give men access to career progression.

In the late 1960s, the Division of Mental Health took further action to secure the place of male psychiatric nurses within the profession. Mirams advertised for an inspecting head nurse to work at a national level within the Division of Mental Health. When no one was willing to take the job at the same pay rate as those they would be inspecting, a position was created for a male nurse advisor in the Division of Nursing. The Department of Health called for applications from male psychiatric nurses holding the Postgraduate Diploma; Mirams firmly 'invited' Sanders to apply. When Sanders took up the position in 1968, he was the first nurse without general nursing qualifications to be employed in the Division of Nursing. In Sanders' words, the move from the familiarity of the psychiatric hospital system to work with highly qualified general nurses, 'quite frankly terrified me'.<sup>118</sup>

### **Nursing education reform: growing pressure for change**

In the late 1960s nursing leaders became increasingly intolerant of the 'outdated' nursing education system. They argued that the apprenticeship system was no longer appropriate for preparing nurses to work in increasingly complex technological and social environments. Nurses, they claimed, were no longer 'handmaids' to doctors; their education should prepare them to assume a role that complemented medicine and other health professionals.<sup>119</sup>

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<sup>118</sup> Peter Sanders interviewed by Margaret Whineray, 13 July 1989, OHInt-0139/1, NERF-PNOHP, ATL, Wellington.

<sup>119</sup> AJHR, 1969, H-31, p.67.

Division of Nursing annual reports iterated evidence of a crisis in nursing: only one third of nurses employed by hospital boards were registered; students carried the greatest burden of patient care; nurses were doing too many non-nursing duties such as housekeeping, cooking and messenger tasks; approximately 45 percent of students failed to complete nursing courses; less than 40 percent of nursing tutors held the postgraduate Diploma in Nursing, a qualification considered to be the minimum standard.<sup>120</sup>

Criticisms included the number of nursing schools. With 62 schools of nursing offering a total of 139 programmes, it was difficult to provide sufficient qualified tutors or educational resources.<sup>121</sup> The issue of curriculum overlap compounded the question of resources. A large number of subjects were common to all the four three-year basic programmes (general, male, psychiatric and psychopaedic). In 1969, a *Review of Hospital and Related Services* identified the need to reduce the number and variety of nursing schools. It suggested that the number of schools could be immediately reduced by incorporating psychiatric and psychopaedic nursing content into the existing general nursing programmes. The review recommended that in the longer term, one quarter of nurses should be university prepared and the remainder should be educated in generalised programmes based in educational facilities, for example, technical institutes.<sup>122</sup>

### ***Nursing education reform: psychiatric nurses respond***

While most psychiatric nurses were relatively unaware of the developing movement towards generalist programmes, those with direct contact with the NZRNA or the N&MB had concerns. Bazley, who in 1966 had replaced Marie Little as the psychiatric nurse member of the N&MB, recalled being at odds with the prevalent views on integration of psychiatric nursing. Several nurse leaders had studied in the United States where they had witnessed nurses caring for psychiatric patients in general hospital clinics. This experience had led them to believe that separate training for psychiatric nurses was unnecessary and unhelpful. Although Bazley was supportive of the need to educate general nurses in psychiatric concepts, she was alarmed by the suggestion that

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<sup>120</sup> AJHR, 1968, H-31, p.65; AJHR, 1969, H-31, pp.67-8.

<sup>121</sup> AJHR, 1969, H-31, p.68.

<sup>122</sup> See: 'Nursing Education in New Zealand – Historical Summary' and extract from *A Review of Hospital and Related Services in New Zealand*, Department of Health, September 1969, 79-032-12-12/5, ATL, Wellington.

preparation for psychiatric nursing could be integrated within general hospital nursing programmes. She was concerned about the potential loss of psychiatric nursing skills.<sup>123</sup>

Bazley's views on the future direction of psychiatric nursing education became shaped and firmed by her experiences while on a study tour in 1969. The tour, funded by a British Commonwealth Nurses War Memorial Fund Scholarship, took Bazley to Canada and Scotland to observe psychiatric nursing education, administration, and practice. While impressed with the developments in both countries, she was convinced that the education-based system in Canada was far better than anything that could be offered in a hospital setting.<sup>124</sup>

Two distinct models of psychiatric nursing education had developed in Canada. In most parts of the country, psychiatric nursing was taught as an affiliated experience in general nursing programmes, similar to the US model. In the Western provinces, psychiatric nursing was a separate registration with direct-entry, hospital-based preparation.<sup>125</sup> It was the former, education-based system that Bazley considered so successful. She commented on the high standard of care and active programmes in the associated psychiatric units at general hospitals. In contrast, she considered the Canadian state psychiatric hospitals to be in a parlous condition. Patients, she noted, were over-sedated, had minimal access to therapeutic programmes and ECT was used excessively.

Bazley was, however, concerned that male nurses appeared to have fallen by the wayside of educational reforms in Canada. Although there were a considerable number of men employed in psychiatric settings, they tended to be less qualified than women and held inferior positions. This was in stark contrast to Scotland, where hospitals provided financial support for ongoing education for male psychiatric nurses. In that country, Bazley noted, many male psychiatric nurses were 'emerging as superior leaders in nursing'.<sup>126</sup>

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<sup>123</sup> Margaret Bazley interview 23 February 2004.

<sup>124</sup> Report by Margaret Bazley on the British Commonwealth Nurses War Memorial Fund Scholarship, 1969, Margaret Bazley private papers.

<sup>125</sup> For a discussion on the development of the two systems, see: Tipliski, *Parting at the Crossroads: The Emergence of Education*.

<sup>126</sup> Report by Margaret Bazley on the British Commonwealth Nurses War Memorial Fund Scholarship, 1969, Margaret Bazley private papers.

### *The Carpenter Review*

Substantial changes in nursing education were finally accomplished as a result of a review undertaken by Dr Helen Carpenter in 1970. Carpenter, the Director of the School of Nursing, University of Toronto, was a qualified nurse who held a masters degree in public health from Johns Hopkins University and a doctorate in maternal and child health from Columbia University.<sup>127</sup> She was sent to New Zealand by the WHO following an appeal for assistance by the New Zealand Government. Shirley Bohm, the Director of Nursing, with the support of Douglas Kennedy, the Director-General of Health, had instigated the call for an external review.<sup>128</sup> Kennedy, who held the position from 1965 until his death in December 1972, was supportive of the need for nursing education reform. Proposed changes were consistent with his stand on a number of issues. He was an advocate for the professionalisation of nursing and was keen to ensure that New Zealand adopted standards set down by the WHO.<sup>129</sup> He favoured the integration of mental health with other areas of health administration and service.<sup>130</sup> Kennedy also encouraged small hospital boards to amalgamate, a policy that was consistent with the move to reduce the number of nursing schools.<sup>131</sup>

Carpenter's original brief was to review the system of basic nursing education. After her arrival in New Zealand, however, this was broadened to include all levels of nursing education.<sup>132</sup> Her two-month visit was tightly scheduled and included discussions with numerous educators from hospitals, universities and technical institutes. She also met with medical superintendents, matrons, representatives of the N&MB and the NZRNA, as well as vice chancellors of universities. Several nursing schools were visited, including Sunnyside, where Carpenter spoke with Bazley. Carpenter was later criticised by Bazley for only speaking to one practising psychiatric nurse and not seeking the views of male psychiatric nurses. She suggested that did not look good to those in the

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<sup>127</sup> KT, 63, 10, 1970, p.5.

<sup>128</sup> Bohm had initially asked for the review to be done by Rae Chittick, a nurse who had visited New Zealand briefly after undertaking a review of post-graduate nursing education in Australia: 5 June 1969, Shirley Bohm to Swann, H-1, W2191, 334/2/24/13/2, 377720, ANZ, Wellington.

<sup>129</sup> Dow, pp.238-9.

<sup>130</sup> *ibid.*, p.184.

<sup>131</sup> Carpenter, *An Improved System of Nursing Education for New Zealand*, p.9.

<sup>132</sup> *ibid.*, p.8.

field.<sup>133</sup> It is likely that Carpenter did consult with Sanders, who was still employed in the Department of Health.

Carpenter's report, *An Improved System of Nursing Education for New Zealand* was released in March 1971.<sup>134</sup> The report painted a picture of nursing education in New Zealand as outdated and unsatisfactory. Although the argument was not new, Carpenter and her New Zealand team had drawn together a convincing array of evidence. Nurses, the report argued, were compelled to undertake programmes that were narrow, rigid and of dubious quality. Hospital-based training was no longer adequate for the changing social and healthcare environments. Nurses needed 'broad-based, health-orientated education'.<sup>135</sup>

Psychiatric and psychopaedic programmes were presented in a particularly poor light. They failed, in Carpenter's view, to prepare graduates for a career in the broader nursing profession. General nurses undertook, on average, seven months theoretical teaching and sat three final examinations. Psychiatric and psychopaedic theory could be covered in three and a half months and students undertook only one final examination for each programme. School Certificate was mandatory for general nursing but not for the other programmes; only 54 percent of psychiatric and 38 percent of psychopaedic students held School Certificate. Student withdrawal rates also compared unfavourably. Sixty-one percent of psychiatric and 57 percent of psychopaedic trainees withdrew before the State Examination. The average withdrawal rate across all the three-year programmes including general nursing was 39 percent.<sup>136</sup>

Carpenter signalled that it was time to transfer nursing education from Health Service to Education. She recommended that there should be three tiers of nursing preparation; university education to equip nurses for top-level roles, generalist education at an intermediate level for the majority of nurses who would be qualified to provide care in all settings, and shortened courses for 'community nurses'. All three programmes should be taught in educational settings. The Report recommended that nursing lectureships be established at universities, that an undergraduate diploma or certificate

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<sup>133</sup> Report on Seminar to Discuss the Report, 'An Improved System for Nursing Education for New Zealand' by Helen Carpenter, Wellington 22, 23 July 1971, pp. 34 and 39, ATL, Wellington.

<sup>134</sup> 8 March 1971, Extract from Director-General's meeting, H-1, W2191, 334/2/24/13/2, 377720, ANZ, Wellington.

<sup>135</sup> Carpenter, *An Improved System of Nursing Education for New Zealand*, p.23.

<sup>136</sup> *ibid.*, pp.10-1.



be instituted at a college of health in an appropriate educational setting and that Wellington Polytechnic be asked to develop a pilot programme to prepare community nurses. Recommendation 1.6 suggested that a committee should be established under the Minister of Education to investigate options for the development of colleges of health.

Carpenter's views on the status of psychiatric nursing were most apparent in the Report's suggested interim measures.<sup>137</sup> She outlined several strategies to improve nursing education until the colleges of health were established. Psychiatric and psychopaedic nursing programmes, she advised, should be phased out when the hospitals were transferred to hospital board control, due to happen in 1972. The general nursing curriculum could be adapted to fill the gap and prepare nurses to practise psychiatric nursing. It seemed that general nursing in a broadened format was the desired goal. Psychiatric and psychopaedic programmes were considered second-class qualifications that should be dispensed with as soon as possible. Carpenter suggested that psychiatric nurses should be supported to qualify for registration as general nurses in the minimum time possible.

### ***Reaction to the Carpenter Report***

Responses to the report were, on the whole, favourable. The Department of Health received numerous telegrams of congratulations.<sup>138</sup> Newspaper articles and editorials, although acknowledging the report's far-reaching implications, were largely supportive of its aims.<sup>139</sup> The New Zealand Nurses' Association (NZNA - the organisation dropped 'Registered' from its name in 1971) was strongly supportive and offered its full co-operation to assist with implementation. Most criticism came from the Hospital Boards' Association (HBA) and from the Medical Superintendents' Association (MSA). The former risked losing their student workforce and the latter, with other doctors, felt sidelined by the process. Both groups complained about the proposed membership of Committee 1.6 that would consider the report's recommendations.<sup>140</sup>

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<sup>137</sup> *ibid.*, pp.30-1.

<sup>138</sup> See H-1, W2191, 334/2/24/13/2, 377720, ANZ, Wellington.

<sup>139</sup> See for example, *Otago Daily Times* (ODT), 17 March 1972, p.5; *Evening Post* (EP), Editorial, 17 March 1972, p.8; EP, 19 March 1972, p.16, *Dominion*, 19 March 1972, p.37.

<sup>140</sup> Report on Seminar to Discuss the Report, 'An Improved System', p.8, ATL, Wellington.

Psychiatric nurses had a mixed response to the report. Like most nurses in other specialties, the majority of psychiatric nurses were unaware of the long-term implications of the recommendations. Those in educational or professional leadership were, on the whole, positive. They recognised the deficiencies of the current system and were aware of the benefits of a more generalist preparation for psychiatric nurses. Joff (James) Nolan, Head Nurse at Tokanui, was enthusiastic about the potential benefits of an education-based system. Bazley's experience in Canada had convinced her that integrated programmes in educational institutions were the only way forward.<sup>141</sup>

Psychiatric nurses' concerns about the Carpenter Report largely focused on their fear of being absorbed by general nursing. The suggestion that psychiatric and psychopaedic programmes be phased out caused considerable anxiety, particularly to male psychiatric nurses. Few of the men held general registration, largely because, prior to 1970, there had been no provision for financial support during training.<sup>142</sup> If comprehensive qualifications were to be the norm, men's career prospects could be in jeopardy.

Comprehensive programmes threatened loss of specialty skills. At a seminar organised by the Hospital Board Association, both Bazley and Nolan warned of the dangers of severely reducing students' time learning psychiatric nursing. Nolan reminded the gathering that psychiatric nursing practice implied a relationship between two people. Relationship skills were learned by involvement with patients in different activities over a period of time. This could not be accomplished quickly. Bazley was more forthright. She claimed to be 'opposed to a programme in which psychiatric nursing is ludicrously reduced, producing staff inadequately qualified to have registration as psychiatric nurses'.<sup>143</sup>

Psychiatric nurses worried about being absorbed into a foreign culture. Bazley was adamant that integrated programmes must not be situated in general hospitals. She warned that psychiatric nurses would not put up with the hierarchical and rigid attitudes prevalent in these settings. Male nurses, in particular, would not want to be subordinate

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<sup>141</sup> See, for example, comments from James Nolan and Margaret Bazley: *Report on Seminar to Discuss the Report, 'An Improved System'*, pp.33-40, ATL, Wellington.

<sup>142</sup> In 1970, the Department of Health agreed to support some psychiatric nurses to undertake their general training on full pay. Prior to this, they had to accept trainee pay on the lower general hospital rate: 22 September, conciliation meeting between PSA and Department of Health, H-1, Acc W2676, 37326, 30/7/6, Box 57, ANZ, Wellington.

<sup>143</sup> Report on Seminar to Discuss the Report, 'An Improved System', pp.33-40, ATL, Wellington.

to a young nurse in the general hospital system.<sup>144</sup> Other nurses expressed concern about what might happen with the imminent transfer of psychiatric hospitals to hospital board control. John Thompson, Head Nurse at Seacliff Hospital, wondered if psychiatric nurses would lose their identity within the ‘maw of general nursing education’. Psychiatric nursing, he suggested, had a particular, more patient-centred, approach, which was potentially incompatible with general nursing that was more ‘procedure-orientated’.<sup>145</sup>

Although the PSA’s Mental Health Group (MHG) discussed the Carpenter Report in 1971, it was not their focus of attention at this time. They were preoccupied with industrial issues related to the imminent transfer of psychiatric hospitals to hospital board control. One educational issue that did capture the attention of the MHG was that of entry qualification. Under the *Nurses Act 1971*, School Certificate finally became the minimum qualification for entry to psychiatric and psychopaedic nursing programmes. The MHG challenged the decision, particularly in relation to staff wanting to bridge from one registration to the other. They claimed that registration should be sufficient indication of ability. Once again, the PSA questioned the N&MB’s competence to represent psychiatric nurses’ professional interests, since there was no direct psychiatric nursing representation on the Board.<sup>146</sup>

It was not until 1973 that the PSA seriously engaged with the implications of the Carpenter Report. The union published its own Report on Nursing Education.<sup>147</sup> This document was highly critical of the Carpenter Report, and its recommendations were almost diametrically opposed to that of Committee 1.6. By this time, however, the first three pilot programmes in polytechnics had begun.

### ***Operation Nurse Education: implementation of the Carpenter Report***

Over the twenty months following release of the Carpenter Report, it seemed to nursing leaders that the opportunity for educational change might slip from their hands. The 1.6 Committee, whose task was to investigate the potential development of Colleges of Health Sciences for the preparation of nurses, did not convene until October 1971.

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<sup>144</sup> Report on Seminar to Discuss the Report, ‘An Improved System’, pp.33-4.

<sup>145</sup> KT, 65, 8, 1972, p.5.

<sup>146</sup> 12 November 1971, Notes on Conciliation between the Department of Health and N.Z. Public Service Association (Inc), YCAA, 1084/139, ANZ, Auckland.

<sup>147</sup> New Zealand Public Service Association, *Report on Nursing Education*, Wellington, 1974.

Chaired by William (Bill) Renwick, the Assistant Director-General of Education, its members included officers of the Departments of Health and Education, a university vice-chancellor, the Clinical Dean of the University of Otago and representatives from the NZNA, the SNA and Technical Institutes' Association. At the advice of McKay, the Minister of Health, additional places were made available for representatives of the National Council of Women, Hospital Boards' Association (HBA), and Medical Association.<sup>148</sup>

From the outset, the 1.6 Committee experienced difficulties. Its membership was split on the crucial question of whether basic nursing programmes should be moved from hospitals to educational settings. NZNA representatives, supported by officers of the Division of Nursing, advocated for the transfer; they provided the committee with extensive information on the status of nursing education and the need for change. They also developed draft curricula for a comprehensive nursing programme.<sup>149</sup> Their opinions reflected NZNA's increasingly firm policy that pilot programmes in Colleges of Education should be commenced as soon as possible. Arthur Wicks of the HBA continued to advocate for hospital-based schools. Geoffrey Wynne-Jones of the Medical Association supported the concept of colleges, but differed from the rest of the committee on the idea of placing nursing programmes in technical institutes.

NZNA and the Division of Nursing became frustrated over delays in implementing Carpenter's recommendations. They faced opposition, however, from both within and outside nursing. Many nurses were unconvinced of the need to change a system they knew well.<sup>150</sup> The HBA actively lobbied against a transfer by means of press releases and direct access to the government. NZNA responded by attempting to educate its members and counteracting public criticism with its own press releases and meetings with Ministers.<sup>151</sup> By mid-1972, it appeared that the call for demonstration (pilot) programmes in educational settings would go unheeded unless nurses took a much stronger approach.

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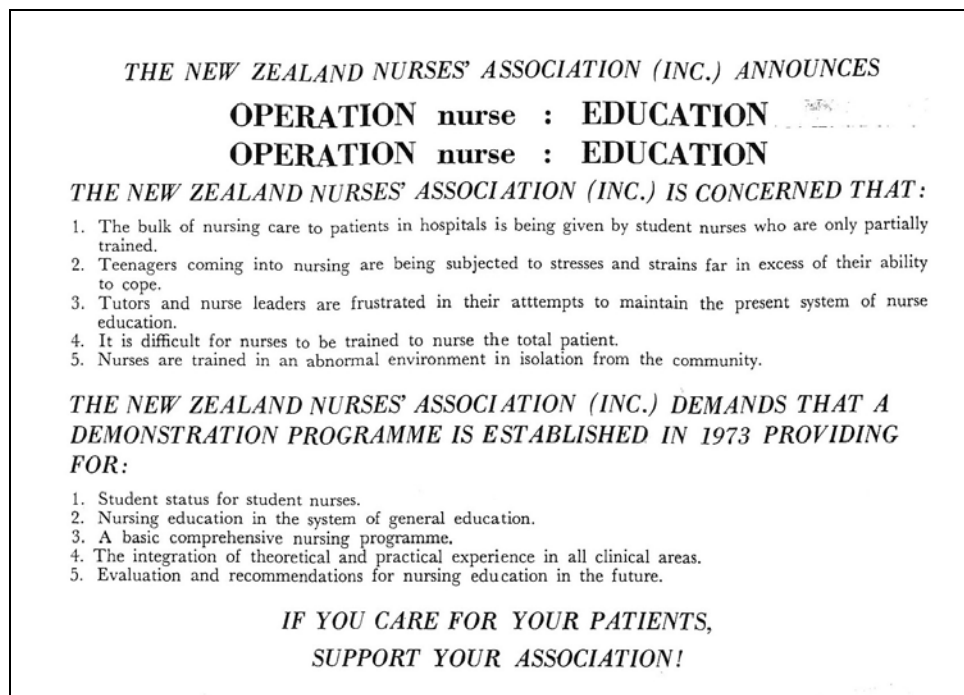
<sup>148</sup> Department of Education, *Nursing Education in New Zealand: Report of a Committee set up to Consider and Report to the Minister of Education on Recommendation 1.6 of the Report of Dr Helen Carpenter entitled 'An Improved System of Nursing Education for New Zealand'*, Wellington, 1972.

<sup>149</sup> KT, 65, 1, 1972, p.15; NZNA papers pertaining to the 1.6 Nursing Education Committee, 79-032-12/5, ATL, Wellington.

<sup>150</sup> KT, 65, 5, 1972, pp. 4-5.

<sup>151</sup> For an outline of NZNA actions concerning implementation of the Carpenter Report see: KT, 66, 1, 1973, p.21-3.

From May 1972 Margaret Bazley, who had been elected unopposed as president of the NZNA at its April conference, led the Association's lobbying efforts. Her background in the working-class, industrially savvy world of psychiatric hospitals appeared to equip her well for this role. She immediately took a more militant approach than anything the NZNA had experienced previously. Setting out to counteract the lobbying efforts of the HBA, she gained the Executive's approval to launch a campaign entitled, 'Operation Nurse Education'. A letter outlining the faults of the current education system was distributed to every National Government Member of Parliament. Posters were distributed to all hospitals, press releases issued, and nurses urged to write or speak to their Members of Parliament. Notices, such as the one in Figure 32, demanded action from the government. Nurses, Bazley announced, were 'not prepared to wait much longer for action'. They intended to put the pressure on the government to implement demonstration educational programmes by 1973.<sup>152</sup>



**Figure 33 Operation Nurse Education advertisement.**  
Source: KT, 65, 8, 1972, p.19.

Many NZNA members were uncomfortable with Bazley's political approach, which they considered unprofessional. Although she received strong support from Thelma Burton, the NZNA National Secretary, and from Shirley Bohm, the Director of Nursing, many of her executive got cold feet. Within a short time, a significant proportion of both

<sup>152</sup> The New Zealand Nurses' Association (Inc.) Press Release, 26 May 1972, Margaret Bazley personal papers.

the Executive and the Management Group had resigned. Many of them were matrons-in-chief, who came under pressure from the HBA. Matrons at some hospitals refused to have the Operation Nurse Education poster displayed because they disagreed with the wording. Nurses, they claimed, ‘do not demand’.<sup>153</sup> In a *Kai Tiaki* editorial entitled ‘Stand up and be Counted’, Bazley suggested that nurses needed to toughen up. She explained that ‘these are hard days in a hard world’ in which ‘polite requests for change go unnoticed’.<sup>154</sup>

Despite the doubts of some members, NZNA continued the political pressure for several months. Each branch lobbied their Member of Parliament and meetings were held with Opposition Members of Parliament and local hospital boards. The Executive, aware that a general election was imminent, pressed the National Government’s Ministers of Health and Education for an early decision. Once it was known that Committee 1.6 had reported back in late September, the NZNA increased its calls for implementation. A month later, with no sign of the report, the Medical Association of New Zealand agreed to assist. Telegrams and letters were sent to Ministers, followed by a request for an audience with the Prime Minister.<sup>155</sup> Cabinet finally considered the report in late October. On 2 November 1972, Lance Adams-Schneider, the Minister of Health, announced that two pilot comprehensive programmes would be set up in 1973 – one in Wellington and one in Christchurch. By this time, agreement had also been reached on the establishment of nursing studies at Massey and Victoria Universities for registered nurses. The new Labour Government, sworn in on 8 December inherited the decisions.

The establishment of two pilot comprehensive nursing education programmes signalled the beginning of the end for a separate psychiatric nursing training and qualification. In 1974 another comprehensive programme was established at Nelson Polytechnic simultaneously with the closure of the three local hospital-based programmes. Approval was gradually given for programmes in other parts of the country. Funding decisions were initially made on an annual basis, but in 1976 it was agreed that comprehensive nursing programmes would be supported indefinitely.<sup>156</sup> Hospital-based nursing education continued alongside comprehensive programmes well into the 1980s. Although the Government encouraged closure of hospital schools, the decision was left

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<sup>153</sup> Margaret Bazley interview 23 February 2004.

