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PSYCHIATRIC SERVICES
IN
PUBLIC HOSPITALS
IN
NEW ZEALAND

BOARD OF HEALTH
(under Health Act 1956)

REPORT SERIES: No. 1

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FOREWORD

Office of the Minister of Health,
WELLINGTON,
January 1960.

It is expected that hospital boards throughout the country and indeed all those interested in psychiatry will study this report because much may be gained from it that will serve as a guide to improving the psychiatric services of the country.

Certain standards of accommodation and staffing are suggested. Some ways are indicated in which improvement in the recruitment and training of necessary staff can be effected. It is quite clear that it will be many years before there can be adequate provision for the needs of the community in the field of psychiatry. This is not a problem peculiar to New Zealand but is a world-wide problem.

As a means towards the training of necessary staff, the report recommends the establishment of facilities for post-graduate training in psychiatry.

The report stresses the need for the integration of the psychiatric services provided on the one hand by the Mental Hygiene Division, and on the other by psychiatrists employed by public hospitals. Each has very important functions and neither is likely to supersede the other. It is believed that by this integration there will be a better understanding of psychiatry. The possibility of exchange of staff will, in its turn, aid recruitment of staff and will lead to better understanding between staffs and avoid duplication of services.

K. R. Mason

Minister of Health.

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PSYCHIATRIC SERVICES IN PUBLIC HOSPITALS

The Board of Health has forwarded to me the report of a Committee constituted by it for the purpose of investigating and reporting upon the psychiatric services in public hospitals.

It was quite clear to the Board when considering the report of the Committee that a matter of the utmost importance was the procurement of adequate staff to implement the recommendations made.

The Board is in agreement with recommendations 2, 3, 4, 5, 6, 9, and 11. It agrees that homes for "elderly confused" did not come within the terms of reference otherwise it has no comment to make in regard to recommendation 10. In regard to recommendation 12, it suggests that should proven elements of the Worthing experiment be adopted in New Zealand, that the Auckland and Sunnyside Mental Hospitals would appear to be suitable centres for the inauguration of a similar study.

The Board has given much consideration to recommendations 7 and 8 and, as these aspects are undoubtedly the key to the problem, it had these suggestions to make.

1. Means of Implementing a Staff Recruiting Programme to Meet Staff Shortages in Mental Hospitals and Public Hospitals

The Board suggests that bursaries should be made available to suitable graduates after two years' internship to enable them to study for two years overseas to qualify as psychiatrists, and on return to be required to serve for a period of three years in either a departmental mental hospital or a public hospital.

The Board considers that the bursaries should be sufficiently generous to permit the holders to live without financial worry and should include travelling expenses.

It is further suggested that the terms of the present bursaries available to Mental Hygiene Division officers be brought into line with new proposals.

For the special bursaries recommended there should be a central selection body set up consisting of the Director of the Division of Mental Hygiene and two other responsible practising members of the medical profession.

The Board hopes that the Otago Medical School would encourage medical practitioners to specialise in psychiatry and also felt that the Mental Hygiene Division should more widely publicise the opportunities presenting in psychiatry.

2. Consideration of the Establishment of a University Chair in Psychiatry in New Zealand for the Purpose of Providing Adequate Training for Psychiatrists

The Board considers that there is a great need for a chair in psychiatry to be established at a university, and recommends the establishment of a chair at a large centre where there is a mental hospital situated in the

metropolitan area or where there is a suitable geographical r
between a large mental hospital and a public hospital.

Should a chair in psychiatry be established it would be hop
University of New Zealand might establish a diploma in ps
medicine.

The Board envisages that those who would come under th
of such a chair would be practising psychiatrists in mental
hospitals, psychiatrists in training for both these services,
psychiatrists, and general practitioners who are interested in t

**3. Establishment of Relative Parity in Salaries and Conditions o
ment for Psychiatrists Whether Employed by the Menta
Division or by the Hospital Boards.**

It is the opinion of the Board that, in the past, the Ment
Division has been understaffed, overworked, and has had a
type of patient to look after, and there has been a tendency
be lost for these reasons.

Even under these difficulties the Division has endeavoured t
clinics in public hospitals and the Board believes that they
given every encouragement to carry on with this work.

The Board places great emphasis on the necessity for the est
of parity of status and conditions and suggests that the parity
between the two services should at least be maintained in t

H. R. Mason

Minister of

REPORT

I. INTRODUCTION

At its meeting on 6 December 1957 the Board of Health set up the following as a Committee, to inquire into the psychiatric services in public hospitals:

Mr P. V. E. Stainton, O.B.E. (Chairman); Chairman, Taranaki Hospital Board; Member of Executive of Hospital Boards Association of New Zealand.

Dr R. G. T. Lewis, M.B., CH.B.; Director of Mental Hygiene Division, Department of Health.