<sup>154</sup> KT, 65, 8, 1972, p.3.

<sup>155</sup> For outline of NZNA’s actions, see, ‘Nursing Education Moves’, KT, 66, 1, 1973, pp.21-3.

<sup>156</sup> Workforce Development Group Department of Health, p.11.

with the individual hospital boards. Seaview Hospital School of Nursing was the last to admit students; the final class graduated in 1992.<sup>157</sup>

### **Generic nursing education: international context and interpretations**

New Zealand's shift to generic nursing education was consistent with international changes in nursing education and professionalisation during the mid to late twentieth century. The various explanations given for the international movement towards generic, education-based training provide insight into the specific contexts in which this shift occurred. In the United States, where psychiatric nursing was affiliated with general nursing at a much earlier date, integration has usually been seen as a 'victory' of nursing's autonomy and professionalisation.<sup>158</sup> Olga Church's 'That Noble Reform: The Emergence of Psychiatric Nursing in the United States, 1882-1963' describes the struggle to pull psychiatric nursing out from under the control of psychiatry.<sup>159</sup> While acknowledging the part psychiatrists played in initiating psychiatric nurse education, she draws attention to the limitations of psychiatry led education and comments on the stultifying effects of apprenticeship-style training in isolated mental hospitals.

Church and others claim that psychiatric nursing came into its own in the USA after the 1946 *National Mental Health Act*, and the subsequent injection of federal funding into postgraduate mental health education. They argue that psychiatric nursing began to flourish during the 1950s and was 'in its prime' during the 1960s.<sup>160</sup> In contrast to the earlier isolating effects of hospital-based programmes, opportunities for Masters and PhD education propelled psychiatric nurses to the forefront of nursing academia and professional leadership. Church argues that the psychiatric nursing's struggle to be accepted within the nursing profession in the USA was a phase in its own professional maturity. She also suggests that psychiatric nursing's success in finding a place within nursing could be attributed to the changing attitudes of nurses towards people with psychiatric problems.<sup>161</sup>

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<sup>157</sup> Brunton, *Sitivation 125*, p.73.

<sup>158</sup> By the end of WWII, more than three quarters of nursing schools in the USA offered their students experience in psychiatric nursing: Church, 'That Noble Reform', p.194.

<sup>159</sup> *ibid.*

<sup>160</sup> Dumas, p.11; Church, 'That Noble Reform', p.205.

<sup>161</sup> Church, 'That Noble Reform', pp.271-2.

Despite the prominence of the ‘victory of professionalisation’ interpretation of postgraduate developments in the United States, there are mixed views on the integration of psychiatric nursing at an undergraduate level. Church suggests that integration experiments in the 1950s posed a threat of ‘dissolution through integration’ for the psychiatric nursing specialty.<sup>162</sup> Tom Olson argues that psychiatric nursing leaders were unclear about whether psychiatric skills were fundamental to nursing or components of specialty practice. His analysis of the work of three prominent nurse academics concludes that they were almost too successful in promoting interpersonal psychiatric nursing concepts as fundamental to all nursing. Their arguments for essentialism had risked the watering down and loss of specialist psychiatric nursing skills in the morass of general nursing.<sup>163</sup>

In contrast to the USA, integration of psychiatric nursing education in the United Kingdom has tended to be viewed as a process of assimilation of a distinct occupational group by a more powerful profession. Dingwall, Rafferty and Webster describe mental nursing as the ‘reluctant partner’ of general nursing.<sup>164</sup> Combined undergraduate programmes were not instituted in the UK until the late twentieth century, when, under the provisions of *Project 2000*, diploma and degree courses were established in educational institutions. In the new programmes, students undertook a common curriculum for part of their undergraduate experience, then specialised in a ‘branch’ of nursing.<sup>165</sup> Dingwall, Rafferty and Webster interpret *Project 2000* as another step in a process in which mental nursing was pressured to assimilate into general nursing.<sup>166</sup>

Michael Arton attributes the failure of mental nursing’s professionalisation in England on the controlling behaviour of general nurses and psychiatrists.<sup>167</sup> Peter Nolan, writing just prior to the implementation of *Project 2000*, suggested that general nurses drove the educational reforms. He claimed that although psychiatric nurses could see the value of raised academic standards, it was general nurses who would benefit most from the changes.<sup>168</sup> Several years later, Nolan offered an even more critical interpretation. With

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<sup>162</sup> *ibid.*, pp.209-18.

<sup>163</sup> Tom Olson, 'Fundamental and Special: The Dilemma of Psychiatric-Mental Health Nursing', *Archives of Psychiatric Nursing*, 10, 1, 1996, pp.3-10.

<sup>164</sup> Dingwall, Rafferty, and Webster, *An Introduction to the Social History of Nursing*, pp.142-4.

<sup>165</sup> Brigid Lusk, et al., 'Preregistration Nursing Education in Australia, New Zealand, the United Kingdom and the United States', *Journal of Nursing Education*, 40, 5, 2001, pp.199-200.

<sup>166</sup> Dingwall, Rafferty, and Webster, *An Introduction to the Social History of Nursing*, pp.142-4.

<sup>167</sup> Arton.

<sup>168</sup> Nolan, *A History of Mental Health Nursing*, p.145.



the reality of drastically reduced clinical experience and the relegation of mental nursing to 'branch programme status', he claimed that critics perceived Project 2000 as a 'serious, and perhaps intended, threat to the identity and very survival of mental health nursing in the United Kingdom'.<sup>169</sup>

In Canada, where two distinct models of psychiatric nursing education had developed by the mid-twentieth century, historical interpretation differs. Veryl Tipliski places the causation for the division in a gendered conflict between medical and nursing interests.<sup>170</sup> She argues that because of their 'gendered limitations' nursing leaders were unable to challenge male psychiatrists' control over nursing education in the Western provinces. Her argument is predicated on the assumption that nursing is a female occupation struggling to gain autonomy against patriarchal pressures. Tipliski implies heroine status for the Canadian Nurses' Association leaders who 'refused to be victims' when, in 1955, they stopped the spread of psychiatry controlled training at the Manitoba-Ontario border.<sup>171</sup> Angela Martin offers a competing interpretation.<sup>172</sup> She presents a picture of Saskatchewan psychiatric nurses struggling to resist attempts by the Saskatchewan Registered Nurses' Association to draw them under their umbrella of control. Although Martin mentions the central role of the industrial union and trained male attendants in establishing a separate registration, she fails to provide an analysis of the issues of class and gender.

These differing interpretations exemplify the difficulties of analysing the historical relationship of psychiatric nursing to the broader nursing profession. Analysis based on the assumption of nursing as a women's profession often fails to offer a plausible explanation for the actions of psychiatric nurses, many of whom were men. Failure to acknowledge the interrelationship of gender and class has also at times led to interpretations that are two-dimensional. It would appear that in each country where the relationship between psychiatric and general nursing has been contested, the processes and outcome have depended on complex inter-relationships between professionalisation, gender, class and the part played by particular individuals.

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<sup>169</sup> Peter Nolan, 'Mental Health Nursing - Origins and Developments,' in *Nursing and Social Change*, Monica Baly, ed., London, 1995, pp.260-1.

<sup>170</sup> Tipliski, *Parting at the Crossroads: The Development of Education*, pp.525-6.

<sup>171</sup> Veryl Margaret Tipliski, 'Parting at the Crossroads: The Emergence of Education for Psychiatric Nursing in Three Canadian Provinces, 1909-1955', *Canadian Bulletin of Medical History*, 21, 2, 2004, pp.253-79.

<sup>172</sup> Martin, *The Other Nurse: Seeking Validation*.

In New Zealand, as in other countries, there have been varying interpretations of the shift to comprehensive education. Most historical accounts have interpreted the introduction of comprehensive education in New Zealand as a triumph of nursing professionalisation. Nancy Kinross's 1984 account, outlines the move to comprehensive nursing and university courses as a logical step in one hundred years of the development of nursing education. For her, the changes addressed clearly identified needs and brought New Zealand into line with overseas developments.<sup>173</sup> Similarly, Kim Filshie claims that the changes that occurred in nursing education between 1960 and 1973 were indicative of nursing's attempt to raise the status of the profession. She argues that changes were driven from within the profession, and achieved despite opposition from within and without.<sup>174</sup> More recently, Debra Wilson's study of 15 senior nurse educators who were involved in establishing comprehensive nursing programmes, also takes a laudatory stance. Wilson applied Foucauldian and feminist analysis to interviews with the nurse educators. The women used heroic metaphors to describe the unique challenges they had faced in establishing nursing departments in polytechnics, and developing curricula that was emancipatory in nature and promoted a 'reorientation of nursing'. Wilson concludes that the traits shared by the nurse educators 'characterised these women as strategic and astute professionals, who successfully negotiated the construction of comprehensive programmes as a legitimate and transformative preparation for nursing registration'.<sup>175</sup>

In contrast to the view that implementation of comprehensive education was an achievement by nursing in its struggle for professional status, Sandra Matheson suggests that the processes of educational reform served to promote general nursing at the expense of psychiatric nursing. Matheson highlights the lack of consideration of psychiatric nursing in most of the discussions and reports concerning the introduction of comprehensive nursing. She argues that the language used in reports exposed the hegemonic position held by general nursing, the words 'general' and 'comprehensive' nursing often being used interchangeably.<sup>176</sup> Matheson questions whether the introduction of comprehensive programmes was based on a flawed assumption that a

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<sup>173</sup> Nancy Kinross, 'Nursing Education in New Zealand: A Developmental Perspective', *International Journal of Nursing Studies*, 21, 3, 1984, pp.193-9.

<sup>174</sup> Filshie,

<sup>175</sup> Wilson.

<sup>176</sup> Matheson, pp. 24-31.

person prepared in a generic programme could be considered as capable or as interested in caring for someone with mental illness as a graduate of a specialist programme.<sup>177</sup>

New Zealand psychiatric nursing's relationship to the movement towards generic nursing education can be understood in several ways. Firstly, it can be seen as a gender and class issue. Educational reforms were a product of the professional aspirations of a largely female middle-class occupation. Psychiatric nursing, which was dominated by male, working-class values, became drawn into general nursing's agenda. Most psychiatric nurses lacked the professional language and analysis to exert their position within this broader movement of professionalisation.

Secondly, the move to generic nursing education was philosophically consistent with the drive to amalgamate psychiatric care with other health services. Not only was amalgamation perceived to be a solution to the problems in psychiatric hospitals, but there was also a broadly held assumption that specialist psychiatric nursing might no longer be required once psychiatric care was delivered in general hospitals. In this respect, comprehensive nursing fulfilled a function of creating hope that serious, unruly, mental disorder may be a thing of the past.

Thirdly, support for comprehensive education from within psychiatric nursing was the result of pragmatic decisions on the part of those concerned about the future status of the occupation. Bazley, in particular, was acutely aware that if psychiatric nursing education remained hospital-based while other nursing programmes moved to educational institutions, it would become a second-rate qualification. She understood the risk that psychiatric nursing theory and skills may become diluted in comprehensive curricula. She also acknowledged that the new system might jeopardise the place of men in the occupation. Bazley, however, was an astute strategist who believed that if psychiatric nursing was not included in the new generic programmes, it risked being left in a professional backwater. For this reason, she supported the call for comprehensive education and fought for the transfer of nurse training to educational institutions where psychiatric nursing would have an opportunity to be recognised alongside general nursing.

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<sup>177</sup> *ibid.*, p. 37.

## **Conclusion**

Educational reforms during the 1960s and early 1970s challenged the isolation and distinct identity of psychiatric nursing. Initially, reforms were aimed at developing psychiatric nurses' specialist skills in forming therapeutic relationships with individuals and groups. There were also moves to tighten the nursing profession's control over the psychiatric nursing curriculum and examination processes. Increasingly, however, psychiatric nursing was being drawn into general nursing's professionalisation project. Driven by philosophies of holism, and the desire to follow North American models, New Zealand nursing leaders called for psychiatric principles to be included in general nursing education. By the early 1970s, comprehensive nursing education was generally considered by nursing organisations and health policy-makers as the way to reform both general and psychiatric nursing.

The educational reforms of this period highlighted the gap between the aspirations of the largely female, middle-class nursing leaders and the concerns of working-class, rank and file psychiatric nurses, many of whom were men. Industrial issues preoccupied most psychiatric nurses during this time as they faced the possible consequences of amalgamation of psychiatric hospitals with hospital boards. For the nurses, the fight to protect their pay and working conditions and to lobby for better services for their patients seemed more pressing than obscure proposals for comprehensive education.

## **Chapter VIII**

### **Holding the Line: industrial issues 1960-1972**

In 1971 psychiatric nurses became the first New Zealand health professionals to go on strike. This action came at the end of a decade of workforce unrest. Nurses had threatened industrial action, taken their concerns to the media, and instigated a 'work-to-rule'. The nurses' actions can be understood as a response to destabilising forces within psychiatric hospitals. The hope for mental health reform and professionalisation of psychiatric nursing was at odds with the reality of overcrowding, understaffing and inadequate physical facilities. Psychiatric nurses' economic security was also threatened by the processes of health service and nursing education reform. These reforms threatened to undermine their economic position and their distinct identity by drawing them into a closer relationship with the female-dominated nursing profession. Psychiatric nurses used working-class, industrial means to fight battles that were both self-serving and reformist.

#### **Political and economic context**

Industrial unrest occurred within the context of changing political, social and economic conditions. By the end of the 1960s New Zealand, like many other western countries, experienced increased levels of political protest and industrial unrest. This time of grassroots action followed a long period of political and economic stability. A 'long economic boom' after the Second World War had been characterised by sustained economic growth, high levels of profitability and productive investment, low inflation, and full employment.<sup>1</sup> Although this period of prosperity is generally considered to have continued until 1973, the year the British joined the European Common Market, problems were appearing before this as the government struggled to contain inflation and to deal with the loss of overseas earnings. Working-class dissatisfaction gradually increased during the economic boom as it became evident that prosperity was not being evenly distributed.<sup>2</sup>

Stability and consensus were the hallmarks of the conservative National Government led by Keith Holyoake between 1960 and 1972. Holyoake's 'easy does it' approach

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<sup>1</sup> Roper, p.4.

<sup>2</sup> *ibid.*, pp.93-4.

resulted in very gradual political change.<sup>3</sup> His most controversial decision was to commit New Zealand troops to fight in the Vietnam War from 1964, a decision that led to increasing levels of political unrest. Anti-war protests were, however, just one sign of a growing presence of the New Left in New Zealand, as it was in other western countries. During the late 1960s and early 1970s, there was an upsurge of social action such as anti-war protests, women's liberation activities and the Maori self-determination movement. According to Brian Roper, these were all signs of a rise in working-class power. Industrial militancy was another indication of the strength of the New Left and the working class.<sup>4</sup>

### **The Mental Health Group – industrial activities during 1960s**

The Mental Health Group (MHG) of the Public Service Association (PSA) entered the 1960s as a working-class, male-dominated section of a predominantly white-collar union.<sup>5</sup> The Group represented all employees of public psychiatric and psychopaedic hospitals. Active members were staunch unionists influenced by both New Zealand and English working-class values.<sup>6</sup> Although the MHG sometimes engaged in debate and lobbying on professional issues, their central focus was salaries and working conditions. Concerns about salaries, hours, uniforms (including years of lobbying for cardigans for female nurses) and staff accommodation dominated annual remits and committee meetings. Members of the MHG belonged to local hospital subgroups, which elected representatives to the Central Committee. Office holders were frequently, but not always, nurses. Although women were sometimes active at a subgroup level, office holders and Central Committee delegates, as illustrated in the photograph below (Figure 33), were almost all men.

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<sup>3</sup> King, *The Penguin History of New Zealand*, pp.449-52.

<sup>4</sup> Roper, p.96.

<sup>5</sup> The Mental Hygiene Group was renamed the Mental Health Group in the early 1960s.

<sup>6</sup> Reg Hyndman, for example, recalled that the older men, particularly the English, were 'hard-line' unionists: Reg Hyndman interview 28 August 2004.

## M.H. CONFERENCE, 1964

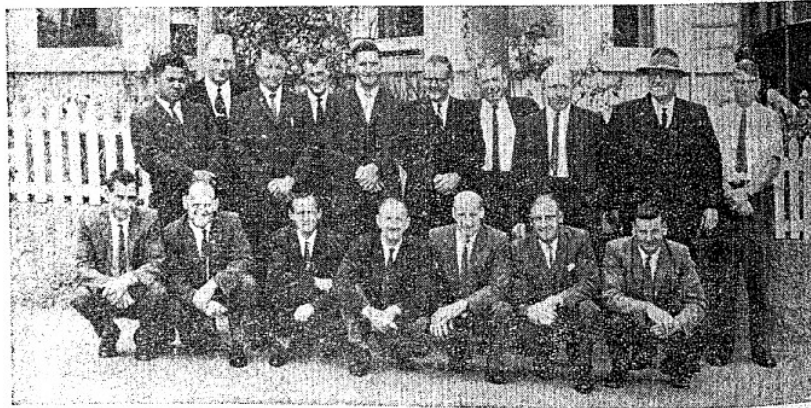


Figure 34 Mental Health Group conference, 1964.  
Source: PSJ, 51, 3, April, 1964, p. 6.

### *Forty-hour week/eight-hour day*

A battle against excessive 'regular' working hours dominated the work of the MHG in the first half of the 1960s. Implementation of an eight-hour day and 40-hour week for all public servants had been PSA policy for many years. The Public Service Commissioner (the employer) had accepted the principle for mental hospital staff as early as 1946, when provisions were made for overtime to be paid for hours greater than 40 per week. Psychiatric nurses, however, still worked 44.5 hours on their regular three-day roster (see Appendix F).<sup>7</sup> On top of this, they frequently worked call-backs (extra days) or extensions (added hours).

Although their union supported the principle of the eight-hour day/40-hour week, psychiatric nurses were ambivalent. Many preferred to continue working longer hours on the existing roster in order to make use of the leave in lieu provision that gained them one month's holiday every six months. The MHG vacillated between demanding an eight-hour day/40-hour week and rejecting the idea. Decisions made by the Central Committee were overturned by ordinary members.<sup>8</sup> Finally, in 1964, the MHG Conference unanimously decided to apply for a settlement which would include a roster based on an eight-hour day/40-hour week. The conference agreed that an application should be lodged for 'appropriate' overtime rates for work in excess of these hours.<sup>9</sup>

<sup>7</sup> In 1946 the nurses worked a 47-hour week over a three-week cycle: PSJ, 33,12, 1946, p.487.

<sup>8</sup> PSJ, 47, 3, 1960, p.6.

<sup>9</sup> PSJ, 51, 4, 1964, p.6.

Even with the decision made, the PSA conceded that the proposed changes were ‘fraught with difficulties’.<sup>10</sup>

On 1 April 1966, a new roster of four shifts per day over an eight-week cycle was piloted at Kingseat Hospital.<sup>11</sup> Hospital administrators had been generally supportive of a new roster system because an eight-hour day required an extra shift in the evenings. This would provide more staff to supervise meal times and evening activities.<sup>12</sup> Despite the promise of a gradual process, it appears that a number of the hospitals proceeded with the new rosters without waiting for the outcome of the Kingseat trial. The result was far from satisfactory, with various interpretations of the new shift system and a lack of communication between the hospitals. Staff dissatisfaction grew, despite attempts by the MHG delegates to sort out the issues. Several PSA members publicly accused their delegates of making ‘foolish’ decisions.<sup>13</sup>

The new roster system was seen by some as a ‘mean deal’.<sup>14</sup> Under the new regime, nurses, particularly the men, worked much more overtime and were no longer entitled to a month’s leave twice a year. They were also required to do more evening work, and the night shift, which started at midnight and finished at 8.30am, was unpopular. Public transport was not available for the midnight start, and the late finish meant that nurses could be required to do heavy work in the last one-and-a-half hours of the night shift.<sup>15</sup>

After a few months, in response to nurses’ displeasure, the Department agreed to limit rostered (compulsory) overtime to eight hours’ per week. Above this limit, overtime would be on a voluntary basis. In exchange, the PSA promised that nurses would be generous in their availability for voluntary overtime.<sup>16</sup> Despite this concession, the MHG remained dissatisfied and viewed the new rosters as a temporary arrangement.

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<sup>10</sup> PSJ, 51, 4, 1964, p.6.

<sup>11</sup> PSJ, 53, 1, 1966, p.12.

<sup>12</sup> The evening shift made it possible to allow patients to stay up longer: Lewis to medical superintendents, 25 July 1961, H-1, Acc. W2191, 30/35/53, 34604, ANZ, Wellington.

<sup>13</sup> PSJ, 53, 8, 1966, p.3.

<sup>14</sup> Margaret Bazley interview 23 February 2004

<sup>15</sup> Patrick Savage to Oakley Subgroup, 6 July 1966, YCAA 1081, 43d, ANZ, Auckland.

<sup>16</sup> Department of Health circular memorandum, 4 August 1966, H-1, W2676, 37326, 30/7/6, box 57, ANZ, Wellington.



Over the next six years, nurses called for a better system, most favouring a four days on/two days off roster.<sup>17</sup>

### ***Salary negotiations: equal pay and relativities***

Three developments had an impact on the context in which the PSA negotiated salaries and conditions for psychiatric nurses during the 1960s. One was the introduction of equal pay for women and men in the public service. Another was the growing industrial savvy of the New Zealand Registered Nurses' Association (NZNA) which represented general hospital nurses. The third development was the move towards closer association between general and psychiatric nurses. These interrelated changes undermined the psychiatric nurses' claim that, insofar as remuneration was concerned, they occupied a unique position.

Equal pay legislation was passed in October 1960 following a protracted period of lobbying and negotiation by the PSA. The legislation not only applied to all public servants, but to all employees who were paid wholly from money appropriated by Parliament. The Act clearly applied to psychiatric nurses. They were public servants whose role was undertaken in almost equal numbers by men and women. General hospital nurses' position was less clear. They were not public servants and only a very few were men. In the event, they were included in the broad parameters of the new legislation which had been extended to include occupations performed exclusively or principally by women, and to which there were no corresponding scales for men to which they could be fairly related.<sup>18</sup>

New salary rates based on equal pay provisions were introduced in three stages from April 1961 to April 1963. For psychiatric nurses, the implications were both immediate and long term. For many women, the result was a much appreciated lump-sum payout and an affirmation of worth. Velda Kelly, a nurse at Sunnyside Hospital, bought her first car with her back pay. She also remembers feeling that the money was recognition that women were doing the same work as the men.<sup>19</sup> Some male nurses were resentful about the changes. They claimed that they should no longer have to undertake gender-

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<sup>17</sup> The Oakley Hospital Subgroup notified the General Secretary in 1966 that they did not wish to go onto the new system. They favoured, instead, a four-on, two-off roster: R. J. Cope, Secretary, Oakley Subgroup to General-Secretary, PSA, 6 July, 1966, YCAA 1081, 43d, ANZ, Auckland.

<sup>18</sup> Margaret Corner, *No Easy Victory: Towards Equal Pay for Women in the Government Service 1890-1960*, Wellington, 1988, pp.97-8.

<sup>19</sup> Velda Kelly interview 26 August 2004.

specific tasks such taking bodies to the mortuary, assisting with post-mortems, killing stray cats, or driving, without compensation of higher pay.<sup>20</sup>

In the longer term, equal pay provisions contributed to a closer association between psychiatric and general nurses, a connection that was resisted by the MHG. In the past salary rates for male psychiatric nurses/attendants had been set in relation to tradesmen or prison officer rates.<sup>21</sup> In self-sufficient, custodial environments, it had been important to attract mature, physically fit men to maintain safety and provide supervision for outdoor work.<sup>22</sup> The attendants/nurses' salaries had therefore been based on a male, bread-winner norm.<sup>23</sup> Female psychiatric nurses' salaries, although lower than the men's, had still been higher than general nurses.

The first suggestion of creating relativity between general and psychiatric nurses' salaries was made by the Equal Pay Implementation Committee when it considered the case of general nurses. The committee decided that it could not recommend that female nurses be given the same pay as male nurses in general hospitals because the discrepancy between their rates was too great. Male nurses in general hospitals were on the domestic workers' award and were, therefore, well paid. Instead, the committee recommended that a new rate for female nurses should be established using a range of other women's occupations as benchmarks. Radiographers, bacteriologists, primary school teachers and psychiatric nurses were all to be considered.<sup>24</sup>

By 1965 when the PSA next made a salary claim for psychiatric nurses, the negotiators found themselves having to counter arguments for pay parity between the general and psychiatric nurses. Russell Flahive, Chairman of the Porirua subgroup, argued strenuously for the maintenance of a 'mental health lead', a term coined by the Whitley Council in the United Kingdom. The Whitley Council had recommended a salary lead

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<sup>20</sup> Peter Sanders described 'tension' between male and female nurses over some jobs: Peter Sanders interviewed by Margaret Whineray, 13 July 1989, OHInt-0139/1 NERF- PNOHP. Some administrators felt that the hiring drivers instead of using nurses, 'could improve relations between the male and female divisions': F. B. Thomas, Secretary, Oakley Hospital to Medical Superintendent, 22 February 1966, YCAA 1081, 43d, ANZ, Auckland.

<sup>21</sup> In 1963, the SSC and Department of Health argued that psychiatric nurses' salaries should be correlated with those of indentured tradesmen: Charles P Hutchinson, *Differential Pay Scale for Psychiatric and Psychopaedic Nurses: First Report of the Royal Commission of Inquiry into Hospital and Related Services*, Wellington, 1972, p.24.

<sup>22</sup> For a background on pay relativities, see: *ibid.*, pp.14-8.

<sup>23</sup> The bread-winner norm is a salary based on the assumption that a man should be able to support his wife and three children. See Chapter I.

<sup>24</sup> KT, 56, 3, 1963, pp.5-6.

for psychiatric and geriatric nurses because of recruitment difficulties. In support of his argument, Flahive claimed that psychiatric nurses possessed all the skills of general nursing but also a special understanding of human behaviour, psychology and sociology. They were also exposed to danger in their work.<sup>25</sup> Relativity with general nurses was not, in the end, used as a basis for deciding the 1966 settlement for psychiatric nurses. The State Services Commission (SSC), however, later confessed that if the NZRNA had made a claim for general nurses at that time, they would have been given parity.<sup>26</sup>

NZRNA's failure to make a salary claim in 1966 was not out of the ordinary. Although becoming more industrially aware, the Association had not traditionally asserted itself strongly on industrial issues. Indeed, some members felt very strongly that nurses should not be unionised. General nurses did not have access to the same negotiation and conciliation processes as public servants. Specifically, they could not refer their claims to an employment tribunal for conciliation. Since 1945, a government committee had set the salary rates for general nurses. The Nurses' Salaries Advisory Committee included a representative of the government and of the hospital boards plus a nurse nominated by the NZRNA. The Association had no direct bargaining role.<sup>27</sup>

Although not strong as an industrial body, the NZRNA was beginning to cast off its anti-union stance. Margaret Pickard, the Dominion Secretary from 1956 to 1968, led the association through a period of increasing industrial assertiveness. In 1964 the NZRNA was successful in persuading the government to establish a special committee to undertake a review of general hospital nurses' salaries and conditions. Ian Lythgoe, a recently appointed official of the State Services Commission, was appointed as chairman.<sup>28</sup> The Lythgoe Committee's report was a breakthrough for general nurses. Most significantly, it recommended the payment of overtime and penal rates. These concessions had been in place for other shift workers for many years. Differentials between male and female nurses' salaries were also to be gradually reduced. Pickard claimed it to be a 'considerable victory' for the NZRNA.<sup>29</sup>

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<sup>25</sup> A Paper Prepared to Assist in Conciliation by R.J. Flahive, Chairman Subgroup, Porirua, 3 November, 1965, Russell Flahive personal papers.

<sup>26</sup> Hutchinson, *Differential Pay Scale*, p.16.

<sup>27</sup> KT, 54, 8, 1951, pp. 7-12.

<sup>28</sup> Henderson, p.323.

<sup>29</sup> KT, 57, 12, 1964, p.18.

Relativity issues caused the breakdown of negotiations in the psychiatric nurses' next salary claim in 1968.<sup>30</sup> Lythgoe, who was by now deputy chairman of the SSC, was at the centre of the dispute. PSA negotiators discovered that Lythgoe, who was the Government assessor on the Government Services Tribunal, was also a member of a three-person committee recently established to settle general nurses' claims.<sup>31</sup> Al White, the PSA conciliator, objected strongly to Lythgoe's involvement and requested an adjournment. He implied that general nurses' salaries had been set in an arbitrary fashion and were therefore unsuitable for use as a benchmark.<sup>32</sup>

Lythgoe, anticipating objections from the PSA, had already subpoenaed Pickard to appear before the Tribunal.<sup>33</sup> His objective was to demonstrate that the process of wage-fixing was not imposed on general nurses despite their lack of access to a tribunal. When Pickard appeared before the psychiatric nurses' Tribunal hearing in June 1968, she explained that the NZRNA had access to a body to hear their claims, but admitted that they would like to have a salaries tribunal.<sup>34</sup>

The PSA's challenge led to prolonged delays in settling the psychiatric nurses' claim. Their objection was referred to the Supreme Court, which did not hear the case until November 1969. A new claim was put to the Tribunal in April 1970, but was withdrawn by the PSA a month later because of errors. The PSA lodged a new claim immediately.<sup>35</sup> By this time, the *State Services Remuneration and Conditions of Employment Act* had been passed.<sup>36</sup> The Act provided for greater coordination in the process of salary setting across government departments and created a new, across-the-board State Services Tribunal.<sup>37</sup> General hospital employees, including nurses, were now covered by the salary setting mechanisms of the state service.<sup>38</sup> The same year occupational classification of state services employees was completed. Salary scales

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<sup>30</sup> EP, 24 May 1968, p.11.

<sup>31</sup> In 1966, the government had decided to establish a Hospital Services Tribunal, but implementation had been delayed. Instead, a special committee was established. NZNA was given the right to make submissions and actively negotiate with the committee: KT, 62, 9, 1969, p.20.

<sup>32</sup> 'Mental Health Case', PSJ, 55, 5, 1968, p.3.

<sup>33</sup> Lythgoe to Pickard, 3 May 1968, New Zealand Nurses Organisation – records, 79- 032-02/06, ATL, Wellington.

<sup>34</sup> 24 June 1968, New Zealand Nurses Organisation – records, 79- 032-02/06, ATL, Wellington.

<sup>35</sup> Hutchinson, *Psychiatric Services at Oakley Hospital: Report of Commission of Inquiry*, p.42.

<sup>36</sup> The State Services Remuneration and Conditions of Employment Act was passed in October 1969.

<sup>37</sup> Roth, p.199.

<sup>38</sup> *ibid.*, p.207.

were now based on occupation rather than by divisions.<sup>39</sup> These changes eased the way for government to insist on pay parity between general and psychiatric nurses.

### ***Non-nursing duties and the Nurses Care Only Campaign***

As discussed earlier, psychiatric nurses became increasingly dissatisfied with having to undertake what they saw as non-nursing tasks. Their growing expectation of a therapeutic role was not matched by the reality of considerable time spent cleaning, cooking, doing outdoor work, and other duties. With fewer 'worker patients' in the hospital population, domestic tasks and outdoor maintenance fell to the nurses to perform. Although the Division and the SSC were aware of the labour shortfall, they did little to make the necessary alterations in staffing establishments. Only minor adjustments to individual hospitals' staffing establishments were made related to growth of patient numbers. A small number of nurse aides (usually women too young to start training) and a few cooks were employed. The problem was exacerbated by difficulties filling existing nursing and domestic vacancies.

During the 1960s the PSA demanded answers to the staffing problems. In 1962, for example, the MHG passed a resolution that nurses should not be required to relieve cooks on their days off, and in 1965 opposed the use of nurses for driving duties.<sup>40</sup> Driving was one of several duties that had become the focus of discontent amongst male staff since the introduction of equal pay. One hospital administrator proffered the opinion that the hiring of drivers, instead of using nurses, 'could improve relations between the male and female divisions'.<sup>41</sup>

Media exposure of the nurses' plight embarrassed the government. In May 1965 the *Auckland Star* published a series of articles on conditions at Kingseat Hospital. 'I was horrified by the things I saw at Kingseat', wrote the reporter Patricia Thomas. 'What distressed me most was the shocking shortage of staff, particularly domestic, and the hopeless burden it imposes on nurses and doctors'.<sup>42</sup> Thomas described how a psychiatric sister, with only three assistant nurses to help her to care for 72 'dementing' patients, also had to clean 40 windows. Thomas' use of dramatic headlines, such as

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<sup>39</sup> *ibid.*, p.202.

<sup>40</sup> Director circular to medical superintendents re 1965 PSA Remits, 10 November 1965, YCAA 1081, 43d, ANZ, Auckland.

<sup>41</sup> F. B. Thomas, Secretary, Oakley Hospital to Medical Superintendent, 22 February 1966, YCAA 1081, 43d, ANZ, Auckland.

<sup>42</sup> *Auckland Star* (AS), 27 May 1965, p.20.

those in Figure 34 ensured that the issue was brought before the public and Parliament. In response to criticism, McKay suggested that nurses sometimes choose to do such work. 'It has often been found that a Sister in charge of a villa is as "villa proud" as any other woman regarding her house'.<sup>43</sup> He also reassured the House that a review of domestic work in psychiatric hospitals was underway.<sup>44</sup>



Figure 35 'Hopeless burden' article, AS, 27 May 1965, p.20.

Union opposition, media publicity and Parliamentary questions galvanised the Division into action, albeit, tentatively. In June 1965, Stan Mirams, the Director of Mental Health, proposed to review staffing numbers and suggested a small increase domestic staff: eight for the larger hospitals, six for Templeton and Levin, and four for Ravelthorpe and Seaview. Because he received ambivalent responses from the hospitals however, he appears to have changed his mind and decided that there was insufficient information to support the case for more domestics.<sup>45</sup>

Introduction of the eight-hour day, 40-hour week in 1966 exacerbated the staffing problem. It was clear that with the existing staffing levels, nurses would have to work excessive overtime to cover the shifts. Unfortunately, by the time the Division realised the extent of the problem, the Government was struggling to contain inflation. In 1967, poor terms of trade led the government to impose deflationary measures, which resulted in a temporary, though marked, increase in unemployment.<sup>46</sup> Cabinet also imposed staff

<sup>43</sup> NZPD, 1965, 342, p.320.

<sup>44</sup> *ibid.*

<sup>45</sup> Mirams, instead, asked for more details on the duties of the existing domestics: Mirams to medical superintendents, 9 June & 9 September, 1965, H-1, 33794, 30/35/26, ANZ, Wellington.

<sup>46</sup> A collapse of wool prices had reduced overseas' earnings: King, *The Penguin History of New Zealand*, p.450.

ceilings in the public service.<sup>47</sup> The Division found itself sandwiched between the pressure from the union for more staff and the Government's imperative to contain costs.

In 1967 the Department of Health proposed an increase of up to 500 nurses, 28 cooks and 130 domestics. The new staff would be part of a restructured nursing workforce in which registered psychiatric nurses would be supported in their work by 'second level' nurses such as student, community, and assistant nurses. Departmental officers argued that the costs of the extra nursing positions would be offset by reductions in overtime and lower salaries for the new, younger, female staff.<sup>48</sup> They conceded that there was likely to be 'strong opposition to all aspects of the proposal' from the PSA.<sup>49</sup> The proposal was thus deferred pending negotiations with the union.<sup>50</sup> In the meantime, in response to requests from the hospitals, Cabinet approved an extra 65 domestic positions, just over a quarter of the number requested.<sup>51</sup>

The increases proved to be too little, too late for the nurses who were struggling with the effects of the new rosters and the heavy demands of non-nursing duties. Kingseat Hospital PSA subgroup took the workload issues into their own hands. They decided to 'work to rule' from 25 April 1968.<sup>52</sup> Nurses at Templeton joined them on 10 May and Oakley nurses on 20 May. The nurses refused to do non-nursing duties such as stoking boilers and stoves, cleaning and polishing floors, walls or windows, performing kitchen duties, driving vehicles or 'manning' the telephone switchboard.<sup>53</sup> The industrial action

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<sup>47</sup> The effect of staff ceilings on mental hospital staffing was described by Adrian Rodda, Chairman, SSC to John Marshall, Chairman Cabinet Committee on Government Administration: 24 April 1968, H-1, 33794, 30/35/26, ANZ, Wellington.

<sup>48</sup> A.E. Galletly, Deputy Director-General (Administration) of Health, draft submission to the Cabinet Committee of Government Administration, 5 October 1967, H-1, 33794, 30/35/26, bundle 2574, ANZ, Wellington; Mirams, draft cabinet paper to Don McKay, Minister of Health, 19 April 1968, H-1, 33794, 30/35/26, bundle 2574, ANZ, Wellington.

<sup>49</sup> Galletly, draft submission to the Cabinet Committee of Government Administration, 5 October 1967, H-1, 33794, 30/35/26, bundle 2574, ANZ, Wellington, p.3.

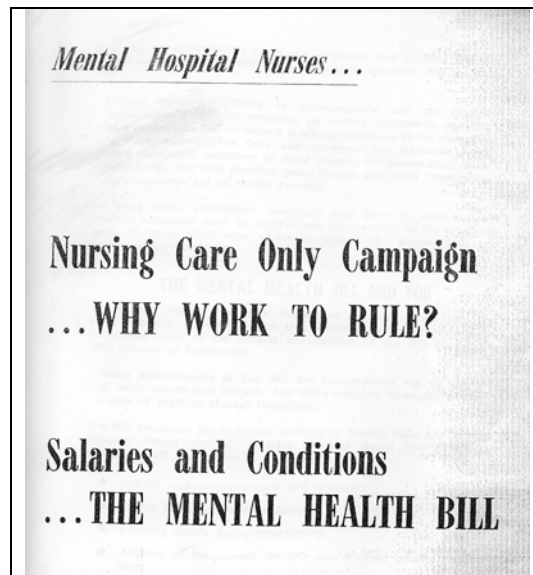
<sup>50</sup> McKay, memo to Cabinet Committee on Government Administration, 19 April 1968, H-1, 33794, 30/35/26, bundle 2574, ANZ, Wellington.

<sup>51</sup> Originally the hospitals had sought an increase of 201 domestics, but the Department had reduced this to 130, and Cabinet subsequently approved half (an increase of 65) in 1967; McKay, memo for Cabinet Committee on Government Administration, 29 April 1968, H-1, 33794, 30/35/26, bundle 2574, ANZ, Wellington.

<sup>52</sup> F. B. Thomas, Secretary, Oakley Hospital memo to Savage, Medical Superintendent, 31 May 1968, YCAA 1081, 43d, ANZ, Auckland.

<sup>53</sup> NEM, 8 May 1968, p.9.

that had begun as a local initiative became a national operation repackaged by the PSA as the 'Nurses Care Only Campaign' (see Figure 36).<sup>54</sup>



**Figure 36 Nurses Care Only Campaign Pamphlet, 1968.**  
**Source: PSA archives, ATL, Wellington.**

Local impact of the nurses' work-to-rule varied according to the conditions in each hospital. At Sunnyside, for example, it proved to be not unduly disruptive in areas where patients were still actively involved in cleaning, and one charge nurse saw it as an opportunity for nurses to engage more with their patients.<sup>55</sup> Kingseat Hospital, however, had to pay large amounts of overtime to their telephonists because the nurses refused to have the phones switched over to the wards at night. Other work also had to be delegated as nurses refused to do any driving duties.<sup>56</sup> By 1969 when the government had done little to remedy the staffing situation, the MHG decided to continue its 'work-to-rule'. In May that year, the Group tightened the restrictions on non-nursing duties in an effort to force the government to employ realistic numbers of domestic workers.<sup>57</sup>

Cabinet finally approved a substantial increase in nursing and catering staff in late 1969.<sup>58</sup> Most of the new nursing positions were for hospital aides and community (second level) nurses, a move the Division saw as the first step in carrying out its

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<sup>54</sup> PSJ, 55, 7, 1968, p.6.

<sup>55</sup> B.T. McElligott, report on inspection of Sunnyside 20, 21 June 1968, H-1, 49/5/9, ANZ, Wellington.

<sup>56</sup> B. T. Mc Elligott, report on inspection of Kingseat Hospital, 24 & 25 September 1968, H-1, 45588, 39/5/9, ANZ, Wellington.

<sup>57</sup> R.C. Tombs, Secretary, Central Committee, Mental Health Group, PSA, circular to Subgroup Secretaries, 13 May 1969, YCAA, 1084, 12c, ANZ, Auckland.

<sup>58</sup> An extra 1,005 positions were approved; 500 nurses and 302 in catering. Of these, 152 were for new units at general hospitals: AJHR, 1970, H-31, pp.69-70.



revised nursing structure. MHG members were particularly cynical about the plan to employ community nurses at lower rates than those paid to assistant nurses.<sup>59</sup> They also argued that community nurses were not properly trained for psychiatric nursing.<sup>60</sup> The increases did not seem to solve the nursing situation. In 1972 the Department reported that, even though there had been substantial increases, staffing establishments were still considered too low in some hospitals. Porirua was particularly badly affected.<sup>61</sup>

### ***Public and union criticism of hospital conditions***

Public criticism of the mental hospital system grew during the mid to late-1960s. Dissatisfaction with mental hospitals paralleled developments in other western countries where psychiatric institutions were being exposed as counter-therapeutic at the best, and abusive and damaging at the worst.<sup>62</sup> In New Zealand, pressure mounted both inside and outside Parliament for the government to address critical problems in mental hospitals, such as overcrowding, inadequate buildings and staffing shortages. Psychiatric nurses, through the MHG, often took a lead in raising these issues. Russell Flahive, who was a member of the Central Committee of the MHG and the Chairman of the Porirua Subgroup, frequently spearheaded these criticisms.

The MHG found a strong ally in Erich Geiringer, a medical practitioner, was also a vociferous critic of mental hospitals. Geiringer was an active political protester on a number of social issues. He had established the New Zealand Medical Association (NZMA) in 1965 to challenge the New Zealand Branch of the British Medical Association which he considered to be in urgent need of reform. He used the NZMA journal to promote his own political agenda, which included his determination to expose mental hospital conditions and force the government to reform the mental health system.<sup>63</sup>

One solution for the problems in mental hospitals was amalgamation with other healthcare services. The Department of Health supported closer relations between psychiatric and general health, and in its submission to a Royal Commission on State Services in 1961–62 had recommended that the hospitals be transferred to hospital

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<sup>59</sup> Oakley Hospital PSA Subgroup minutes, 10 November 1969, YCAA, 12c, ANZ, Auckland.

<sup>60</sup> PSJ, 55, 8, 1969, P.1.

<sup>61</sup> AJHR, 1972, H-31, p.76.

<sup>62</sup> Jones, p.163.

<sup>63</sup> George Salmon, *Tribute to Erich Geiringer, 1917-1995* 1995; available at: <http://www.wnmeds.ac.nz/academic/dph/ippnw/ERICH.HTML> (2 March 2004)

board control.<sup>64</sup> This was seen to be a logical step in the movement towards de-stigmatising mental illness and placing mental problems on the same basis as other health complaints. Administrative changes, however, required amendment to the *Mental Health Act* to legitimise admission of legally committed patients to general hospitals.

Revisions of the *Mental Health Act* were first drafted in 1963, but a bill was not introduced into the House for another four years.<sup>65</sup> In the meantime, public frustration about hospital conditions and staffing grew and the National Government came under attack. Opposition members of Parliament, while agreeing in principle to hospital board administration, were critical of any suggestion that this would solve fundamental problems in psychiatric hospitals. They accused McKay of being out of his depth and ‘merely passing the buck’ in a staffing situation that was so desperate it deserved a Royal Commission of Inquiry.<sup>66</sup> The MHG criticised McKay for avoiding his responsibility to address overcrowding and understaffing. Flahive suggested that McKay’s plan for transfer ‘may save future Government direct embarrassment, but the patients’ welfare will remain unimproved’.<sup>67</sup>

McKay was forced to admit that there were serious problems in psychiatric hospitals and that mental health was the ‘Cinderella’ of the Health Services.<sup>68</sup> This admission was used against him many times over the next few years. Flahive, for example, immediately published a satirical story in the *PSA Journal* (see Appendix L). ‘A Grim Fairy Tale’ compared mental hospitals with Cinderella and accused the government of progressively washing its hands of responsibility for them. Public exposure of mental hospitals’ ‘threadbare condition’, he suggested, was the real reason for the government’s proposed transfer of mental health to hospital board control.<sup>69</sup>

In 1966 the *Public Service Journal* published a series of articles exposing the poor working conditions at Porirua Hospital. The accompanying photos included images of damaged flooring, overcrowded dormitories and leaking coke stoves. The articles claimed that staff members had suffered injuries because of the broken flooring and that

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<sup>64</sup> Warwick A. Brunton, ‘The Development of Psychiatric Services in New Zealand’, 1972.

<sup>65</sup> AJHR, 1964, H-31, p.60.

<sup>66</sup> NZPD, 1965, 342, p.993 & p.838.

<sup>67</sup> Russell J. Flahive, ‘A Paper Prepared to Assist in Conciliation’, 3 November 1965, p.4, Russell Flahive personal papers.

<sup>68</sup> NZPD, 1965, 342, pp. 635-7.

<sup>69</sup> Russell Flahive, ‘A Grim Fairy Tale’, *PSJ*, 52, 6, 1965, p.4.

two nurses had been disciplined for falling asleep beside stoves that later were discovered to be leaking carbon monoxide.<sup>70</sup> Improvements occurred immediately after the articles were published. The PSA journalist mused that '[i]t is a sad reflection on the Government, the State Services Commission and the Departmental authorities, that it is left to the organisation representing the staff to give the necessary publicity to the conditions suffered by patients at a mental Hospital to have them improved'.<sup>71</sup>

The Porirua subgroup invited a local city council health inspector to visit their hospital. His report revealed 40 breaches of the *Health Act* and was so negative that the City Council thought he must have exaggerated.<sup>72</sup> When councillors visited the hospital, they were shocked to discover that conditions were as bad as the report had indicated. Porirua's Mayor, W.J. Brown, wrote to McKay questioning why successive governments had ignored the need to upgrade the facilities. 'One can only ponder', he wrote, 'on the enormity of this crime, for that surely is the only true description of this sad state of affairs'. Brown warned the government that he and his council could not necessarily resist the pressure from outside groups to follow through with their statutory obligations to prosecute the Department under the *Health Act 1956*.<sup>73</sup> His reference to 'outside groups' probably related to Geiringer and the NZMA.

In June 1967, armed with an affidavit from Flahive, Erich Geiringer took a private prosecution against Porirua's Medical Superintendent. The prosecution was based on a section of the Health Act, which forbade the creation of nuisances. Geiringer claimed that the overcrowding and poor conditions identified in the health inspector's report constituted a nuisance to health. Flahive's affidavit included examples of overcrowding and inadequate facilities as well as instances when the PSA had made complaints about the conditions at Porirua with no result.<sup>74</sup> In the event, the details of the complaints were not heard because the defence argued that under Section 6 of the *Mental Health Amendment Act 1935*, those responsible for patients could not be prosecuted except by

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<sup>70</sup> PSJ, 53, 3, 1966, p.6.

<sup>71</sup> PSJ, 53, 4, 1966, p.6 & 53, 5, 1966, p.7.

<sup>72</sup> Porirua 98 12/44 City Health Inspector's Report, 10 June 1966 cited in Williams, p.236.

<sup>73</sup> W.J. Brown, Mayor of Porirua City Council to Hon. D.N. McKay, Minister of Health, 27 July 1966, cited in Williams, pp.236-9.

<sup>74</sup> Affidavit by Russell James Flahive in the matter of S.33 of the Health Act 1956, June 1967, Russell Flahive personal papers.

leave of a Supreme Court Judge and then only if bad faith or lack of reasonable care could be demonstrated.<sup>75</sup>

The court case caused a furore in Parliament. Opposition members asked the Minister what steps were being taken to ensure that the *Health Act* was observed in Department of Health hospitals.<sup>76</sup> McKay at first denied that the *Health Act* had been infringed, then when confronted with examples, agreed that things were not as good as he would have hoped. He suggested, however, that part of the problem was increased public awareness caused by the large number of people who now visited psychiatric institutions. McKay proclaimed, '[t]hat is good, that is grand, that is something we want, but some of these people are being critical of the conditions they see, and they are not aware of what conditions were like even 10 or 15 years ago'.<sup>77</sup>

### ***Mental Health Bill, Clause 7***

By the late 1960s psychiatric nurses' dissatisfaction centred largely on Clause 7 of the Mental Health Bill, a provision that would allow for the transfer of psychiatric and psychopaedic hospitals from the Department of Health to local hospital board control.<sup>78</sup> As soon as the Bill was introduced into the House in 1967, PSA opposition mounted. Hospital subgroups held meetings to discuss the issue, nurses lobbied their members of parliament, and 2,652 members signed a petition asking that the provisions of Clause 7 not be accepted.<sup>79</sup> Not only was the MHG concerned about the condition of psychiatric hospitals, but they were also worried about the threat to psychiatric hospital workers' salaries and conditions. The ultimate threat of Clause 7 was that the PSA could lose its right to represent the hospital staff, since they would be transferring out of the Public Service.

Because of the level of controversy surrounding Clause 7, the Bill was allowed to lapse but was reintroduced to Parliament with modifications in 1968. It was then referred to the Statutes Revision Committee where it was the subject of a large number of

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<sup>75</sup> *New Zealand Medical Association News*, 3, 8, July 4, 1967, p.2.

<sup>76</sup> NZPD, 1967, 352, pp.2165-6.

<sup>77</sup> NZPD, 1967, 352, p.2173.

<sup>78</sup> The Department of Health first raised the possibility of transfer of psychiatric hospitals to hospital boards in its submissions to the Royal Commission on the State Services in 1962: Hutchinson, *Psychiatric Services at Oakley Hospital: Report of Commission of Inquiry*, p.53.

<sup>79</sup> Notice of meeting to members of PSA Auckland Section, November 1968, YCAA, 12c, 6/37/1, ANZ, Auckland. A public meeting at the Ngawhatu Community Centre in Nelson was attended by over 100 people opposed to the Bill; NEM, 17 June 1969, p.8.

submissions. Flahive and other PSA officials warned of dire consequences for mental health services if they were moved out of centralised government control. Hospital boards, they argued, were struggling to manage their finances and already had waiting lists for treatment of people with physical ailments. Adding mental health would unduly strain an already overloaded system. They suggested that the proposed transfer was ‘not in the interests of efficient administration of mental hospitals in New Zealand and consequently are not in the best interests of the community or the patients’.<sup>80</sup>

The PSA also argued for the welfare of its members, requesting protection of conditions of service for current mental hospital staff. Losing public service provisions such as its wage-fixing machinery and occupational classification would, they claimed, particularly disadvantage psychiatric nurses. They also noted that psychiatric nurses might have to work under the control of general nurses who would have difficulty understanding their ‘different orientation’. The submission highlighted the advantages of PSA representation, and in particular, the role of the MHG which, as a specialist body, was able to focus its attention on issues pertaining to mental health. The staff, they emphasised, did not want to lose the PSA as their representative body.<sup>81</sup>

PSA resistance increased as the Bill came close to enactment. Telegrams were sent to McKay and members threatened industrial action.<sup>82</sup> In May 1969, PSA Executive Officers met with the Minister in an attempt to persuade him to omit Clause 7 from the Bill. When he refused, they asked for provisions in the Bill to protect conditions for existing staff in any future transfer. McKay assured the MHG that the Department of Health would undertake full consultation with the PSA and the Hospital Boards’ Association before any transfers of hospitals were made and that staff’s interests would be protected ‘to the fullest extent possible’.<sup>83</sup> He fell short, however, of offering to amend the legislation. In a last ditch effort, PSA executive officers and members of the MHG met with the Prime Minister, Keith Holyoake, and McKay on 24 June.<sup>84</sup> Holyoake reiterated McKay’s assurances but the MHG remained unconvinced.<sup>85</sup> In an

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<sup>80</sup> 15 January 1969, Submission to Statutes Revision Committee of the House of Representatives from the NZPSA (Inc.), Russell Flahive personal papers.

<sup>81</sup> *ibid.*

<sup>82</sup> PSJ, 56, 5, 1969, p.1.

<sup>83</sup> Department of Health circular for staff notice boards, 27 June 1969, YCAA, 12c, 6/37/1, ANZ, Auckland.

<sup>84</sup> Department of Health memo to medical superintendents for posting on staff notice boards, 27 June 1969, YCAA, 1084, 12c, ANZ, Auckland.

<sup>85</sup> *Evening Post (EP)*, 26 June 1969, p.15.

effort to support the work of the executive officers, however, the MHG directed its members to hold off on industrial action.<sup>86</sup>

The *Mental Health Act* was passed in July 1969. The government had remained firm in its refusal to guarantee existing conditions for hospital employees. McKay had however made a concession. An amendment was passed that provided for future legislation to safeguard the interests of psychiatric hospital staff in the event of a transfer to hospital boards.<sup>87</sup> The PSA had won a partial victory, but their members were not happy; some accused the PSA of not being militant enough.<sup>88</sup>

The *Mental Health Act* gained considerable support from both sides of the House because of its liberal stand on processes for admission and its more modern, less stigmatising terminology. ‘Mentally subnormal’ was replaced by ‘intellectually handicapped’ and ‘public institution’ became ‘psychiatric hospital’. Certain categories of people, such as ‘epileptic’ and ‘socially defective’, were removed as categories under the Act. The most significant change was the removal of statutory regulations for informal and voluntary patients. In the future, a hospital would not be obliged to notify a magistrate of the admission of person under a medical certificate, for 21 days. This, McKay argued, would substantially reduce the number of committed patients, since many would recover during the three weeks.

### **Increasing industrial unrest, 1969-1971**

Over the next few years, psychiatric nurses’ dissatisfaction spilt over into direct industrial action. Instigated largely from the ranks, the action exposed the gap between the PSA’s head office and its members. It also highlighted issues of gender and the intersection of professional and working-class values within psychiatric nursing. Differences between psychiatric and general nurses were accentuated as the PSA once again came into conflict with the NZRNA.

Psychiatric nurses’ industrial action occurred within a context of escalating industrial unrest in New Zealand. Triggered in 1968, when the Arbitration Court judge delivered a

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<sup>86</sup> Minutes, Central Committee of Mental Health Group, PSA, 1 July 1969, PSA, YCAA, 1084, 12c, ANZ, Auckland.

<sup>87</sup> NZPD, 1969, 361, p.1,612.

<sup>88</sup> 10 November 1969, Minutes of Special General Meeting of Oakley Subgroup, YCAA, 1084, 12c, ANZ, Auckland.

Nil Wage Order, unions engaged in a level of militancy that had not been evident since the 1951 Watersiders' lockout.<sup>89</sup> Frustrated by rising prices and losing trust in a centralised bargaining system and union bureaucracies, workers pressed their cases through direct action.<sup>90</sup> Despite attempts by unions and employers to shore up control, incidences of decentralised bargaining escalated, and claims based on relativities caused wage rates to spiral upwards.<sup>91</sup>

Following the passage of the *Mental Health Act*, PSA officials entered into intense negotiations with the SSC, the Division of Mental Health, and the Hospital Boards' Association (HBA) to thrash out the details of conditions for employees under a proposed transfer of psychiatric hospitals to hospital board control. These conditions were to form the basis of the Hospital Employment (Transition and Miscellaneous Provisions) Bill. The planned transfer date was 1 April 1971. Stan Rodger, the President of the PSA, recalls spending 'endless hours' working on the arrangements with Eric Heggie, a senior official of the SSC.<sup>92</sup> Over the months of negotiation, cracks began to show between the PSA head office and psychiatric hospital employees. The union's attempts to keep its members informed did not appear to allay fears about the transition.<sup>93</sup>

By November 1970 when the Hospital Employment Bill came before the House, an information brochure had been circulated to all staff. The brochure outlined the agreement that had been reached by the PSA, Hospital Board Association and Department of Health.<sup>94</sup> Reaction from staff was far from positive. To the embarrassment of the PSA, a document that their executives had agreed to was being severely criticised by its members.<sup>95</sup> Central to members' concerns was the future of the mental health salary lead, the differential between general and psychiatric nurses' salaries. The bill also proposed that salaries of current employees should be protected through a top up allowance, but it suggested nothing for those who would be employed

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<sup>89</sup> The NWO was replaced soon afterwards by a five percent order instigated by a combined application by the Federation of Labour and the New Zealand Employers' Federation. See: Pat Walsh, 'An "unholy alliance": The 1968 Nil Wage Order', *New Zealand Journal of History*, 28, 2, 1994, pp.178-93.

<sup>90</sup> Roper, pp.96-9.

<sup>91</sup> Walsh, 'An "unholy alliance"', pp.178-93.

<sup>92</sup> Stan Rodger interview 3 March 2004.

<sup>93</sup> NZPD, 29 May, 1970, 366, pp.1179-80. Criticism was later levelled at the PSA for having refused the Department's suggestion of a combined road show to explain the transition agreement to all hospital staff. Hutchinson, *Psychiatric Services at Oakley Hospital: Report of Commission of Inquiry*, p.53.

<sup>94</sup> NZPD, 3 July, 1970, 366, p.1,517.

<sup>95</sup> NZPD, 19 November 1970, 370, pp.5,125-5,132.

by hospital boards in the future. The level of protest was such that McKay announced that the bill would go to select committee to allow for submissions and further discussion; the transfer date would have to be postponed.

Psychiatric nurses remained unhappy about a number of issues. They were unconvinced about arrangements for the transfer to hospital boards. Staffing shortages continued to be a problem and levels of overtime were in some places excessive. The shift system was unsatisfactory, and had not been resolved despite numerous submissions and attempts at negotiation. Last, but not least, their salary negotiations, commenced in 1967, had still not been settled.<sup>96</sup> The delay was in part the fault of PSA negotiators, who, as discussed previously, had over a period of two years, botched their claim to such a degree that they had been compelled to withdraw it in May 1970 and lodge a new claim.<sup>97</sup>

Nurses at Oakley Hospital faced particular problems. The hospital, instead of opening up and engaging in psychotherapeutic and rehabilitative activities, had over the past few years, become more closed, crowded, and custodial. In part, this was because of the large numbers of referrals from the courts and prisons. Oakley's role in forensic psychiatry had not, as expected, diminished with the opening of the National Security Unit at Lake Alice Hospital. A psychiatric unit at Paremoremo Prison, which had been expected to treat the most difficult forensic patients, was not being used.<sup>98</sup> Mentally unwell prisoners from the wider Auckland region were therefore transferred to Oakley's Male 3 and Male 7 Wards. Some remand patients were placed on acute wards. The hospital's overcrowding was exacerbated by the medical superintendent's policy of not turning away referrals.<sup>99</sup>

In January 1971 Oakley Hospital Subgroup, unhappy with their conditions, took matters into their own hands. They notified the media that they had invited local Labour Members of Parliament to visit the hospital and discuss their complaints.<sup>100</sup> At the meeting, attended by Norm King (Birkenhead) and Eddie Isbey (Grey Lynn), the

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<sup>96</sup> For an account of the process of the salary claim, see: Hutchinson, *Psychiatric Services at Oakley Hospital: Report of Commission of Inquiry*, pp.42-3. Although mental health nurses had received regular pay increases applied to the public service generally, they had not received a separate increase since 1966: Heggie to N. King, 10 February 1971, H-1, W2676, 8303, 30/7/6, Box 65, ANZ, Wellington.

<sup>97</sup> Heggie to N. King, 10 February 1971, H-1, W2676, 8303, 30/7/6, Box 65, ANZ, Wellington.

<sup>98</sup> NZPD, 1971, 372, p.1,149.

<sup>99</sup> Hutchinson, *Psychiatric Services at Oakley Hospital: Report of Commission of Inquiry*, p.55.

<sup>100</sup> YCAA, 12c, 6/37/1, ANZ, Auckland.



subgroup decided to refuse voluntary overtime from the beginning of February unless the Department showed evidence that it was addressing their concerns.<sup>101</sup> They also threatened that, in the absence of satisfactory progress, they would ban ‘compulsory’ overtime (eight hours per week) two weeks later.<sup>102</sup> Oakley Subgroup’s concerns were in two categories: first, their salaries and conditions and second, the staff shortages and its underlying causes. Members believed that the solution to their employment problems lay in a national inquiry into psychiatric services, something they felt should be executed before psychiatric hospitals were handed over to hospital board control.<sup>103</sup>

The Oakley decision placed the subgroup at odds with the Central Committee of the MHG and the PSA’s national body. Under pressure, the Oakley chairman, Adrian Moerenhout, agreed to postpone their date for action but was explicit about the nurses’ frustrations.

I must point out to you that we find the delay somewhat infuriating. It is precisely because of delays and general slowness to react to a steadily deteriorating situation that staff at Oakley have come to a breaking point.... We are now faced with acute staff shortage combined with overcrowded wards, while there is no sign of constructive steps being taken, rather it seems the situation is not fully recognised or [is] ignored. This has created a feeling of hopelessness.<sup>104</sup>

The next day Moerenhout retracted his offer to delay; his members had decided to abide by their original decision.<sup>105</sup> They commenced the action, as planned, on 3 February. A week later, Kingseat nurses decided to follow suit.<sup>106</sup>

Refusal of voluntary overtime caused problems for Oakley’s senior medical and nursing staff. Changes had to be made to patients’ routines and plans were drafted for possible

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<sup>101</sup> Voluntary overtime constituted any hours above the eight that the union, in 1966, had agreed could be required of nursing staff; nurses frequently worked extra days (‘call backs’) on a voluntary basis. Compulsory overtime referred to the eight rostered hours per week that nurses regularly worked as extensions at the end of their shifts.

<sup>102</sup> Oakley Subgroup minutes, 2 February 1971, YCAA, 12c, 6/37/1, ANZ, Auckland.

<sup>103</sup> *ibid.*

<sup>104</sup> Moerenhout to Central Committee, MHG, 2 February 1971, YCAA, 108, 12c, ANZ, Auckland.

<sup>105</sup> *ibid.*

<sup>106</sup> Kingseat nurses withdrew voluntary overtime on 15 February.

closure of wards, curbs on visiting, and restrictions of evening activities.<sup>107</sup>

Administrators anxiously awaited the deadline for extension of the overtime ban.

By 17 February, with no evidence of a substantive response from the SSC or the Division, the Oakley nurses decided to ban all overtime. Moerenhout explained to his members that, ‘As nurses you will find it difficult to stand by and see patient care reduced to a minimum. It is, however, the knowledge that improvements for staff will ultimately benefit the patients that you have chosen to take the action which is really against your nature as nurses.’<sup>108</sup> PSA officials, disturbed by the unilateral action, tried to bring the Oakley subgroup into line. J. Stewart, the Executive Officer, asked the subgroup to postpone their action until the MHG Conference could formulate a national plan. The conference was brought forward three weeks to hasten the process. In the meantime, Oakley Subgroup decided to continue its industrial action.<sup>109</sup>

The MHG Conference, held on 24-25 February, professed support for the Oakley and Kingseat nurses who, they concluded, had been forced into industrial action by the Department’s ‘maladministration’ and the lack of progress on salary negotiations. The conference resolved to implement a national ban on voluntary overtime from 15 March unless a favourable decision had been made on their claim. A ban on all overtime would be put in place two weeks later if there was still no decision. Delegates also resolved that the MHG would no longer accept the principle of compulsory overtime.<sup>110</sup>

Following the conference, SSC officers met with the PSA. They agreed to establish ‘Grievances Committees’ that would tour the country to hear complaints at each hospital.<sup>111</sup> A joint working party would also to be established to work on a new shift and roster system. The SSC, however, made it clear that negotiations could not proceed if nurses imposed a total ban on overtime. The MHG Central Committee, therefore, decided to defer the total ban until 12 April.<sup>112</sup> Undeterred, Oakley and Kingseat nurses resolved to continue with their total overtime bans.<sup>113</sup>

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<sup>107</sup> Meetings of Oakley Hospital senior staff, 9 & 11 February 1971, YCAA, 108, 12c, ANZ, Auckland.

<sup>108</sup> Moerenhout memo Oakley Subgroup members, 17 February 1971, YCAA, 108, 12c, ANZ, Auckland.

<sup>109</sup> Oakley Subgroup minutes, 18 February 1971, YCAA, 108, 12c, ANZ, Auckland.

<sup>110</sup> PSJ, 58, 2, 1971, p.8.

<sup>111</sup> *ibid.*

<sup>112</sup> MHG Central Committee minutes, 25 February 1971, YCAA, 108, 12c, ANZ, Auckland.

<sup>113</sup> Oakley Subgroup minutes, 1 March 1971, YCAA, 108, 15c, ANZ, Auckland.

Psychiatric nurses' salary negotiations were occurring in the context of tightening government fiscal policy. In response to an economic downturn and spiralling inflation, the government imposed a three month price freeze followed by a price justification scheme. Tight controls were also placed on staff ceilings and spending in government departments.<sup>114</sup> Wage control legislation was introduced in February 1971. The Stabilisation and Remuneration Bill proposed a ceiling on salary increases which could only be exceeded with the consent of the Remuneration Authority. Salary rates were to remain in force for at least 12 months.<sup>115</sup>

Both psychiatric and general nurses' salary claims were considered by Cabinet in the light of the proposed employment legislation. It was agreed that because nurses' salaries had fallen behind other employment groups, such as prison officers, there should not be a delay in settling their claims. Cabinet recommended, however, that salary increase for nurses should be spread over two or three years to stave off claims from other employee groups.<sup>116</sup> There was one overriding proviso in approving salaries for general and psychiatric nurses; pay parity was to be achieved. A committee, established by the SSC, had concluded that there was no justification for continuing a salary differential between the two groups of nurses.<sup>117</sup>

Under pressure from other subgroups, Oakley and Kingseat nurses agreed to resume eight hours' overtime per week so that salary negotiations could recommence.<sup>118</sup> The SSC made an offer that matched one previously presented to the general nurses. The offer included a plan to top up the general nurses' salaries a year later to bring parity between the two groups.<sup>119</sup> The PSA accepted the proposal as a basis for negotiation and engaged in almost weekly meetings over the next month.<sup>120</sup> Negotiators reached agreement on 15 April. After consultation with members, however, the MHG decided to provisionally accept the offer but attempt to improve certain aspects. They requested the

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<sup>114</sup> Roth, p.208.

<sup>115</sup> *ibid.*, pp.208-9.

<sup>116</sup> Cabinet Committee on the State Services, 1 March 1971, H, 1, W2676, 38303, 30/7/6, box 65, ANZ, Wellington.

<sup>117</sup> Hutchinson, *Differential Pay Scale*, pp.25-6.

<sup>118</sup> Moerenhout circular to Oakley Subgroup members, 15 March 1971, YCAA, 108, 12c, ANZ, Auckland.

<sup>119</sup> Eric Heggie, Deputy Director-General of Health to all medical superintendents, 18 March 1971, YCAA, 108, 12c, ANZ, Auckland.

<sup>120</sup> NZPD, 1971, 372, p.1,153.

increase be backdated to June 1970 and asked for an extra week's leave for nurses.<sup>121</sup> Hopes for a resolution faded when the SSC rejected the requests and the PSA withdrew its provisional acceptance.<sup>122</sup>

Relationships within the MHG, which were already strained, deteriorated further. Oakley members rejected the offer as unacceptable because it did not retain the mental health salary lead. Against the wishes of the PSA Executive, they decided to resume a full ban on overtime.<sup>123</sup> Over the next few weeks, nurses at Kingseat and Oakley discussed various options for direct industrial action and circulated pamphlets outlining alternatives.<sup>124</sup> Worried about the effects on negotiations, the Executive appealed to its members to act in unity.<sup>125</sup>

By June the situation at Oakley was tense. After the prolonged period of reduced working hours, the standard of patient care had deteriorated. Some wards had been closed and patients' activities were seriously curtailed. Nurses were divided over what to do next. Some wanted to resume normal hours and trust the negotiating team to resolve the issues. Others suggested lifting the total overtime ban for a month to reduce the stress on patients. Some pressed for more militant action. Debate was fiery. Moerenhout believed the conflict reflected the 'weariness of our nurses and their impatience with the present situation, which is becoming intolerable'.<sup>126</sup> As it became evident that the dilemma was both professional and industrial, Moerenhout suggested that any further decision should be made by secret ballot in which only nurses could participate. The subgroup agreed.<sup>127</sup>

Oakley nurses pinned their fading hopes on the outcome of a meeting between the SSC and the PSA due to be held on 16 June.<sup>128</sup> In the event, they were disappointed. The SSC was willing to consider backdating and salary increments for trainees but these seemed hollow assurances since they had not been put to the government for approval.

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<sup>121</sup> NZPD, 1971, 372, p.1,154.

<sup>122</sup> The SSC agreed to commence fresh negotiations in the near future: A. J.A. White, Acting General Secretary, PSA to Subgroups, 26 May 1971, YCAA, 108, 12c, ANZ, Auckland.

<sup>123</sup> Oakley Subgroup circular to members, 7 May 1971; A.J.A. White telegram to Oakley Subgroup, 7 May 1971, YCAA, 108, 12c, ANZ, Auckland.

<sup>124</sup> Special General Meeting minutes, Oakley Subgroup, 8 June 1971, YCAA, 1084, 15c, ANZ, Auckland.

<sup>125</sup> A.J.A. White, Acting General Secretary, PSA to subgroups, 28 May 1971, YCAA, 1084, 15c, ANZ, Auckland.

<sup>126</sup> Moerenhout circular to members, 16 June 1971, YCAA, 1084, 15c, ANZ, Auckland.

<sup>127</sup> Oakley Subgroup Special General Meeting, 8 June 1971, YCAA, 1084, 15c, ANZ, Auckland.

<sup>128</sup> Moerenhout circular to members, 16 June 1971, YCAA, 1084, 15c, ANZ, Auckland.

The Oakley Subgroup committee decided to put the following resolution to its members. ‘Due to the Government’s failure to recognise the seriousness of the situation at Oakley Hospital, we the Oakley nurses will, in desperation withdraw all nursing services as from 8.30 a.m. Thursday, June 24th.’<sup>129</sup>

It was the women nurses’ support that finally tipped the balance at Oakley. Lindsay Johnston (nee Corlett) who was a member of the Oakley Subgroup Committee, recalled that women finally agreed to withdraw their labour once they had extracted an agreement from their male colleagues that improved patient conditions would be a primary goal.<sup>130</sup> Although salaries may have been an important consideration for the men, this had been insufficient cause for most of the women to go on strike.<sup>131</sup> The subgroup listed among its demands: an inquiry into the underlying causes of staff shortages; an upgrade of patient services at all hospitals; and publicity of the two-month old report on grievances at Oakley.<sup>132</sup> On 21 June, Oakley nurses voted to take unilateral strike action, that is, without seeking approval from the union.

The Oakley strike caught the PSA by surprise. As Johnston later reflected, ‘The tail was wagging the dog’.<sup>133</sup> When executive officers flew to Auckland to try to dissuade the subgroup, they were met by a wall of angry nurses refusing to budge. It was a meeting that clearly made an impact on all involved. Stan Rodger, the PSA president, remembers that the Wellington party had been held up by a bomb scare on their plane. Their tardiness further incensed the waiting nurses.<sup>134</sup> Moerenhout recalls having to pull a PSA officer off the rostrum to protect him from the angry nurses. He warned the speaker, ‘If you go on like that you will be killed.’<sup>135</sup>

### ***The 1971 psychiatric nurses’ strike***

‘Soldiers Inside, Nurses Stay Out’ announced the Nelson Evening Mail (NEM) on 25 June.<sup>136</sup> Oakley nurses had been on strike for less than 24 hours when, at the request of the Medical Superintendent, Patrick Savage, himself a military man, the armed forces

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<sup>129</sup> Oakley Subgroup circular, 18 June 1971, YCAA, 1084, 15c, ANZ, Auckland.

<sup>130</sup> Lindsay Johnston interview February 2001.

<sup>131</sup> Moerenhout was also of the opinion that the men were more focused on salaries and the women on patients’ conditions: Adrian Moerenhout interview 11 April 2004.

<sup>132</sup> AS, 24 June, 1971, p.1.

<sup>133</sup> Lindsay Johnston interview February 2001.

<sup>134</sup> Stan Rodger interview 3 March 2004.

<sup>135</sup> Adrian Moerenhout interview 11 April 2004.

<sup>136</sup> *Nelson Evening Mail* (NEM), 25 June 1971, p.5.

had come to assist.<sup>137</sup> Over the next two weeks, soldiers provided much of the nursing care on the male wards and conducted regular security checks of the hospital grounds. Two soldiers were also sent to Park House to assist with the ‘more difficult’ female patients. The army personnel on the male wards were supervised by medical staff and the five senior male nurses who had remained on duty. On the female wards, nursing care was provided by the 16 fulltime and seven part-time nurses who had not gone on strike. They were assisted by volunteers, many of whom were public health nurses and female doctors from the ‘School of Medical Service’.<sup>138</sup> Oakley’s senior social workers and occupational therapists also assisted with ward supervision.<sup>139</sup>



**Figure 37 Striking Nurses outside Oakley Hospital, 24 June 1971.**  
**Source: Bert Roth, *Remedy for Present Evils: A History of the New Zealand Public Service Association from 1890*, Wellington, 1987, p.211.**

The strike soon spread to other hospitals. Templeton nurses withdrew their labour on 26 June and Kingseat on 29 June. Tokanui followed suit three days later. Sunnyside nurses decided to impose a work to rule. They refused to do anything other than ‘essential services’ for 11 days, after which they also withdrew their labour for 24 hours. The Sunnyside action, although seemingly less militant, caused considerable disruption and distress. By demanding the right to define and monitor ‘essential nursing tasks’ the union, in effect, took over control of nursing services. Other subgroups imposed

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<sup>137</sup> Savage was brought up in a military family and served in the NZEF during World War II. He served in the Territorial Army until his retirement: ‘Obituary’, NZMJ, 116, 1170, 2003, p.373. Savage had arranged with an army officer to assess the situation the week before the strike. On the day the strike started, he requested permission to bring in military support. Permission was given at 4.30pm: Patrick Savage interview January 2001.

<sup>138</sup> Presumably this refers to the Auckland School of Medicine.

<sup>139</sup> P.P.E. Savage, Report re Strike – Oakley Hospital, circa July 1971, YCAA, 4272/3b, ANZ, Auckland.

overtime bans or worked to rule. Altogether, psychiatric hospitals sustained a combined total of 39 days without nursing services (see Appendix M for timetable of events).

A strike by nurses was unheard of in New Zealand. Even within the public service, complete withdrawal of labour was most uncommon. Events surrounding the period of industrial action exposed conflicting values, not only in the union, but also in the nursing profession and in New Zealand society more broadly. Rodger found himself having to defend the indefensible; public hospital nurses neglecting their patients. Industrial solidarity, however, dictated that the PSA get behind its members.<sup>140</sup> Publicly, the PSA stood by the nurses, but internally, the union was challenged to look at its own processes. Over the next few years, the PSA developed a code of practice for handling strikes. Among other things, it resolved that subgroups could not take industrial action without permission from the central body.<sup>141</sup>

A sense of responsibility to their patients and colleagues shaped many of the practical decisions nurses made about the strike. At Oakley, nurses decided to attend the hospital for all their shifts and stay in the grounds so that they could be available to respond to emergencies. Nurses at Kingseat and Tokanui did the same.<sup>142</sup> The nurses wanted to ensure that their non-striking, senior colleagues would not be left unsupported and that the patients' care would not be neglected.<sup>143</sup> When the Sunnyside subgroup planned their strike action, they suggested that staff members could provide relief for the senior (non-striking) nurses to protect them from becoming exhausted. The idea was scotched by Margaret Bazley who reminded the committee that direct action would not be effective if it appeared to be too comfortable.<sup>144</sup>

Union orientated, workers' rights appeared to have underpinned other decisions by the striking nurses. Templeton nurses went on strike with only 24 hours' warning. After the first two days, they imposed even tighter restrictions, pulling the senior nurses off the wards and setting up a picket line to stop strike breakers.<sup>145</sup> The picket's main targets

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<sup>140</sup> One dilemma for the union was that the PSA represented all employees of the Department of Health. Its members were on both sides of the conflict: Stan Rodger interview 3 March 2004.

<sup>141</sup> *ibid.*

<sup>142</sup> At Tokanui, nurses also provided a 24 hour fire crew in recognition of the hospital's isolated rural position: AS, 2 July 1971, p.1.

<sup>143</sup> The nurses were surprised that their offer of assistance was never taken up: Lindsay Johnston interview February 2001.

<sup>144</sup> Sunnyside Subgroup Special Committee Meeting, 1 July 1971, Margaret Bazley personal papers.

<sup>145</sup> Senior nurses were ordered off the wards on the third day of the strike: *Press*, 29 June 1971, p.1.

were dental nurses employed by the Department of Health, and university students whose assistance had been coordinated by the Canterbury University Students' Association.<sup>146</sup> The students' arrival in hospital buses particularly angered the strikers.<sup>147</sup> It was soon evident that the Templeton nurses were losing public sympathy.<sup>148</sup> They were criticised by politicians and by the hospitals' Welfare Council.<sup>149</sup> Moerenhout was also worried about the effect of their behaviour on the rest of the MHG. He recalls telling the Templeton leaders, 'For goodness sakes, we are nurses; we don't do that sort of thing.'<sup>150</sup> Under pressure, the nurses agreed to soften their approach. They allowed senior nurses to return to work and came to an agreement with the Students' Association to allow students to volunteer on an individual basis.<sup>151</sup>

Public support for the psychiatric nurses was surprisingly good. Two nights before the strike began, Maurice Venville, the Oakley Chaplain, made an impassioned speech at the Anglican Church synod commending the nurses as 'good, sensible, feeling and devoted people' who were acting, he argued, as much for the benefit of their patients as for themselves.<sup>152</sup> The next day, Kenneth Prebble, Archdeacon of Hauraki, introduced a motion urging the government to carry out a full inquiry into the cause of disquiet among the psychiatric nurses. He expressed appreciation for the 'indispensable service rendered to the community' by the psychiatric nurses.<sup>153</sup> The Anglican Church's support for the motion proved an embarrassment for the government in Parliament.<sup>154</sup>

The media, although not condoning strike action, was largely sympathetic to the nurses' cause. The *Auckland Star*, for example, castigated the government for its 'dilatatory handling' of the dispute. Psychiatric nurses, it claimed were 'by and large dedicated people who have been prepared to put up with many things that few other workers would tolerate'.<sup>155</sup> The daily newspaper also related nurses' stories of frustration over

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<sup>146</sup> The Department of Health decided to advise dental nurses not to volunteer their services: *ibid.*

<sup>147</sup> Canterbury Students' Association organised students at the request of the Templeton Hospital Voluntary Association; *Press*, 28 June 1971, p.1.

<sup>148</sup> For example, see: Editorial, AS, 30 June 1971, p.8; Editorial, NEM, 29 June 1971, p.6.

<sup>149</sup> Templeton's Welfare Council, who was initially supportive of their claims, began to lose patience: *Press*, 5 July 1971, p.1.

<sup>150</sup> Adrian Moerenhout interview 11 April 2004.

<sup>151</sup> *Press*, 30 June 1971, p.1.

<sup>152</sup> NZPD, 1971, 372, p.1157.

<sup>153</sup> NZH, 24 July 1971, p.3.

<sup>154</sup> NZPD, 1971, 372, p.1157.

<sup>155</sup> Editorial, AS, 23 June 1971, p.8.



patient conditions.<sup>156</sup> Other editors were not as sympathetic. The Nelson Evening Mail suggested that by abandoning their dependant patients, the nurses ran a grave risk of forfeiting public sympathy.<sup>157</sup>

Oakley nurses undertook their own publicity campaign. They produced information material and took every opportunity to invite the media and the public to come to the hospital to discuss the issues. One visitor was Archdeacon Prebble, who was so moved by the nurses' stories and their evident lack of political guile that he visited the *New Zealand Herald* offices on their behalf. Not able to find the editor, he instead prevailed upon Gordon Minhinnick, the cartoonist, to do something about representing the nurses' position.<sup>158</sup> A sympathetic cartoon appeared within a few days (see below).



**Figure 38 Minhinnick cartoon of striking nurses confronting government ministers.**  
Source: NZH, 30 June 1971, p.8.

Nurses, in uniform, collected signatures on a petition and distributed an information pamphlet in Auckland's city streets. *The Case of the Nurses and their Patients*, explained that 'One in ten New Zealanders will need psychiatric treatment sometime during their life.'<sup>159</sup> It also suggested that 'Neglect of nurses means neglect of patients.'<sup>159</sup> Other nurses were sent to address trade union meetings where they explained their grievances and gathered signatures. By the end of the strike, 15,000 people had signed the petition.<sup>160</sup>

<sup>156</sup> AS, 28 June, 1971, p.26.

<sup>157</sup> NEM, 29 June 1971, p.6.

<sup>158</sup> Kenneth Prebble, personal communication.

<sup>159</sup> Roth, p.211.

<sup>160</sup> AS, 6 July, 1971, p.1.

Government ministers were under increasing pressure to resolve the dispute and attend to problems in psychiatric hospitals. McKay was criticised for not flying immediately to Auckland to try to avert the strike.<sup>161</sup> His claims of having instigated substantial reforms in psychiatric services began to sound hollow beside the nurses' stories of understaffing and lack of resources.<sup>162</sup> The government only gradually realised that the situation would require more than a cursory response. On Day Two of the strike, the SSC settled the general nurses' claim and then offered the same package to the mental health nurses. The PSA rejected it out of hand.<sup>163</sup> On 28 June, four days into the dispute, Holyoake met with PSA officers.<sup>164</sup> That afternoon Cabinet offered to establish a one-person inquiry into services at Oakley. Again, the nurses rejected the offer. They wanted a national inquiry and a guarantee that the mental health lead would be continued.<sup>165</sup>

Public opinion shifted even further towards the nurses' side when Gallery, a current affairs programme, aired their issues on television. McKay did not come over strongly and Doug Kennedy, the Director General of Health, was criticised for not appearing on the programme.<sup>166</sup> Nurses' stories about their patients' welfare seemed more convincing than McKay's assertions of his government's accomplishments. The next day, the *Auckland Star* suggested it was time for McKay to 'snap into action' to address Dickensian hospital conditions and the nurses' distress.<sup>167</sup> Faced with negative publicity, the SSC and the Department of Health spent \$2,000 on large newspaper advertisements explaining the 'facts' in daily newspapers.<sup>168</sup>

Other factors worked in favour of the striking nurses. To the surprise of the nurses and most other people, they received their normal pay. It is unclear how this occurred except that it was not a decision made at the individual hospitals.<sup>169</sup> The influx of volunteers into psychiatric hospital wards also had a positive spin-off for the nurses. Volunteers

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<sup>161</sup> NZPD, 1971, 372, p.1,149.

<sup>162</sup> McKay eventually visited Oakley on the third day of the strike: AS, 28 June 1971, p.1.

<sup>163</sup> The general nurses' settlement was announced on 25 June. Two days' later, the psychiatric nurses rejected an offer for the same amount because it would not include a salary lead: *Press*, 28 June 1971, p.14.

<sup>164</sup> AS, 28 June 1971, p.1.

<sup>165</sup> AS, 29 June 1971, p.3.

<sup>166</sup> Editorial, AS, 30 June, 1971, p.8; NEM, 2 July 1971, p.4.

<sup>167</sup> Editorial, AS, 30 June 1971, p.8.

<sup>168</sup> NZPD, 1971, 373, p.1,652.

<sup>169</sup> Patrick Savage interview January 2001: NEM, 30 June 1971, p.11.

were exposed to the conditions in which psychiatric nurses worked. Some told their stories in newspaper letters and articles.<sup>170</sup>

A week into the dispute, as nurses at more hospitals were preparing to strike, the government began to discuss the possibility of conducting a national inquiry into psychiatric hospitals.<sup>171</sup> Hopes for a settlement were raised when a delegation of nurses from Oakley, Kingseat, and Porirua met McKay in Wellington. Fifty nurses also walked on parliament in a silent protest.<sup>172</sup> By the next day, however, there were doubts about whether the government's new offer would be acceptable to the subgroups. The major sticking point was the mental health salary lead.<sup>173</sup> The government refused to guarantee retention of the salary differential but offered to include the subject in an inquiry into psychiatric hospitals. Hospital subgroups met over that weekend to decide on their responses. On Monday 5 July, the MHG gathered in Wellington for a two-day conference. Opinion was divided, but at least two subgroups wanted to hold out for a guarantee on the mental health lead.<sup>174</sup>

NZNA action, in the end, forced the psychiatric nurses to step down.<sup>175</sup> Tensions between the PSA and NZNA had increased before and during the strike. On the Gallery programme and in previous media releases, the PSA had alleged that the general nurses rode on their industrial coattails. Salaries negotiated for psychiatric nurses, they argued, were subsequently applied to general nurses. The implication was that the NZNA was merely a 'tea and cakes outfit', not capable of being a real union.<sup>176</sup> The NZNA had experienced difficulties countering such public assertions. Though disapproving of strike action, the Executive had taken care not to criticize the PSA publicly. In a letter to McKay, the NZNA supported the PSA's call for an immediate inquiry at Oakley Hospital and a full inquiry of all psychiatric hospitals, but had emphasised their belief that the mental health salary lead should be dispensed with.<sup>177</sup>

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<sup>170</sup> 'This Job is Sheer Hell', *NZ Truth*, 6 July, 1971, p.1; 'Templeton Volunteer Says: I've Been Proud to Help Out', *Dominion Sunday Times*, 4 July, 6, 'Hospital Like a "Forgotten World"', *Press*, 30 June, 1971, p.1.

<sup>171</sup> AS, 1 July 1971, p.3.

<sup>172</sup> AS, 2 July 1971, p.1.

<sup>173</sup> AS, 3 July 1971, pp.1 and 40.

<sup>174</sup> AS, 5 July 1971, p.1.

<sup>175</sup> In 1971, the NZRNA changed its name to NZNA.

<sup>176</sup> NZNA confidential branch circular, 20 July 1971, Margaret Bazley personal papers.

<sup>177</sup> NZNA branch circular, 1 July 1971, Margaret Bazley personal papers.

It seems that the PSA underestimated the NZNA's industrial skills. On 5 July when PSA officials arrived for a meeting with the Prime Minister Keith Holyoake, they met Thelma Burton, the NZNA's National Secretary, who had just delivered a letter to him. Burton had reminded the Holyoake that parity with psychiatric nurses was a core undertaking of the salary offer recently accepted by the general nurses. She condemned the 'emotional and other pressures' that were being brought to bear by the PSA in order to preserve the mental health lead. Burton later claimed that she had not intentionally arrived at the same time as the PSA representatives.<sup>178</sup>

Burton's letter seemed to bolster the government's resolve and took the wind out of the PSA's sails. Jack Marshall, the deputy Prime Minister, read the letter to the union's representatives. As the delegation left, debate between the PSA representatives and Ministers continued in front of reporters. Brian Talboys, Chairman of the Cabinet Committee on State Services, claimed that the lead was a public issue that should be decided in public (by an inquiry). Holyoake stated that the Government could not affirm the principle of a salary lead because it might not be acceptable to the NZNA.<sup>179</sup> Burton's actions were later interpreted by the media, in her view wrongly, as calculated interference.<sup>180</sup>

When the PSA later tried to have the NZNA expelled from the Combined State Services' Organisation (CSSO), Burton was able to demonstrate that her organisation had acted in good faith throughout the parallel salary negotiations. Despite feeling that she had set the record straight, however, Burton was under no illusion that the problem would go away. The parting shot of the dispute was by Dan Long, the PSA General Secretary, who asserted that the psychiatric nurses would 'get the mental health lead come hell or high water'. Burton astutely concluded that, 'I believe we won the round but would not like to be certain that we have reached the end of the story.'<sup>181</sup>

The day after their meeting with Holyoake and Marshall, as Sunnyside nurses commenced their strike, the MHG conference decided to advise their members to accept the latest offer.<sup>182</sup> Mental hospital subgroups reluctantly accepted. Templeton, Kingseat,

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<sup>178</sup> NZNA branch circular, 20 July 1971, Margaret Bazley personal papers.

<sup>179</sup> *Press*, 6 July 1971, p.14.

<sup>180</sup> NZNA branch circular, 20 July 1971, Margaret Bazley personal papers.

<sup>181</sup> Thelma Burton to the Acting Secretary, CSSO, 3 August 1971, Margaret Bazley personal papers.

<sup>182</sup> AS, 6 July 1971, p.1.

Tokanui and Sunnyside nurses returned to work on 7 July. Oakley nurses' disappointment was such that some booed when the negotiators returned from Wellington. The subgroup, however, voted to accept the deal because most believed they would lose public sympathy if they did not.<sup>183</sup> They recommenced work on 8 July, exactly two weeks after withdrawing their labour.

The effect of the nurses' industrial action had been varied. For senior nurses, doctors and administrators, the experience was tiring and stressful. Soon afterwards, Bazley described the work-to-rule period at Sunnyside as 'undoubtedly the most traumatic days of my life'.<sup>184</sup> Many patients, however, enjoyed the change of routine. Volunteers, well supplied with sweets and cigarettes, had been willing to engage with patients in a way that the regular staff could not. Shona Finchum, an assistant matron at Oakley, noted that '[m]any patients have told me they felt they really mattered, really counted for something with all these new faces around'.<sup>185</sup> In some circumstances, the wards had been better staffed and better stocked with linen and other supplies than usual.<sup>186</sup>

### ***The Oakley Inquiry***

As promised, an inquiry was held into psychiatric services at Oakley Hospital soon after nurses returned to work. Charles Hutchinson, an Auckland judge, was chosen to head the three-person team.<sup>187</sup> Public hearings started in mid-August and lasted three weeks. The inquiry proved to be a cathartic opportunity for the nurses to express the years of frustrations over hospital conditions. Moerenhout had encouraged them to consider this as a 'golden opportunity to force the pace of updating our hospitals'.<sup>188</sup> He had invited the nurses to discuss the problems with each other, with their colleagues and with patients, to identify the obstacles to providing good nursing care and to make written submissions. He had cautioned them, however, to keep to a discussion of issues and not to attack individuals.<sup>189</sup>

The 'Oakley Report', released in September 1971, substantially supported the nurses' complaints. It painted a picture of a hospital that had been allowed to become

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<sup>183</sup> AS, 7 July 1971, p.1.

<sup>184</sup> Bazley speech notes, circa late 1971, Margaret Bazley personal papers.

<sup>185</sup> AS, 8 July 1971, p.7.

<sup>186</sup> Lindsay Johnston, interview 21 September 2001.

<sup>187</sup> Other inquiry members were David Barlow, a medical superintendent from Melbourne and William Hutchings, the former Secretary of Defence.

<sup>188</sup> Moerenhout to Oakley Subgroup members, 9 August 1971, YCAA, 1084, 12c, ANZ, Auckland.

<sup>189</sup> *ibid.*

increasingly entrenched in custodial care. Approximately one-third of the patients were accommodated in locked wards and little progress had been made in developing outpatient and day patient services. Wards were overcrowded and in many cases, unsuitable for patient comfort, privacy or therapeutic function.<sup>190</sup> Staffing at Oakley had deteriorated. Not only were there significant nursing shortages, but the establishment figures were woefully inadequate. As a result, nurses worked long overtime hours and experienced frequent ward changes, which interfered with continuity of care for their patients.<sup>191</sup>

Forty-two recommendations were made in the report. These included such things as establishing outpatient clinics and a day-stay unit. It suggested that greater emphasis should be placed on psychological services such as group therapy. A staffing review and new establishments were required urgently. Recommendations were made on some of the nurses' national issues. Top priority, for example, was given to the need for completing the national review of shifts and rosters. The report also considered that nurses had not been given adequate information on the conditions of transfer to hospital boards. It recommended that a brochure should be distributed as soon as the empowering legislation had passed through Parliament.<sup>192</sup>

A year after the Oakley inquiry, the Director-General claimed that considerable progress had been made in implementing some of the recommendations. He admitted however that the critical attitudinal changes were less readily achieved and more difficult to measure.<sup>193</sup> In the nurses' assessment, none of the forty-two recommendations had been fully implemented. Several nurses broke a media ban to complain on national television about the blatant lack of progress.<sup>194</sup>

### ***Transition to hospital boards***

The *Hospital Employment (Transitional and Miscellaneous Provisions) Act* was passed in November 1971. Few changes had been made to the original bill. Salaries of employees transferring to hospital boards were safeguarded as an interim measure by means of allowances. The question of the mental health salary lead was left for the

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<sup>190</sup> Hutchinson, *Psychiatric Services at Oakley Hospital: Report of Commission of Inquiry*.

<sup>191</sup> *ibid.*, p.40.

<sup>192</sup> *ibid.*, pp.9-12.

<sup>193</sup> AJHR, 1972, H-31, p.77.

<sup>194</sup> Lindsay Johnston interview 21 September 2001.

hospital inquiry to decide. The government promised that nurses could continue to be represented by the PSA for five years, but other occupational groups were not given this guarantee. Workers whose occupations were covered by the *Industrial Conciliation and Arbitration Act* (IC&A) were legally obliged to belong to their respective unions. Other occupations were to be covered by a new organization, the Society of Hospital Employee Organisations (SHEO).<sup>195</sup>

On 1 April 1972 the control of all psychiatric hospitals except Lake Alice was transferred from the Department of Health to hospital boards.<sup>196</sup> Apart from a last minute challenge from the PSA over industrial representation of the non-nurses, the transition happened relatively smoothly. Several residual issues, however, led to industrial activity later that year. Hospital employees complained that those who were employed after 1 April received different conditions than those who were already on staff. For nurses, most of the existing conditions applied to new recruits, but for other occupations, there were significant differences.

In October, staff at Templeton Hospital decided to blacklist all new appointments until the SSC guaranteed that new staff would receive the same conditions as transferring employees. Sunnyside, Braemar and Ngawhatu staff banned new appointments soon afterwards.<sup>197</sup> Hospitals managed the disruption over the summer because they were able to employ university students as temporary workers, but by the end of January 1973, the situation had become critical. Vacation workers were about to leave and a new group of nursing students was unable to take up employment<sup>198</sup> To avert a crisis, over 400 staff at Sunnyside, including PSA officers and hospital administrators, signed a petition asking the new Labour Government to intervene urgently.

Robert Tizard, the Minister of Health and State Services in the newly-elected Labour Government, was shocked to discover an ‘unbelievably confusing situation’.<sup>199</sup> He initially suggested that responsibility laid with individual hospital boards but under pressure, he must have changed his mind. Within a week, Tizard held a meeting with

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<sup>195</sup> D. Thomson, Chairman, Cabinet Committee on State Services to Dan Long, General Secretary, PSA, 13 March 1972, H-1, 39029, 30/13/1, bundle 2801, ANZ, Wellington.

<sup>196</sup> The transfer date had been postponed twice, first to October 1971, then to April 1972. Because of the National Forensics Unit, Lake Alice was left under central control.

<sup>197</sup> There is some suggestion that action also spread to Porirua Hospital: Margaret Bazley personal papers.

<sup>198</sup> Bazley personal papers.

<sup>199</sup> *Press*, 17 January 1973, p.2.

representatives the HBA, SSC, Department of Health, the PSA and the Federation of Labour.<sup>200</sup> An agreement was reached for all staff to be paid at State Services rates whether or not they commenced work before the transition.<sup>201</sup> Once again, the PSA had won a significant victory in its fight to retain conditions for mental hospital employees.

## **Rosters and salary lead finally resolved?**

### ***Four and two rosters***

Despite prolonged negotiations, the question of a new roster system had still not been resolved by mid-1972.<sup>202</sup> The MHG favoured a six-week roster of four days on and two days off with three shifts per day.<sup>203</sup> The main obstacle to reaching an agreement was the PSA's insistence that the nurses should work no more than eight hours per day. This would give nurses an extra 16 days off per year, something their employers were not willing to consider. Apart from extra costs, this arrangement would put mental health nurses at a distinct advantage over others in the health sector. The SSC and Department of Health argued that the 'four and two' roster could be implemented if nurses were prepared to work 8.35 hour shifts.<sup>204</sup>

The Oakley subgroup considered the delays in implementing a new roster as a failure to enact one of the core recommendations of the Oakley Inquiry.<sup>205</sup> Frustrated, they once again took matters in their own hands. Nurses instigated their own rosters based on the 'four and two' roster with eight-hour shifts. Between July and September, subgroups around the country followed Oakley's lead.<sup>206</sup>

Staff satisfaction with the new system was such that there was little attempt to enforce the official roster. John Shennan recalls a 'wonderful, humorous situation' at Kingseat where, each Sunday, Bert McCaughan, the Assistant Head Nurse, walked across to the

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<sup>200</sup> In November 1972, the PSA had lost a test case in the Supreme court over representation of mental hospital workers covered by the IC&A Act. The union had been forced to relinquish those members to other unions and negotiate with the FOL over joint arrangements for discussion of employee issues: PSA Auckland Section circular to psychiatric hospital members, 13 December 1972, YCAA, 1084, 12c, ANZ, Auckland.

<sup>201</sup> PSJ, 60, 1, 1973, p.1.

<sup>202</sup> A joint working party with the Department of Health and the PSA on shifts and rosters was established in April 1971: CAHW, CH890/7d, ANZ, Christchurch.

<sup>203</sup> Report on Sub-Committee on Shifts and Rosters, MHG Conference, 24-5 February 1971, H1, W2676, 38303, 30/7/6, box 65, ANZ, Wellington.

<sup>204</sup> Department of Health to Hospital Boards, 28 July 1972, CAHW, CH890/7d, ANZ, Christchurch.

<sup>205</sup> Special Committee of Oakley Subgroup, 23 July 1972, YCAA, 1084, 12c, ANZ, Auckland.

<sup>206</sup> At all hospitals except one, nurses adopted their own rosters: AJHR, 1973, E-10, p.87.



male staff quarters to post the official roster.<sup>207</sup> A few minutes later, a PSA delegate would pin the alternative roster beside it; this is the one everybody followed.<sup>208</sup> After a few weeks, the Department of Health suggested that to save confusion, matrons and head nurses could post both the official and unofficial rosters.<sup>209</sup>

It was quite clear that all parties wanted to find a solution to the roster problem, but also to save face. To hold the line over the eight-hour day issue, the Department directed hospital boards to ensure that the nurses were docked the 35 minutes per day per shift.<sup>210</sup> Negotiations were also suspended during the industrial action. By the end of September, the PSA agreed on a compromise. The nurses would begin working the officially negotiated 'four and two' roster (with the extra 35 minutes per day) but only as an interim measure while negotiations continued on the eight-hour day (see Appendix F for rosters). The agreement came with a promise from the government of 373 more nurses.<sup>211</sup> A year later, the nurses were still working the interim roster.<sup>212</sup>

Implementation of the four and two roster was more a victory than a failure for the MHG. Intensive negotiation had won them the general pattern of rosters and shifts that they desired. Direct action brought it into being. Their failure to win an agreement on the eight-hour day was not surprising in the context of integration with other health services. It was in the government's interests not to amplify the differences between mental hospital nurses and other health workers.

### ***The mental health lead***

The promise of an inquiry into all psychiatric hospitals was never fulfilled. Instead, there was an inquiry into the need for a continuing salary differential between general and psychiatric (and psychopaedic) nurses.<sup>213</sup> The inquiry was the first stage of a broader *Royal Commission into Hospital and Related Services*. Because of a change of government from National to Labour, the Royal Commission was disbanded in 1973

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<sup>207</sup> There is some question over spelling of McCaughan (alternative McGowan). Robert McCaughan was listed as an assistant head nurse at Kingseat in 1969: Public Service List, 1969.

<sup>208</sup> John Shennan interview 10 March 2004.

<sup>209</sup> Department of Health teletext to hospital boards, 18 August 1972, CAHW, CH890/7d, ANZ, Christchurch.

<sup>210</sup> Director-General to hospital boards, 3 August 1972, CAHW, CH890/7d, ANZ, Christchurch.

<sup>211</sup> AJHR, 1973, E-10, p.87.

<sup>212</sup> Director-General to hospital boards, 29 October 1973, CAHW, CH890/7d, ANZ, Christchurch.

<sup>213</sup> Hutchinson, *Differential Pay Scale*.

after completing only three reports.<sup>214</sup> The Labour Government preferred to rely on its own ideas for health reform.<sup>215</sup>

The *Inquiry into Differential Pay Scales for Psychiatric and Psychopaedic Nurses* reported in December 1972.<sup>216</sup> The Commission concluded that a salary lead was not justified on the grounds of job content, responsibility, or conditions of work. Nevertheless, it recommended that the mental health lead continue in the form of an allowance for the foreseeable future.<sup>217</sup> Recruitment and retention issues were cited as the main reason for maintaining the lead, even though the inquiry team acknowledged that there was little evidence to suggest that higher salaries facilitated retention. The team was concerned that psychiatric nurses, already in a state of turmoil over their working conditions, would interpret the loss of a salary differential as a 'blow to their status' and an indication that their work was not appreciated. They were particularly mindful of the possible impact on recruitment and retention of men.<sup>218</sup>

The PSA had based its argument for retention of the mental health lead on the unique difficulties inherent within psychiatric nursing including job content, working conditions, and recruitment difficulties. Psychiatric nurse witnesses claimed that many of their patients were unpredictable and violent, did not appreciate the need for treatment, and were ungrateful or resistant to nursing interventions. Although it was conceded that general nursing could be stressful, they argued that psychiatric nursing was worse.<sup>219</sup>

In the process of fighting for their own conditions, the nurses highlighting the negative aspects of their work, thus undermining the efforts that had been made over the past decade in opening up hospitals, emphasising relationship aspects of their work, and convincing the public that mental illness should not be feared. A similar phenomenon occurred in the United Kingdom around this time. Vicky Long noted that mental nurses

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<sup>214</sup> The two other reports completed were: *Proposed Institute of Psychiatry: Second Report of the Royal Commission of Inquiry into Hospital and Related Services*, 1973; *Services for the Mentally Handicapped: Third Report of the Royal Commission of Inquiry into Hospital and Related Services*, 1973.

<sup>215</sup> Warwick Brunton, 'Mental health: The Case of Deinstitutionalisation,' in *Health and Public Policy in New Zealand*, Peter Davis and Toni Ashton, eds, Oxford, 2001, p.192.

<sup>216</sup> Hutchinson, *Differential Pay Scale*.

<sup>217</sup> The Commission suggested that a salary lead should not be extended to those who were not already entitled to it; this included psychiatric nurses working in general hospitals and general nurses, community nurses and hospital aides working in psychiatric hospitals: *ibid.*, p.90.

<sup>218</sup> *ibid.*, p.89.

<sup>219</sup> *ibid.*, pp.30-6.

in the United Kingdom, when faced with the threat of radical down-sizing of psychiatric hospitals, reverted to stigmatising and self-serving rhetoric.<sup>220</sup> Unlike their United Kingdom counterparts, however, New Zealand psychiatric nurses were faced, not just with the potential deterioration of hospital services, but with a threat to their unique position and conditions of service.

Gender issues were central to the arguments put before the Royal Commission. While the PSA did not explicitly lay claim to salaries based on sex difference, this justification was implied. William Glassey, a hospital chaplain who supported the PSA position, argued that psychiatric nursing was particularly taxing on young, female nurses who may find patients' 'offensive behaviour' difficult to accept. In words that resonated with the public concerns from the 'manpowering' years of the Second World War, Glassey suggested that parents were opposed to young women going straight from school into psychiatric nursing.<sup>221</sup>

Those who argued against retention of the lead promoted the view that psychiatric nursing was closely related to general nursing, and by implication, suitable for women. The work, the NZNA and others claimed, if undertaken in a planned, therapeutic manner, was no more stressful or dangerous than general nursing.<sup>222</sup> Women, therefore, should not need special incentives to undertake psychiatric nursing. If all nurses were paid properly, they argued, there would also be no need specifically to lure men with high salaries for this branch of nursing.

One of the central questions addressed by the inquiry was whether psychiatric nursing was indeed nursing. For the NZNA, this question was not only industrial, but deeply professional. The debate was closely aligned with their contemporaneous struggle to persuade the government to implement comprehensive nursing education. NZNA witnesses emphasised that 'nursing is nursing' wherever it was practiced.<sup>223</sup> For the PSA's case, demonstration of the uniqueness of psychiatric nursing was crucial. Witnesses argued that, unlike general nurses, psychiatric nurses possessed special interpersonal and communication skills. While general nurses needed to observe and

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<sup>220</sup> Long, p.130.

<sup>221</sup> Proceedings of the Royal Commission of Inquiry into Hospital and Related Services: Mental Health Lead for Psychiatric Nurses, 14 July, 1971, pp. 525-6, Russell Flahive personal papers.

<sup>222</sup> Bazley cross-examined by Flahive, 14 July 1972, Royal Commission of Inquiry into Hospital and Related Services, Proceeding, Russell Flahive personal papers.

<sup>223</sup> Hutchinson, *Differential Pay Scale*, p.13.

assess a person's physical symptoms, psychiatric nurses, they claimed, also had to understand patients' personality and behaviour. Although the Commission was not prepared to state that psychiatric nursing was more skilled or stressful than general nursing, it did conclude that the two occupations were different.<sup>224</sup>

The commission put great store on the historical differences between psychiatric and general nurses. It noted that, '[i]t is clear that psychiatric nursing has developed not so much as a branch of nursing as a separate evolution from custodial care'.<sup>225</sup> The Commissioners reminded readers that psychiatric nurses had traditionally been paid more than general nurses because of the need to attract mature men. Male attendants had been rewarded for their ability to supervise physical work, contain patients safely, and for just being male.<sup>226</sup> The Commission noted that new roles for psychiatric nurses may not be as highly valued. During the 1966 nurses' salary negotiations, the government assessor had suggested that new treatments and methods in psychiatric hospitals may have lightened the nurses' burden, therefore reducing their right to higher pay.<sup>227</sup> Although the Commission's decision to recommend retention of the lead was largely pragmatic, it appeared to reflect a lingering belief that psychiatric nursing was an occupation more suitable for men than women.<sup>228</sup>

## **Conclusion**

Industrial action taken by psychiatric nurses during the 1960s and early 1970s was a product of instability in their occupational and professional environments. Until this time, psychiatric nurses' identity and status had been closely associated with the structures of the centrally-administered mental hospital system. As that system came under threat from service integration, the culture and identity of psychiatric nursing in its current form was challenged. Nurses predicted that under hospital board administration, their working conditions would be undermined, the hospitals would be under-resourced, and that the patients would be neglected. Nursing educational reforms also threatened the nurses' distinct identity and position of economic privilege.

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<sup>224</sup> *ibid.*, pp.25-30.

<sup>225</sup> *ibid.*, p.87.

<sup>226</sup> *ibid.*, p.15.

<sup>227</sup> *ibid.*, p.16.

<sup>228</sup> The mental health salary lead was finally lost during negotiations in 1978 when the PSA traded it for improved salaries for trainees: Roth, p.258.

Changes in the mental health system and nursing education were more of a threat to male than female nurses. Men's status within psychiatric nursing had, in the past, been founded on a tradition of custodial care and physical work. As these aspects of mental hospital care had become devalued, the place of men in the workforce had been questioned. It remained to be seen whether roles based on interpersonal skills would be considered suitable for men. If so, would they carry the same economic value as physical strength or the ability to withstand danger?

Psychiatric nursing's future was uncertain. Changes in the nurses' environment were happening at a time when they were beginning to forge a new collective identity as mental health professionals. Psychiatric nurses faced difficult choices.

Professionalisation implied closer relationship with general nursing and risked the loss of economic privileges associated with being a male, working-class occupation. If they retained an identity as mental hospital workers, however, they risked being left behind in a professional backwater.

## Conclusion

Working with people with psychiatric problems must be the most rewarding. To see people, really seriously mentally ill, and then to see them back home carrying on with their normal jobs again – I think of that as the most wonderful thing.<sup>1</sup>

This nurses' perspective of her role is far from the image of psychiatric nurses that is commonly portrayed in the public arena. The image of Nurse Ratched in the 1975 movie *One Flew over the Cuckoo's Nest* dominates the public perception of mid-twentieth-century psychiatric nursing. Her controlling, heartless behaviour is generalised to all psychiatric nurses. At best, nurses are seen as pawns in a system of state and social control, at worst, as uncaring, custodial, and cruel. Psychiatric nurses became a symbol of what was wrong with mental hospitals. Not only were they the face of a system that incarcerated people, but they were implicated in the process of dehumanising hospital inmates and creating madness from sanity.

### Personal perspective

It is the gap between common public perception and my experience in mental health nursing that first led me to this thesis topic. As a student nurse in a comprehensive programme in the mid-1970s, I was attracted to the mental health specialty. It seemed to be an area in which I could gain satisfaction from helping people get better and pick up the pieces of their lives, hopefully having learned new skills. The nurses who taught me were inspirational. I learned to look for meaning in all behaviour, and about the importance of respectful engagement with clients. I was also taught about the considerable changes that had happened in psychiatry, the implication being that modern practice was enlightened in comparison to what had occurred in the not-too-distant past. I was fascinated and horrified by the stories I heard about conditions in psychiatric hospitals of yesteryear. These were not difficult to imagine because the hospital in which I was learning my trade was, in itself a relic of the past. Established in the nineteenth century, Carrington Hospital had thick brick walls, huge dayrooms, long corridors, and shuttered seclusion rooms.

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<sup>1</sup> Margaret Roberts interview 29 August 2004.

As I worked alongside nurses who had been employed in psychiatric hospitals for many years, I found myself questioning my assumptions about psychiatric nursing in the past. I was curious about why people worked in an occupation that was stigmatised by association with mental illness. What sort of people were they? If conditions in psychiatric hospitals were as bad as they had been portrayed, why did people choose to work there? More to the point, why did they stay?

I noticed that some nurses I worked with were skilled, knowledgeable, and caring practitioners. Others were uncaring, unskilled, or bullies. I was challenged to consider that the recent history of nursing in public mental hospitals must have been more complex than the progressivist myths would suggest. I wondered how nurses developed their skills, values and attitudes. What sort of training had they received? What institutional processes supported or discouraged, caring, skilled practice?

The psychiatric nurses I got to know took pride in being different from general nurses. They believed themselves to be more relaxed, less caught up in protocols and hierarchies, more willing to challenge medical authority, and more able to have a good time socially. They were also doggedly committed to fighting for their rights through their union. I was left wondering about the source of these perceived differences. Did psychiatric nursing attract a particular type of person or was there something about the work and the system that created a distinct culture? How did the presence of substantial numbers of male nurses affect the collective identity and culture of the workforce?

### **Psychiatric nursing since the 1970s**

Large psychiatric hospitals were closed in New Zealand by the mid-1990s. Mental health care is now provided through community services, acute units attached to general hospitals, and specialist services such as forensics, child and adolescent, drug and alcohol and elder care.<sup>2</sup> Many people, who in the past would have lived in psychiatric hospitals, are now living in the community. Others with diagnosed or undiagnosed mental illness, who may previously have been treated in psychiatric hospitals, are now

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<sup>2</sup> During the past eight years, there has been substantial growth in clinical and specialist mental health services, a continuing move towards community care, and growth in non-governmental and Maori mental health providers: Ministry of Health, *Te Tahuhu: Improving Mental Health 2005-2015: The Second New Zealand Mental Health and Addiction Plan*, Wellington, 2005, p.1.

incarcerated in prisons.<sup>3</sup> In New Zealand, as in other countries, debates continue about whether mental health services provide enough support and protection for consumers, their families, and the community. In the absence of large psychiatric institutions, it is sometimes asked whether people with mental illness are receiving enough support.<sup>4</sup> In a philosophical climate in which consumer rights are valued, it is asked how society ensures that a person is protected from harming themselves or others.<sup>5</sup> Consumers (service users) remain unconvinced that they have fully achieved the right to participate in society on an equal footing with other citizens.<sup>6</sup>

Hospital training for psychiatric nurses finished in 1988. Nurses now prepare for roles in mental health through comprehensive nursing programmes followed by specialist new graduate mental health courses. A separate register for psychiatric nurses no longer exists. When the *Health Practitioners' Competence Assurance Act 2003* replaced the *Nurses Act 1977*, the title 'registered nurse' absorbed other nursing titles such as 'psychiatric' and 'comprehensive'. Nurses now share the single title 'registered nurse' but are restricted to work within their own 'scope of practice', mental health being one such scope.

It is discourses of consumer rights and partnership that now dominate mental health nursing policies. According to the New Zealand Ministry of Health, mental health nurses aim to work within a recovery approach. This involves 'working in partnership with clients to promote their full participation in society, protecting service users' rights, and helping service users to create supportive environments, as well as providing diagnosis and illness treatment services'.<sup>7</sup> These ideals seem to be a far cry from the practice of psychiatric nurses in public mental hospitals of the mid-twentieth century.

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<sup>3</sup> P.M.J. Brinded, et al., 'Prevalence of Psychiatric Disorders in New Zealand Prisons: A National Study', *Australian and New Zealand Journal of Psychiatry*, 35, 2, 2001, pp.166-73(8).

<sup>4</sup> See, for example: Sue Bradford, *It's time to pull mental health out of the 'too hard basket'* Green Party, 11 August 2005; available at: <http://www.greens.org.nz/searchdocs/PR9091.html>

<sup>5</sup> See, for example: Muriel Newman, *Solving Crime not Rocket Science* New Zealand Centre for Political Debate, 3 December, 2005; available at: <http://www.murielnewman.co.nz/weekly11.htm>

<sup>6</sup> Office of Disability Issues, *Progress in Implementing the New Zealand Disability Strategy 2003: Rights of Citizenship*; available at: <http://www.odi.govt.nz/nzds/progress-reports/july02-june03/rights-of-citizenship.html> (20 October 2006)

<sup>7</sup> H.P. Hamer, et al., *Mental Health Nursing and its Future: A Discussion Framework* Ministry of Health, 2006; available at: <http://www.moh.govt.nz/moh.nsf/by+unid/B346445EF1D22266CC257180001439D5?Open> (17 October 2006)



From the vantage point of twenty-first century ‘enlightenment’, it is easy to dismiss the practice of psychiatric nurses of the past. Recent complaints from ex-patients about their treatment in mental hospitals during the 1960s and 1970s seem to suggest that criticisms of the nurses’ behaviour are well-founded.<sup>8</sup> There is a danger, however, that contemporary values, language, and beliefs are being used to measure past behaviour. Negative stereotyping, such as that which produced the Nurse Ratched image, adds to that risk.

### **Summary of the position taken in and findings of this thesis**

Psychiatric nursing in public mental hospitals can only be understood within a historical context. This assertion is not intended to justify abusive behaviour or to suggest that poor practice did not exist. There is value, however, in trying to understand psychiatric nursing in terms of its relationship with social, political, philosophical, and economic trends. It may then be possible to gain insight into the world of psychiatric hospitals and the actions of the nurses. In this thesis, I have asked questions about the context in which psychiatric nurses lived and worked between 1939 and 1972. I asked who the nurses were, what motivated them to choose this occupation, and how they constructed their identity. What were the factors that influenced practice and how did this change over this period? How did changes in mental health policy and nursing professionalism influence the way nurses acted and their sense of occupational identity?

This thesis suggests that the identity of psychiatric nurses in public mental hospitals in mid-twentieth-century New Zealand was primarily related to the idea of ‘worker’ rather than ‘professional’. They engaged in a task considered by those outside of psychiatric nursing as morally and physically ‘dirty’. As such, the occupation was deemed to be more suitable for men than for women. During the 1940s and 1950s, asylum-type hospital conditions and public perceptions of the worker’s roles shaped their staffing patterns, working conditions and collective culture. From the 1960s however, changes in treatment approaches and mental health policy began to shift expectations about the role of psychiatric nurses. Rather than being viewed merely as an ‘extra pair of hands’, employed to undertake any tasks required to maintain the institutions, psychiatric nurses began to be perceived as having a therapeutic role based on their interpersonal

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<sup>8</sup> A class action lawsuit is currently in process involving over 300 former patients of New Zealand psychiatric hospitals: *Press*, 15 July 2004, p.A9.

relationships with patients. At the same time, educational reforms set new standards for registered psychiatric nurses and drew the occupation into a closer association with the nursing profession. These changes exposed a gap between therapeutic and professional ideals, and the worker's reality.

The first half of this thesis examines the period 1939 to 1959. During this period, the culture and identity of mental hospital attendants and nurses was primarily shaped by the physical and social isolation of the institutions and by the public perception of their work. Mental hospital nursing was a working-class occupation that was more attractive to men than to women. Although there were significant differences between the male and female sides, overall the culture was dominated by male working-class values, including loyalty to the trade union. In this respect, it differed fundamentally from the culture and identity of general nursing in this period.

Staffing shortages, particularly of female nurses, were at critical levels throughout these two decades. Wartime demands for women's labour were followed by a period when women were encouraged to move out of the labour market and back into the family home. Mental hospitals suffered greater shortages of women workers than most industries because of stigma, isolation and other difficulties associated with the work. Families were particularly wary of allowing their daughters to engage in an occupation that could expose them to physical and moral dangers. For men, the idea of 'dirty work' created few social or cultural barriers to their employment in mental hospitals as attendants.

Many aspects of 'attendant care' persisted in New Zealand mental hospitals until the end of the 1950s. Although new somatic therapies and medications were introduced during this time, they had little overall effect on nursing care. Hospital conditions such as overcrowding, shortages of staff, poor resourcing and increasing numbers of chronically ill or disabled patients shaped the work of attendants and nurses. Patient care was dominated by the need to manage large numbers of patients safely and efficiently. Institutional demands for manual labour also determined the nature of the nurses' work. Manual work was differentiated on the basis of gender. Male attendants and patients worked outdoors in the farms and gardens while the female nurses and patients worked indoors doing domestic tasks.

Employment concerns and the culture of mental hospitals delayed enforcement of new educational standards during this period. Educational reforms between 1939 and 1959 were designed to raise the standard of psychiatric nursing by bringing it under the authority of the nursing profession. Psychiatric nursing registration, established in 1945, was seen as a significant step in this direction. Implementation of educational improvements, however, was a slow process. Attempts to upgrade the curriculum and standards of teaching were impeded by lack of resources within the hospitals and of a lack of specialist psychiatric nursing expertise. The Division of Mental Hygiene was also reluctant to disrupt its stable male workforce by insisting on new standards for promotion.

By the late 1950s, it became evident that the female-dominated nursing profession had gained a degree of authority over the working-class mental hospital workforce. Realisation led to resistance. Male attendants, in particular, were reluctant to see their union-based power diminished by what they perceived as the interference of middle-class, female nursing leaders. Psychiatric nurses' resistance was evidenced in the ongoing conflict between the union (PSA) and the nurses' professional organisation (NZRNA). This conflict continued for more than a decade.

Between 1960 and 1972, significant changes happened in the psychiatric nurses' working context. Although most psychiatric care remained located in large public institutions, the focus moved from custody and containment to treatment and rehabilitation. The Department of Health looked for ways to integrate mental health care with other health services. Psychiatric nursing practice began to be seen as an interpersonal relationship rather than as physical and supervisory tasks. Changes in the nursing profession also had an impact on mental hospital nursing. Nurse leaders called for reforms that reflected a belief in the unitary nature of the profession. Nursing education was shifting from an apprenticeship to a tertiary education model.

Staffing patterns in mental hospitals changed during the 1960s. The workforce became differentiated as the distinction between qualified and unqualified staff became clearer and auxiliary positions such as domestics and nurse aides were created. Changes also occurred in the makeup of the nursing workforce and in recruitment patterns. The 'old guard' of men brought into the service during the 1930s economic depression began to retire. Recruitment of women increased and of men decreased. The occupation also

became more attractive to reasonably well educated young women and men. Despite these changes, psychiatric nursing continued to be an ‘accidental’ career option. Most people joined the workforce for reasons of convenience or chance rather than as a career choice.

Psychiatric nursing retained a distinct identity and culture throughout the 1960s and into the 1970s. Nurses’ association with the stigma of mental illness shaped the culture of the workforce. Psychiatric nursing was still largely seen as ‘dirty work’. Nurses coped with the nature of their work and their own marginalisation by developing close-knit communities and by using humour and through socialising. Their position on the margins of society arguably made this group of workers more tolerant of differences among themselves. Psychiatric nursing was a community where people who were marginalised by their own differences found a measure of acceptance.

During the 1960s, the concept of interpersonal relationship became accepted in New Zealand hospitals as the theoretical basis of psychiatric nursing. There was a gap, however, between theory and reality. Despite the success of new medications and the introduction of therapeutic and rehabilitation approaches, New Zealand psychiatry was struggling to shake off the remnants of asylum-type care. In places where new therapeutic models were established and the burden of care for physically dependent patients was reduced, psychiatric nurses were able to develop practice based on the ‘therapeutic relationship’. In other areas, where institutional conditions persisted, nursing retained many qualities of custodial care.

Educational reforms of the early 1970s highlighted the gap between the aspirations of professional nursing leaders and the ambitions of rank and file psychiatric nurses. Nurse leaders fought successfully to gain government approval for comprehensive nursing education in polytechnics and nursing studies in universities. In the process, psychiatric nursing was drawn into general nursing’s professionalisation agenda. Most psychiatric nurses lacked the professional language and analysis to engage in debates about the changes. They were also preoccupied by the more familiar male, working-class task of fighting to protect their pay, conditions and job security.

Industrial action taken by psychiatric nurses in the late 1960s and early 1970s was a product of fundamental changes that were happening in the nurses’ professional and

occupational environments. Until this point, psychiatric nurses' identity had been closely associated with the centrally administered mental hospitals in which they worked and the multiple roles they had previously fulfilled. Their economic worth had been measured on the assumption that mental hospital nursing was essentially a man's job. Physical strength, practical outdoor skills, and ability to manage danger had been valued. The male-dominated workforce had retained its position within the mental hospital system largely through the work of its union, the PSA.

By the late 1960s, a new identity was being constructed for psychiatric nurses. An identity as mental health professionals was beginning to replace that of mental hospital workers. Skills in therapeutic engagement were being seen as valuable rather than the ability to supervise work, chop firewood or stoke boilers. Success in state examinations was now valued above length of service for promotion purposes. Psychiatric nurses as mental health professionals was, however, a new and contested identity. It remained to be seen whether this would be perceived to be a man's job. It was also unclear whether therapeutic skills would be as valued economically as physical strength and the ability to withstand danger.

External events disrupted psychiatric nursing at a time when the occupation had just begun to construct its new identity. Plans to transfer the hospitals to hospital board control created uncertainty. Nurses feared that their conditions would be undermined and that their patients would be subject to further neglect in the proposed hospital board system. Educational reforms also threatened the nurses' economic security and distinct identity. Psychiatric nurses faced difficult choices. Professionalisation implied closer relationship with general nursing and risked the loss of economic privileges associated with being a male, working-class occupation. If they retained an identity as workers, however, they risked being left behind in a professional backwater.

The fifty nurses who walked silently in support of their striking colleagues through the streets of Wellington in 1971, epitomised the complexity of the period. By wearing their uniforms, they identified as nurses and as mental health professionals. In taking industrial action, they drew on their strengths as unionised workers to fight a battle that was both altruistic and self-serving. Psychiatric nurses were largely unaware that they were facing a watershed in their profession but they knew that they were fighting to retain their employment conditions and for the welfare of their patients.

In the process of assuming a professional identity, psychiatric nurses were not about to give up aspects of their culture associated with male breadwinner values. The feminised, self-sacrificing and demure image of general nursing did not sit comfortably with psychiatric nurses' understanding of themselves. As one male nurse, who started work at Seaview Hospital in 1961, explained, 'We were not only concerned for our jobs and the patients and working conditions, but we had our families to think of and mortgages...the security factor'.<sup>9</sup> Both male and female psychiatric nurses shared a cultural identity forged from the experience of working in a stigmatised role. It was a job that attracted ordinary men and uncommon women who were motivated by a desire to help a less privileged group and to make a living.

### **Contribution of the Thesis**

This thesis contributes to a small but growing body of international literature on the history of psychiatric/mental health nursing. As the first focussed study of the history of New Zealand psychiatric nursing, it provides a basis for further historical analysis of the topic and related issues. The thesis makes a significant contribution to the historiography of New Zealand psychiatry and psychiatric services. By investigating the social and cultural aspects of the nursing workforce, it provides a rare insight into institutional life in the network of twentieth century public mental hospitals. It is one of only a few studies that consider mental health services across the whole of the country. Extensive use of a wide range of archival material has created a resource that will be of use to future researchers in both psychiatric and nursing history. Oral history interviews supplement the written record and provide an insider's view of the experience of working life within mental institutions.

Some findings challenge existing historical assumptions concerning the practice of psychiatric nursing. For example, it has been suggested that the tenets of moral therapy were limited to nineteenth-century asylum practice. Whereas it is apparent from this study that both moral therapy and asylum-type custodial practice continued in New Zealand mental hospitals into the second half of the twentieth-century. Also challenged is the assumption that nursing has always been a female profession with men marginalised within it. In psychiatric nursing in New Zealand it has been men who have

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<sup>9</sup> Reg Hyndman interview 28 August 2004.

played a central role in creating its unique culture. The title of my thesis, 'Ordinary Men and Uncommon Women' portrays the gendered nature of the workforce.

Future New Zealand historical research could usefully focus on: the effects of deinstitutionalisation and comprehensive nursing education on the psychiatric nursing from the 1970s onwards; changes to nursing practice from the consumers' perspective; and biographical studies of particular nurses such as Dame Margaret Bazley, Rita McEwan, Winston Maniapoto, and Fuimaono Karl Pulotu-Endemann. Internationally, there is room for research that explores the place of gender within nursing specialties without assuming women's dominance of the occupation.

# Appendices

## Appendix A: Ethics Approval



Research Office  
Office of the Vice-Chancellor  
The University of Auckland  
Private Bag 92019  
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Level 2, 76 Symonds Street  
Auckland, New Zealand  
Telephone: 64 9 - 373 7599 ext 87956  
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### UNIVERSITY OF AUCKLAND HUMAN SUBJECTS ETHICS COMMITTEE

14 March, 2003

**MEMORANDUM TO:**

K. Prebble  
History

**Re: Application for Ethics Approval**

The Committee met on 12 March, 2003 and considered the application for ethics approval for your research titled "A History of Mental Health Nursing in New Zealand 1939 - 1989" (Our Ref. 2003 / 054).

Ethics approval was given for a period of three years.

The Committee suggests that you do not supply your home address in the Participant Information Sheet

If the project changes significantly you are required to resubmit your application to the Committee for further consideration.

**In order that an up-to-date record can be maintained, it would be appreciated if you could notify the Committee once your project is completed.**

Please contact the Chairperson if you have any specific queries relating to your application. She and the members of the Committee would be most happy to discuss general matters relating to ethics provisions if you wish to do so.

A handwritten signature in black ink, appearing to read 'M. Rotondo'.

Margaret Rotondo  
Executive Secretary  
University of Auckland Human Subjects Ethics Committee

c.c. Head of Department, History

K. Prebble  
103 Garnet Road,  
Westmere,  
Auckland. 1002.



## Appendix B: Participant information for nurses

DEPARTMENT OF HISTORY



THE UNIVERSITY OF AUCKLAND  
NEW ZEALAND

5-7 Wynyard Street  
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The University of Auckland  
Private Bag 92019  
Auckland, New Zealand

### PARTICIPANT INFORMATION SHEET FOR MENTAL HEALTH NURSES

**Research study:** A History of Mental Health Nursing in  
New Zealand 1939 – 1973

My name is Kate Prebble. I am a mental health nurse currently enrolled in my Ph.D. with the Department of History, University of Auckland.

You are invited to take part in a research study of the history of mental health nursing in New Zealand from 1939 to 1989. This study will include an exploration of the make-up of the workforce (who the nurses were), the nature of practice (what nurses actually did), the work environment, nursing education, working conditions and industrial relations. I will be gathering information from primary sources including oral history interviews and archival materials. I am intending to interview between 30 to 50 nurses. I will also be interviewing people in official positions such as administrators, nurse educators and trade union officials. This study has already commenced and I expect to be completing by 1<sup>st</sup> July 2005.

I am seeking a range of nurses who practised in this period including:

- males and females
- individuals who practised at different times over the 50 year period
- nurses from a variety of ethnic backgrounds (including Maori)
- representatives from all or most of the mental hospitals
- nurses who worked in a range of specialities

#### **If I decide to participate, what will it involve?**

It will involve one interview lasting approximately 60 – 90 minutes. In some cases a second interview may be necessary. The interviews will be conducted at a place that is private, convenient and agreed upon by the two of us. You may also be invited to join a focus group to discuss a particular event or explore a specific issue from a particular focus.

In the interview(s) we will explore the reasons for you becoming a mental health nurse and your experiences of nursing education (training) and practice. You will be asked to tell me about the working conditions and significant influences on mental health nursing during your working life.

In the focus groups we will explore various issues that emerge from the interviews. The size of the focus groups will vary from 4 –12 depending on the issue being explored and will meet once or twice for one to two hours.

The interview(s) and focus group sessions will be audio-taped and later selected parts will be transcribed. These tapes and transcripts will remain confidential to my typist, my thesis supervisors and myself until the thesis is published. A pseudonym can be used on your tapes, transcripts and reports to protect your identity, if you choose not to identify yourself.

Because of the value of the historical information to present and future generations, the audio-tapes could be stored for future research purposes. If you consent to this, the audio-tapes will be deposited in the Alexander Turnbull Library Oral History Collection in Wellington. These are kept forever and are accessible to the public.

**I do not anticipate any risks to you from the study, however, at times in such interviews sharing your thoughts, insights and personal recollections can be uncomfortable. You do not have to answer all the questions and you may stop the interview at any time.**

While it is unlikely that there will be direct benefits to you, many people who have participated in similar research feel that it is very worthwhile contributing to collective historical knowledge by sharing their unique perspective and understanding of past events and experiences.

**What will happen to the results of this study?**

The final result will be published as a Ph.D. thesis that will be available in the University of Auckland Library. Short articles relating to the research may be published in relevant professional journals and presented at conferences and seminars.

**Your participation in this research is entirely voluntary. You do not have to take part. If you do agree to take part you are free to withdraw from the study, including withdrawal of any information, until the data collection is complete (1<sup>st</sup> December 2004). If you choose to withdraw you do not have to give a reason.**

If you have any concerns about this study, please contact me or either of my supervisors. You are also welcome to contact the members of the University of Auckland Human Subjects Ethics Committee (AUHSEC) or the Maori consultant for the project . I have listed the contact details on the next page.

## **Contacts**

Researcher: Kate Prebble, 103 Garnet Rd, Westmere, Auckland 1002. Ph. (09) 360 6384 (Home) or 021 884 662, [kateprebble@xtra.co.nz](mailto:kateprebble@xtra.co.nz)

Supervisor: Dr. Linda Bryder, Department of History, University of Auckland, Private Bag, 92019, Auckland. Ph. (09) 3737-599 Ext. 87319. [l.bryder@auckland.ac.nz](mailto:l.bryder@auckland.ac.nz)

Head of Department: Professor James Belich, Department of History, University of Auckland, Private Bag, 92019, Auckland. Ph. (09) 3737-599 Ext. 87967. [j.belich@auckland.ac.nz](mailto:j.belich@auckland.ac.nz)

Maori Consultant: Erina Morrison-Ngatai, Lecturer, Massey University, Private Bag 11222 Palmerston North, Ph.(06) 350 –5799 Ext.2724, [E.Morrison-Ngatai@massey.ac.nz](mailto:E.Morrison-Ngatai@massey.ac.nz)

Chair of Ethics Committee: The Chair, University of Auckland Human Subjects Ethics Committee, University of Auckland, Private Bag, 92019, Auckland. Ph. (09) 373-7599, Ext. 87830.

Thank you

Thank you for taking the time to read this information. If you have any further questions about the study or would like to participate please feel free to contact me. If you do wish to participate you will also need to sign the attached consent form.

Approved by the University of Auckland Human Subjects Ethics Committee on twelfth of March 2003 for a period of three years, from 1/4/2003, Reference 2003/054.

## Appendix C: Participant information for others

DEPARTMENT OF HISTORY



THE UNIVERSITY OF AUCKLAND  
NEW ZEALAND

5-7 Wynyard Street  
Auckland, New Zealand  
Telephone 64 9 373 7599 ext. 87309  
Facsimile 64 9 373 7438

The University of Auckland  
Private Bag 92019  
Auckland, New Zealand

### **PARTICIPANT INFORMATION SHEET**

**For individuals who have related to mental health nursing  
in their professional or official positions**

**Research study: A History of Mental Health Nursing in  
New Zealand 1939 – 1989**

My name is Kate Prebble. I am a mental health nurse currently enrolled in my Ph.D. with the Department of History, University of Auckland.

You are invited to take part in a research study of the history of mental health nursing in New Zealand from 1939 to 1989. This study will include an exploration of the make-up of the workforce (who the nurses were), the nature of practice (what nurses actually did), the work environment, nursing education, working conditions and industrial relations. I will be gathering information from primary sources including oral history interviews and archival materials. I am intending to interview between 30 to 50 nurses. I will also be interviewing people in official positions such as administrators, nurse educators and trade union officials. Other health professionals may also be interviewed. This study has already commenced and I expect to be completing by 1<sup>st</sup> July 2005.

#### **If I decide to participate, what will it involve?**

It will involve one interview lasting approximately 60 – 90 minutes. In some cases a second interview may be necessary. The interviews will be conducted at a place that is private, convenient and agreed upon by the two of us.

In the interview(s) I will ask you about your memory and understanding of particular aspects of mental health nursing during the study period.

The interview(s) will be audio-taped and later selected parts will be transcribed. These tapes and transcripts will remain confidential to my typist, my thesis supervisors and myself until the thesis is published. A pseudonym can be used on your tapes, transcripts and reports to protect your identity, if you choose not to identify yourself. This may, however not be possible if you held a public position in relation to mental health nursing.

Because of the value of the historical information to present and future generations, the audio-tapes could be stored for future research purposes. If you consent to this, the audio-tapes will be deposited in the Alexander Turnbull Library Oral History Collection in Wellington. These are kept forever and are accessible to the public.

**I do not anticipate any risks to you from the study, however, at times in such interviews sharing your thoughts, insights and personal recollections can be uncomfortable. You do not have to answer all the questions and you may stop the interview at any time.**

While it is unlikely that there will be direct benefits to you, many people who have participated in similar research feel that it is very worthwhile contributing to collective historical knowledge by sharing their unique perspective and understanding of past events and experiences.

**What will happen to the results of this study?**

The final result will be published as a Ph.D. thesis that will be available in the University of Auckland Library. Short articles relating to the research may be published in relevant professional journals and presented at conferences and seminars.

**Your participation in this research is entirely voluntary. You do not have to take part. If you do agree to take part you are free to withdraw from the study, including withdrawal of any information, until the data collection is complete (1<sup>st</sup> December 2004). If you choose to withdraw you do not have to give a reason.**

If you have any concerns about this study, please contact me or either of my supervisors. You are also welcome to contact the members of the University of Auckland Human Subjects Ethics Committee (AUHSEC) or the Maori consultant for the project. I have listed the contact details below.

**Researcher: Kate Prebble**, 103 Garnet Rd., Westmere, Auckland 1002.  
Ph. (09) 360-6384 or 0261884 662, [kateprebble@xtra.co.nz](mailto:kateprebble@xtra.co.nz)

**Supervisor: Dr. Linda Bryder**, Department of History, University of Auckland, Private Bag, 92019, Auckland. Ph. (09) 3737-599 Ext. 87319. [l.bryder@auckland.ac.nz](mailto:l.bryder@auckland.ac.nz)

**Head of Department: Professor James Belich**, Department of History, University of Auckland, Private Bag, 92019, Auckland. Ph. (09) 3737-599 Ext. 87967. [j.belich@auckland.ac.nz](mailto:j.belich@auckland.ac.nz)

**Maori Consultant: Erina Morrison-Ngatai**, Lecturer, Massey University, Private Bag 11222 Palmerston North, Ph.(06) 350 -5799 Ext.2724,  
[E.Morrison-Ngatai@massey.ac.nz](mailto:E.Morrison-Ngatai@massey.ac.nz)

**Chair of Ethics Committee:** The Chair, University of Auckland Human Subjects Ethics Committee, University of Auckland, Private Bag, 92019, Auckland.  
Ph. (09) 373-7599, Ext. 87830.

**Thank you**

Thank you for taking the time to read this information. If you have any further questions about the study or would like to participate please feel free to contact me. If you do wish to participate you will also need to sign the attached consent form.

Approved by the University of Auckland Human Subjects Ethics Committee on 12/3/03. for a period of 3 years, from 1.1.4.03. Reference... 2003 / 054

## Appendix D: Consent to participation

DEPARTMENT OF HISTORY



THE UNIVERSITY OF AUCKLAND  
NEW ZEALAND

5-7 Wynyard Street  
Auckland, New Zealand  
Telephone 64 9 373 7599 ext. 87309  
Facsimile 64 9 373 7438

The University of Auckland  
Private Bag 92019  
Auckland, New Zealand

### Consent to Participation in Research

Title of Project: **A History of Mental Health Nursing in New Zealand  
1939 – 1989.**

Researcher: **Kate Prebble**

Project Supervisors: **Associate Professor Linda Bryder and Dr. Deborah  
Montgomerie**

- I have read and understood the information provided about this research project.
- I have had an opportunity to ask questions and to have them answered.
- I understand that the interview(s) and focus group will be audio-taped and transcribed.
- I understand that as this is historical research my name may be used with my permission within the thesis and in subsequent publications. Consent for this will be negotiated toward the end of the project.
- I understand that I can choose to use a pseudonym rather than use my own name for the purposes of this research.
- I understand that the audio-tapes could be retained in the Alexander Turnbull Library Oral History Collection. Consent for this will be negotiated toward the end of the project.
- I understand that I may withdraw myself or any information that I have provided for this project at any time prior to the completion of data collection (1<sup>st</sup> December 2004), without being disadvantaged in any way. If I withdraw from the project, I understand that all relevant tapes and transcripts will be destroyed.
- I agree to take part in this research.

Participant signature: .....

Participant name: ..... Date:.....

**Approved by the University of Auckland Human Subjects Ethics  
Committee on 12/3/2003 for a period of three years, from 1/4/2003  
Reference: 2003/054**

**Appendix E: Registered psychiatric nurse interviewees: brief biographical details for period 1939-72.**

Name	Date of birth	Started nursing	Iwi affiliation	Mental Hospital
Marney Ainsworth	Not known	1971		Sunnyside
Percy Atkinson	9.1.1913	1934		Seaview (rose to Asst Head Nurse, then Head Nurse)
Dame Margaret Bazley (nee Hope)	23.1.1938	1956		Oakley; Tokanui; Seacliff (Asst Matron); Sunnyside (Matron, Principal Nurse)*
Mere Balzer	Not known	1970	Te Arawa, Ngati Ranginui, Ngati Raukawa	Tokanui
Joy Collins	27.8.1940	1958		Porirua
Brian Craig	1933	1961		Lake Alice; Kingseat
Betty Dracevich	Not known	1948		Oakley
Bob Elliott	2.9.1937	1965	Ngati Maniapoto, Hauraki, Kahungunu	Tokanui
Russell Flahive	12.6.1929	1951		Porirua**
Francis Gugich	2.6.1932	1958		Seaview
Meretene (Mary) Ray Hammond	12.3.1939	1960	Ngati Kahungunu	Porirua
Margaret Harraway	26.10.1947	1967		Sunnyside
Althea Hill	4.4.1946	1968		Oakley
Jamesina Hippolite	Not known	1957	Ngati Koata, Ngati Toa, Ngati Kahungunu	Porirua; Ngawhatu; Levin; Tokanui
Reginald (Reg) Hyndman	19.11.1939	1961		Seaview



Lindsay Johnston	26.5.1943	1968		Oakley
Wikepa (Wi) Keelan	16.5.1950	1968	Ngati Porou, Ngati Kahungunu	Porirua; Lake Alice
Velda Kelly	16.4.1937	1955		Seacliff; Sunnyside
Tilly Lloyd	1954	1972		Cherry Farm; Carrington.
Winston Maniapoto	5.11.1941	1960	Ngati Maniapoto, Ngati Raukawa, Tuwharetoa	Tokanui; Oakley; Lake Alice
Tony McCulloch	13.2.1945	1970		Whitecroft Hospital, Isle of White; Porirua
Rita McEwan	19.9.1918	1939		Nelson & Ngawhatu; Oakley (Sister Tutor); Tokanui (Asst Matron); Levin (Matron); Porirua (Principal Nurse)***
Kath McLeod	18.12.1921	1940		Seacliff; Orokonui; Cherry Farm
Adrian Moerenhout	1925	1959		Oakley
Barbara Milne (nee Nolan, aka Chapman)	14.6.1937	1960		Oakley
Fuimaono Karl Pulotu-Endemann	11.8.1950	1971		Oakley; Carrington
Gordon Rapson	24.8.1931	1950		Seacliff; Cherry Farm
June Rapson (nee Page)	19.11.1927	1951		Seacliff; Cherry Farm (Tutor)
Viaata Reeves (nee Nuitonga)	11.4.1940	1958	Ngati Tahu, Nuiean, pakeha	Seaview
Richard Rillstone	23.1.1944	1963		Seacliff; Paremoro Prison, mental health unit

Margaret Roberts (nee Gugich)	23.7.1938	1956		Seaview
John Shennan	1.10.1951	1972		Kingseat
Elsie Wilson	1914	1956		Seaview
Not named (KP1)	Not known	1936		Porirua
Audrey (pseudonym)	Not known	1959		Un-named

\* Margaret Bazley: member of the N&MB, 1966-72; president of NZNA, 1972-3.

\*\* Russell Flahive: member of the central committee of the PSA's Mental Hospital Group (MHG) from mid-1950s, and chairman of MHG for most of 1960s.

\*\*\* Rita McEwan: WHO postings to Singapore 1957-60 and Iran from 1965-8; Nurse Inspector in Department of Health, 1961-5; member of the N&MB, 1955-7.

## Appendix F: Nursing Rosters

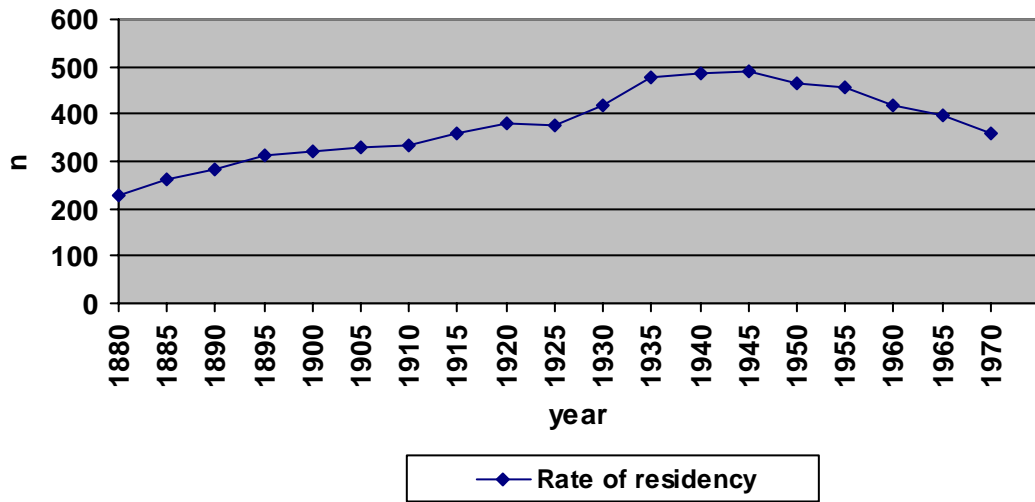
Three-day cycle – introduced in 1936
Total of 45 hours per week One long day: 7am to 8pm (including two hours for meal breaks) One short day: 7am to 4.30pm (or 5pm) (including two hours and 15 minutes for meal breaks) One day off *
Night duty: 7.45pm to 7am for five nights consecutively, then one night off (third night counted as overtime).
Sources: Isla Frew, 'Psychiatric Nursing: A Study of psychiatric nursing at Seacliff Mental Hospital', Preventative Medicine Dissertation, Otago University, Dunedin, 1958, pp.10-1; KT, 36, 3, 1943, p.56.

Four shifts, 40 hour week – introduced 1966
An eight-week roster designed to give nurses 2 consecutive days off in each week. Over eight weeks, nurses would have 3 Saturdays and 3 Sundays off.
A Shift            12 midnight to 8.30am B Shift            7am to 3.30pm C Shift            8.30am to 5 pm D Shift            3.30pm to 12.10am
Source: Differential Pay Scale for Psychiatric and Psychopaedic Nurses. First Report of Royal Commission of Inquiry into Hospital and Related Services, Wellington, December 1972, p.38.

Four and two roster – introduced 1972 as an interim arrangement after nurses took over own rosters
Six-week cycle. Nurses worked four days on then had two days off. Each shift was 8 hours 35 minutes. The extra 35 minutes made up for the shorter (32 hours) worked on the 5th and 6th weeks. Nurses were paid for 40 hours work each week despite the variation.
A Shift            11pm to 8.05am, B Shift            7am to 4.05pm, C Shift            8.05am to 5.10pm, D Shift            1.55pm to 11.10pm
Source: PSA circular, 28 September 1972, CAHW, CH890/7d, ANZ, Christchurch.

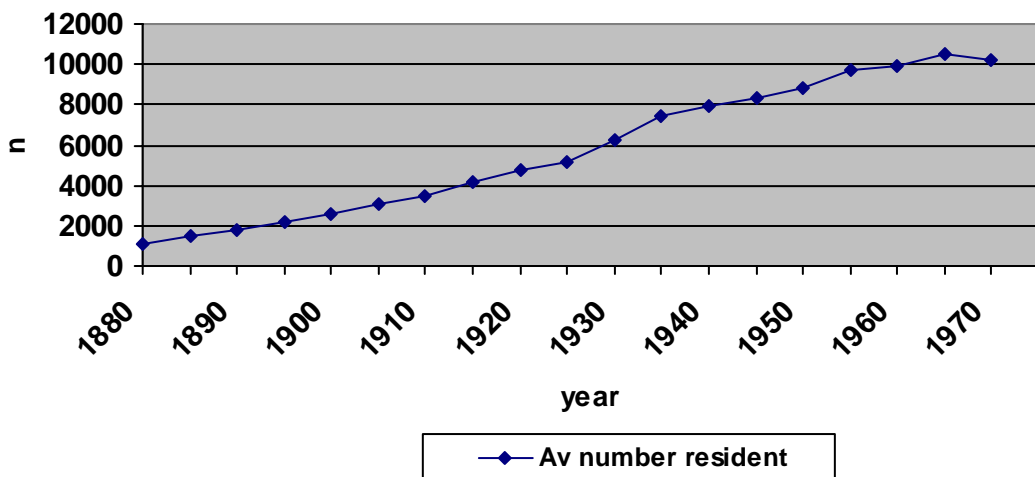
**Appendix G: Psychiatric hospital population: average number resident, 1880-1970**

Average number of patients resident in psychiatric hospitals, rates per 100,000 population, 1880-1970.



Source: National Health Statistics Centre, Mental Health Data 1973, Wellington, 1973, p.5.

Average number of patients resident in psychiatric hospitals, 1880-1970.



Source: National Health Statistics Centre, Mental Health Data 1973, Wellington, 1973, p.5.

## Appendix H: Numbers of nurses listed as assisted immigrants, 1949-59

### Occupation of Assisted Immigrants from the United Kingdom and the Netherlands

	Male nurses and attendants	General nursing trainees (female)	Trained nurses (female)*	Mental hospital nurses (female)
1949	1 mental nurse	160	44	nil
1950	**14 male nurses	93	122	nil
1951	nil	nil	nil	nil
1952	1 male nurse 1 mental attend.	9	79	10
1953	1 male nurse 11 mental attend.	26	118	13
1954	3 male nurses 5 mental attend.	19	122	9
1955	***nil	18	93	6
1956	nil		82	2
1957	nil	6	65	3
1958	nil	9	84	2
1959	nil	9	64	nil

\* This figure probably includes registered psychiatric nurses, though this is not clear.

\*\* It could be assumed that 'male nurse' means general nurse trained rather than mental or psychiatric.

\*\*\* From 1955, there is no reference to mental hospital occupations for men, but there may have been a few within the professional category. If so, the numbers were very small.

\*\*\*\* A small number of registered maternity nurses immigrated each year. They have not been included.

Source: AJHR, H.11, appendices, 1950-1960.

## **Appendix I: Duties of attendants on B Ward Seacliff Hospital, 7 August 1953.**

(Three hours only given, as example).

### **No. 1 Charge Attendant**

- 7am: take over from senior attendant on 'M' (patient) – take out his night attire and blankets, give him day clothing and uncheck window shutter; check all attendants present and signed Attendance Book and C.O. Cards; start round with Night Attendant; fill in duties of attendants and check over day and night book and task book and duties of attendants through to Head Attendant; consult diary to see if anything due; check how many in bed; clear the ward and go through to Dining Hall; check his patients to see if all present and his attendants on Hall duty
- 7.50am: breakfast
- 8.20am: see patients out of Hall when A Charge is ready, see that door downstairs if check locked; when C patients are out, take B patients out, see that they are all out, follow through to B yard where Senior Yard man will give him the count; check to see if correct
- 8.30am: do a round of ward to see what is needed for day
- 8.55am: see that the Big Gates are locked and the A and C Charges are present then draft B working patients out
- 9.30am: Take 'M' out to his Pen with two attendants who are on duty with him
- 10am: Do a round of ward and park with the doctor and Head Attendant – report to doctor anything outstanding. Collect mail and parcels, also Day Report Book

### **No.2 Attendant**

- 7am: sign attendance book; get patients up in E.P and faulty dorm; supervise dressing and washing
- 8.20am: distribute medicine and pills; visit all bed patients and apply dressings where necessary, see secluded patients and tidy their rooms
- 9.30am: assist clearing yard to airing courts; escort patient 'H' to airing court, open all doors except seclusion and supervise cleaning
- 10.20am: go to laundry with soiled linen

### **No. 3 Attendant**

- 7am: sign attendance book; on duty in yard – open all doors on far side of yard, give patients clothes, take out soiled linen and supervise his Junior man to do same on near side of yard; see all patients into A yard, check B yard is clear & all secluded patients' doors are locked before going into A yard; dish out porridge in dining hall
- 7.50am: Breakfast
- 8.20am: back in dining hall, stand at B yard door & count B patients – give count to charge who will check it. He is responsible to see all rooms cleaned, dishes collected & taken to B ward. 'He is also responsible for the dressing of patients also that they clean their teeth in the wash Hand-basin in the room provided. See that the patients' footwear and clothing are alright, lavatories etc., clean and tidy'.
- 9.30am: to airing court and 'take over Bottom beat', see that lavatories are clean & tidy and 'supervise patients all around him', be present when 'M's attendants are changing over

No. 4 Attendant

- 7am: sign Attendance Book, special on patient M, see that no-one converses with him or passes anything to him, door never opened unless 2 attendants etc.
- 8.20am: relieved by junior for breakfast
- 9.30am: charge and junior escort M to his pen in large airing court – he will stay in pen with M till relieved at 10.30am by junior attendant, to stay outside pen

No. 5 Attendant

- 7am: attendance book; go with Deputy-Charge to E.P. and Faulty dorm – arise patients, dress them, see have wash before putting them out into the yard, then make all beds in Faulty Dorm
- 7.30am: get M's breakfast and collect 2 other patients' breakfast, help No.10 feed patients in bed
- 7.45am: Breakfast
- 8.20am: relieve senior attendant with M
- 9.30am: to airing court with Charge and M, remain outside M's pen, relieve senior attendant in pen at 10.30am

No. 6 Attendant

- 7am: attendance book; get patient up on left side of yard – out into yard etc
- 8.20am: take position on Bottom tables and when coming out of Hall come last with Charge. In yard –assist senior attendant see all patients dressed, cleaning and teeth
- 9.30am: when charge of park is ready to go to park, go to airing court and take up position on the beat on the right side – 'patrol from the top of Park to the shed on the bottom and be alert for anything unusual'.

No. 7 Attendant

- 7am: attendance book; upstairs to B Top, see all patients up, washed and dressed, take down shutters and tidy beds, remove soiled linen; assist with breakfast; relieve attendant in Male Hospital for breakfast
- 8.55am: answer bell and receive duties from Head Attendant. as noted on working list

No. 8 Attendant

- 7am: attendance book; upstairs to East wing (as above)
- 8.55am: answer working bell and receive duties from HA

No. 9 Attendant

- 7am: sign attendance book; to H top, arouse patients, washed, dressed, etc.
- 8.55am: answer bell –duties from Head Attendant

No. 10 Attendant

- 7am: sign attendance book; wash all bed patients and tidy and make beds
- 7.25am: get meals from dining hall for bed patients, bring on food trolley. With assistance of junior, feed all pats. Remain on ward till relieved for breakfast at 8.20am
- 8.55am: answer bell get duties

Source: DAHI, Acc D266, 402g, ANZ, Dunedin.

Note: Wording has been adapted slightly for ease of reading and presentation.

## Appendix J: Register of Psychiatric Nurses: numbers of nurses added, 1945-72

	Senior (departmental) exam*	N&MB (state) final exam	Britain**	Other countries***
1945	234	-	-	-
1946	208	10	-	-
1947	209	27	7	-
1948	22	25	-	-
1949	31	21	12	-
1950	7	43	8	1
1951	2	25	2	-
1952	7	10	5	4
1953	1	44	12	1
1954	-	49	10	-
1955	6	47	1	3
1956	4	51	9	2
1957	4	47	10	4
1958	5	51	5	-
1959	7	60	12	5
1960	1	88	3	2
1961	-	43	8	3
1962	53	61	8	1
1963	10	54	9	3
1964	3	46	11	4
1965	2	67	7	8
1966	4	66	17	15
1967	-	61	11	6
1968	**** 1	32	4	8
1969	2	62	9	4
1970	1	95	5	4
1971	8	92	6	8
1972	1	104	5	14

\* Senior Examination (qualified before 1945) or Institutional Final Examination (after 1968)

\*\* Includes registration under RMPA, GNC, Irish or Scottish Registration Boards

\*\*\* Includes the Netherlands, Australia, Canada, USA.

\*\*\*\* From 1968 these nurses were added to the register under Section 14 (1)c of the Nurses & Midwives Act

Source: ABYO, 7889, W5148, 30, ANZ, Wellington; ABYO, 7889, W5148, 31, ANZ, Wellington.



## Appendix K: Examples of psychiatric nurses' examinations

Final Qualifying Examination, Subject: Psychiatry, December 1945

NURSES AND MIDWIVES REGISTRATION BOARD

### (Examination) Final Qualifying Examination for Psychiatric Nurses\*

(Subject) Psychiatry\*

\*These particulars must be entered on the cover of your answer-book

5th December, 1945

Time allowed: Three hours

All questions should be attempted. Candidates should read the questions carefully and answer only what is asked.

NOTE.—The maximum marks allotted for each question are shown in parentheses at end of each question.

1. A patient is admitted to your hospital for observation with a history of having "seizures" (fits). The question to be decided is whether the condition is one of hysteria or epilepsy. Describe in detail the observations you would make so that you could supply the medical officer with a report which would enable him to differentiate between the two conditions. Show in your answer the points of difference between the two conditions.  
(20 marks)
2. Name three types of melancholia. Give the main symptoms, and from your experience of such cases give the usual course each type follows. Describe in detail the nursing care and management of a case of melancholia.  
(20 marks)
3. The electro-shock method of convulsive treatment:—
  - (a) Describe the method by which the treatment is given.  
(6 marks)
  - (b) Describe in detail the nursing technique and management of a case receiving this treatment.  
(14 marks)
4. You are appointed to be the sister in charge of a ward which has been badly managed, and the patients in it have become unsettled. Describe how you would go about making the ward the place you would like it to be.  
(25 marks)
5. Describe a case which you know of paranoid schizophrenia (also known as the paranoid form of dementia præcox).  
(15 marks)

50/11/45—11597]

Source: H, 1, W2262, 34853, 1/12/1, ANZ, Wellington.

NURSES AND MIDWIVES BOARD

(Examination) State Preliminary Examination \*

(Subject) Anatomy and Physiology \*

\* These particulars must be entered on the cover of your answer-book

4 May 1955

Time allowed: Three hours

Answer **eight only** of the following questions. Candidates should state concisely **ONLY** what is asked. Remarks should be illustrated by diagrams wherever necessary, **but a diagram alone will not be accepted as a satisfactory answer.**

State briefly what you know of—

1. The blood supply to the kidney, giving the course of blood through the organ.
2. (a) Lacteals; (b) enamel; (c) tunica vaginalis; (d) optic disc.
3. The grey matter of the spinal cord, stating what types of neurone are found there and giving their situation.
4. The right atrium of the heart and the openings found there.
5. The digestion of proteins, mentioning the enzymes concerned and indicating where they are formed.
6. The medulla of the adrenal gland, stating its functions.
7. The root of the lung, giving its situation and naming the structures found in it.

**[Turn over**

State Preliminary Examination, Subject: Anatomy and Physiology,  
May 1955, p.2

2

8. The factors concerned in maintaining the flow of blood in the systemic veins.
9. Stratified squamous epithelium, mentioning two situations where it is found and indicating why this type of epithelium is found there.
10. The nerve supply to (a) the muscles of the tongue, (b) the muscles of facial expression, (c) the muscles of mastication.

950/3/55—45402

Source: H, 1, W2262, 34853, 1/12/1, ANZ, Wellington.

NURSES AND MIDWIVES BOARD

(Examination) State Preliminary Examination \*

(Subject) Elementary Nursing and Hygiene \*

\* These particulars must be entered on the cover of your answer-book

4 May 1955

Time allowed: Two hours

All questions **must** be attempted. **Candidates should answer briefly and concisely only what is asked.**

1. What can a junior nurse—
  - (a) Observe and report to her ward sister about the patients?
  - (b) Learn from studying the daily ward report?Of what significance is the ward report in regard to the patients themselves? (30 marks)
2. What daily routine nursing care should patients receive in order that their recovery may be as speedy and comfortable as possible? (30 marks)
3. How can a junior nurse in a children's ward help to ensure the health and safety of the children while they are in hospital? (30 marks)
4. What solutions and their strengths are generally recognized as being suitable for the following:
  - (a) Storage of thermometers?
  - (b) Soaking of infected linen?
  - (c) Storing of the sterilizing room lifting forceps?
  - (d) Aseptic care of the vulva and perineum? (10 marks)

800/3/55—45403

State Preliminary Examination for Pupil Psychiatric Nurses, Subject: Elementary  
Psychiatry, November 1956

NURSES AND MIDWIVES BOARD

(Examination) State Preliminary Examination for Pupil Psychiatric  
Nurses\*

**(Subject) Elementary Psychiatry\***

\*These particulars must be entered on the cover of your answer-book

**8th November 1956**

Time allowed: Three hours

**ALL QUESTIONS TO BE ANSWERED**

All questions are of equal value in marking

1. What is:

- (a) Sublimation,
- (b) Idiocy,
- (c) Volition,
- (d) A delusion of reference,
- (e) An illusion?

2. What is:

- (a) Intelligence,
- (b) The Intelligence Quotient?

What level of education would a person with an I.Q. of 70 be likely to reach? At what might he earn his living?

**[Turn over**

State Preliminary Examination for Pupil Psychiatric Nurses, Subject: Elementary  
Psychiatry, November 1956

2

**3.** What responsibilities has the nurse in regard to:

- (a) A patient in seclusion,
- (b) A patient who complains that another nurse has assaulted her,
- (c) A suicidal patient,
- (d) The care and issuing of sedatives,
- (e) Relatives who visit patients?

**4.** The following processes may occur in everyday life. They may be seen to an abnormal degree in certain of the mentally ill. Write brief notes on each of them, indicating the circumstances under which they may occur in normal people, and the psychiatric conditions that may arise when they occur to an exaggerated degree:

- (a) Projection,
- (b) Depression,
- (c) Phantasy.

**5.** How may parental attitudes in regard to sex affect the future happiness of children?

200/8/56—87307

Source: H, 1, W2262, 34853, 1/12/1, ANZ, Wellington.

## Appendix L: A Grim Fairy Tale

### A Grim Fairy Tale by Russell Flahive

Once upon a time in the land of Keith there was a King who lived with his three young and glamorous sisters named Minister, Health Department and State Services. Now the King also had a daughter named Mental Hospital. Round about 1947 the King died but before this he called his sisters together and in return for the free use of castles he charged them with care and kindness to his only child. The King directed the younger and more glamorous of his sisters to take special care and all this was written on a Royal document called the Act and in this Act she was charged to feed, train and make Mental Hospital into a healthy young woman. However Mental Hospital was a plain child so State Services took an old cloak she had previously used to cover other poor beggars and the name of this cloak was Oath of Secrecy. So tightly did she wind this cloak about Mental Hospital that she could not speak nor hardly could she breathe. Now from long and frequent use the cloak was rather thin and though it bound her tight it hardly served to comfort.

One night in the old King's palace, the three sisters decided to have a ball and it was held in a great hall called 'Parliamentium'. All the people came from miles about and while they were dancing and feasting, Minister, the older sister rose to address the people. Now unbeknown to all, Mental Hospital's Cloak of Secrecy, having become extremely threadbare, fell apart and she emerged naked from the place where she had been kept, into the huge hall called 'Parliamentium', where all the people were. The people raised their hands in horror and cried 'shame!' Minister, a very resourceful lady also raised her hands in horror and cried 'shame!' and her two sisters likewise and pointing to the people she said 'Shame upon you that you have ignored her, henceforth she shall be called "Cinderella" and as I am a great and generous lady I shall call upon the mighty Baron Hospital Board to marry Cinderella, for he has many castles and he will make her a fine husband.

Soon after Cinderella was bedecked in fine robes and jewels and with much shouting and rejoicing, Minister, Health Department, State Services and all the people danced at the wedding and watched the great Baron Hospital Board carry Cinderella off to his castles. Whereupon the people went home mightily pleased and Minister, Health Department and State Services returned to their ivory castles and smiled upon the land, casting occasional coins to the poor beggars far below.

Meantime Cinderella had been taken to the Baron Hospital Board's greatest castle and to her horror discovered Baron Hospital Board had many other wives, who when they saw this poor creature bedecked in jewels and finery, stripped them from her, and wrapped her in a great Hospital Blanket so big it smothered her and carried her to some distant place where she was to remain forever, but:-

Now and then a traveller  
Softly hears at night  
'I'm Cinderella, Cinderella, so  
keep me out of sight,  
I'm wrapped up in a blanket  
To hold me good and tight'  
And from across the land, an echo:  
'She'll be bloody right'.

Source: PSJ, 52, 6, 1965, p.4.



### Appendix M: Psychiatric Nurses' Strike, 1971: timetable of events

	Hospital Activity	Other Developments
Monday 21 June	Oakley nurses vote to withdraw labour	
Tuesday 22 June		Venville supports nurses in Auckland Anglican Synod
Wednesday 23 June	PSA officers visit Oakley to dissuade nurses from strike	Synod motion supports nurses
Thursday 24 June	8.30am Oakley nurses withdraw 6pm Army arrives	
Friday 25 June	Templeton decide to strike Sunnyside decide to work to rule from midnight and strike on 5 July	Announcement of salary settlement with general nurses
Saturday 26 June	3.30pm Templeton withdraw labour; university students organise roster Sunnyside do essential services only	
Sunday 27 June	More than 150 students helping at Templeton	Salary offer to mental health nurses, same as general nurses - rejected McKay visits Oakley
Monday 28 June	Templeton nurses decide to set up picket	PSA deputation meet PM Cabinet offers a one man inquiry at Oakley
Tuesday 29 June	Kingseat withdraw labour Ngawhatu bans all overtime	Gallery Programme on television All nurses receive normal pay
Wednesday 30 June	Levin agree to strike on 4 June Cherry Farm bans all overtime, essential services only	
Thursday 1 July	Reports of Oakley nurses collecting signatures in city streets Porirua bans all overtime	
Friday 2 July	Tokanui withdraws labour Ngawhatu & Braemar consider action Oakley nurses address workers including Freezing Works	PSA reps meet McKay, 50 nurses' silent walk to Parliament Government makes new offer (Remaining disputed points are full inquiry & lead)
Saturday 3 July	Sunnyside nurses discuss offer	
Sunday 4 July	Templeton & Oakley reject offer - hold out for lead Orokonui bans all overtime Levin decide to hold off action	

Monday 5 July	Welfare Council at Templeton losing patience with nurses	MHG conference starts PSA reps meet PM & Ministers Burton delivers letter to PM Government agree to national inquiry but not to salary lead
Tuesday 6 July	Sunnyside withdraw labour Voting by subgroups; Templeton, Kingseat unhappy but agree to return	MHG conference vote to accept offer & stop action but call for removal of NZNA from CSSO
Wednesday 7 July	Sunnyside, Templeton, Tokanui & Kingseat return to work Oakley reluctantly vote to finish strike	
Thursday 8 July	Oakley nurses return to work	

Sources: Daily and weekly newspapers, PSA minutes, NZNA archives, Patrick Savage, Report on Oakley Strike.

**Appendix N: Details of photographs, Figure 24 and Figure 28.**

**Names of nurses in photo of the inaugural staff at the Maximum Security Unit, Lake Alice Hospital, 1960 (Figure 24).**

Back Row, L-R: Ainsley Price SN, Winston Maniapoto SN, Jim Grant SN, Tom McGreavey SN, Patrick Gallagher PA, Frank Veuger CN, Bert Hall SCN, Arnold Gruys CN, Terry Walklin CN, M. Mahon PA.

Front Row, L-R: Bill Hodgson SN, Len Cox CN, Les Kietch PA, Jack O'Connell SN, Harold Wright HN, Bill Miles DHN, Tom Quinlan CN, Dave Garland PA, John Mullins SN

Key: HN = Head Nurse; DHN = Deputy Head Nurse; SCN= Supervising Charge Nurse; CN = Charge Nurse; SN = Staff nurse; PA= Psychiatric Assistant

**Names of people in photograph of Sunnyside Hospital State Finals graduating class, November 1960 (Figure 29).**

Back row, L-R: W. McLelland, E.A. Williams, K.D. Dasler, A.Parker, D. Murphy.  
Front row, L-R: W.G.C. Thompson (tutor), V.L. Kelly, E.D. Yorke, M.F. Fowler, N.H. Brand, G. Miles, Dr. Y.S. Mouat.

**Appendix O: Years of service of attendants and nurses, 1939.  
Mental hospital staff by occupational category, 1939, 1949, 1959, 1972.**

Years of service of attendants and nurses, 1939

Male Attendants									
	>1 yr	1- 4	5-9	10-14	15-19	20-24	25-29	30-34	35-39
HA	-	-	-	-	1	3	7	7	2
CA	-	1	-	6	16	14	14	2	1
DCA	-	-	6	19	35	13	5	1	-
SA	-	37	56	81	34	10	2	1	-
JA	41	194	9	5	1	-	-	-	-
Total	41	232	71	111	87	40	28	11	3

Female Nurses									
	>1 yr	1- 4	5-9	10-14	15-19	20-24	25-29	30-34	35-39
M	-	-	1	6	8	9	3	1	-
CN	-	7	46	32	4	1	-	-	-
DCN	-	51	15	1	-	-	-	-	-
SN	-	5	2	1	-	-	-	-	-
JN	144	237	-	-	-	-	-	-	-
Total	144	290	64	40	12	10	3	1	-

Source: New Zealand Public Service List, 1939.

HA = head attendant

CA = charge attendant

DCA = deputy charge attendant

SA = senior attendant

JA = junior attendant

M = matron

CN = charge nurse

DCN = deputy charge nurse

SN = senior nurse

JN = junior nurse

Mental Hospital Staff by Occupational Category, 1939, 1949, 1959, 1972.

Year	Nurses and attendants	Treatment - medical, OTs, social workers, psychologists	Clerical	Tradesmen, farm workers, gardeners, cleaners, cooks, laundry and others.
1939	1,210	26	39	176
1949	1,204	47	106	337
1959	1,539	159	143	555
1972	2858	379	375	1,712

Source: NZPL, 1939, 1949, 1959/60; National Health Statistics Centre (NZ), Mental Health Data 1973, Wellington, p.76.

## Appendix P: Mental hospital nurses and attendants by title, 1939, 1949, 1959, 1972

### Females

	Matr	Ass Matron	Superv Sist	Sen Tut	Tutor sister	Sister	Dep- sister	S/N	Senior Nurse	Nurse	Senior Asst N	Asst Nurse	Comm Nurse	Hospit Aid
1939	29				8	***90	67	*8		383				
1949	30				11	105		52		314				
1959	33				11	97	25	27	4	*385		53		3
1972	9	26	16	4	9	135		129		392	48	87	46	221

### Males

	Head Attend	Ass H/A	Superv C/N	Sen Tut	Tutor	C/N	Dep C/N	S/N	Senior Atnd	Attend	Senior Asst N	Asst Nurse	Comm Nurse	Hospit Aid
1939	21					54	79	**223		250				
1949	26					78	102	224		262				
1959	33					117	138	225	3	*388				
1972	16	35	30	6	12	241		358		211	120	41	9	82

Source: NZPSL, 1939, 1949, 1959/60, 1972.

Note: Men were called 'attendants' until 1960. \*'Nurse' and 'attendant' grade became 'trainee nurse' from 1960s; \*\*Until 1945, the first level of qualified mental nurses and attendants were called 'senior nurses' and 'senior attendants' rather than 'staff nurse'; \*\*\* sisters called 'charge nurses' until 1945; Matr = matron; H/A = head attendant; supr v sis = supervising sister, sen tut = senior tutor, C/N = charge nurse; S/N = staff nurse; nur = nurse; asst nurse = assistant nurse, comm nurse = community nurse; hospit aid = hospital aid.

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H, 1, 31097  
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H, 1, 28739  
H, 1, 33330, 1/11/38  
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H, 1, 32400, 1/13/109  
H, 1, 32393, 1/13/99  
H, 1, 45588, 39/5/9  
H, 1, 33794, 30/35/26  
H, 1, 49/5/9  
H, 1, 45598, 49/1/35  
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