Dr C. A. Taylor, M.B., CH.B., M.R.C.P., F.R.A.C.P.; Director, Division of Hospitals, Department of Health.

Dr W. Ironside, M.D., CH.B., D.P.M. (R.C.P., R.C.S.); Senior Psychiatric Physician and Senior Lecturer in Charge of Psychiatry Department, Otago Hospital Board.

Mr W. E. Bate, O.B.E., L.L.M.; Chairman, Hawke's Bay Hospital Board, Mayor of Hastings, President of Hospital Boards Association of New Zealand.

The order of reference was as follows:

(i) The extent and deficiencies of the existing inpatient and outpatient psychiatric services in New Zealand Public Hospitals:

(ii) The provision which should be made in public hospitals for the diagnosis and treatment of psychiatric illness

(a) For clinical facilities;

(b) Staff establishments:

(iii) The need or otherwise for a type of institution intermediate between the public hospital and the mental hospital:

(iv) The allocation of responsibility of hospital boards and the Mental Hygiene Division of the Department of Health for staffing psychiatric services in public hospitals:

(v) Such other matters as appear to come within this field.

The chairman had difficulty in arranging meetings to the convenience of all members. The Committee first met on 21 March 1958 and subsequently on 9 May 1958, 3 October 1958, 12 December 1958, and 10 March 1959.

II. EXTENT OF INQUIRIES

(i) The Committee invited and considered:

(a) Replies to a questionnaire sent out to medical superintendents of all public hospitals as regards the present service given.

(b) Replies to a questionnaire sent out to medical superintendents of all mental hospitals as to the extent of the service they provided in public hospitals.

(c) Submissions by the Medical Superintendents Association Zealand and interviewed the secretary of the association, Archer, M.B., CH.B., F.R.C.S., Medical Superintendent of North Hospital.

(d) Submissions by the New Zealand Branch of the Britis Association and interviewed their representatives Dr J. M D.S.O., M.D., F.R.C.P., M.R.C.P., F.R.A.C.P., and Dr D. G. M M.D., D.P.M. (The Royal Australasian College of Physicians in the B.M.A. submission.)

(e) Submissions by the Paediatric Society of New Zealand in child psychiatry and interviewed Dr Alice M. Bush., M M.R.C.P., M.R.A.C.P., D.C.H (R.C.P., R.C.S.), a representat Society.

(f) Submissions by the Advisory Committee on the Care of

(g) Submissions by the Australasian Association of Psychiatr Zealand Branch).

(h) Submissions by the South Canterbury Hospital Board and i Dr J. Campbell McKenzie, M.B., CH.B., and Dr S. C. Ha CH.B. The South Canterbury Hospital Board was invitec submissions as this Board put forward a remit at the las Boards Association Conference advocating the provision o psychiatric services in public hospitals.

(i) Submissions by Dr W. Ironside, Senior Psychiatric Phy Senior Lecturer in Charge of Psychiatry Department, Otag Board, and a member of this Committee.

(j) In addition, Dr Lewis and Dr Ironside personally analysed the admissions and outpatient attendances at psychiatric u four main centres and considered details respecting the a of psychiatric cases at the child health and psychological Auckland.

(ii) The Committee also considered submissions submitted in capacity by:

(a) Dr C. Graham Riley, M.B., CH.B., M.R.C.P., F.R.A.C.P., Christchurch.

(b) Dr D. W. Rowntree, M.B., CH.B., D.P.M. (R.C.P., R.C.S.

(c) Dr I. M. McGregor, M.R.C.S., L.R.C.P., D.P.H., Medical Supe of Silverstream Hospital, Wellington.

The Hospital Boards Association felt that as two members of it were members of this Committee there was no need for it to submissions.

In addition to the above evidence and submissions, memb Committee have considered certain articles on psychiatric service

(iii) In all, some 200 pages of typewritten evidence and form sions have been considered.

The Committee was particularly impressed with:

(a) The amount of time expended and care taken in preparing the British Medical Association's submissions and was assured that this paper expressed the combined opinion of the Divisions in New Zealand.

(b) The opinions expressed by the Medical Superintendents of both public and mental hospitals.

III. SUMMARY OF EVIDENCE AND SUBMISSIONS

(A) Item (i) of Order of Reference – "The extent and deficiencies of the existing inpatient and outpatient psychiatric services in New Zaland Public Hospitals."

All submissions expressed, with some varying qualifications, the opinion that the existing inpatient and outpatient psychiatric services in public hospitals were inadequate to meet the demand of many categories of mental illness in our communities.

(B) Item (ii) of Order of Reference – "The provision which should be made in public hospitals for the diagnosis and treatment of psychiatric illness (a) for clinical facilities, (b) staff establishments."

(a) *The South Canterbury Hospital Board* advocated obtaining six highly qualified and experienced consultants from overseas, for placement strategically throughout the country, to act as specialist consultants to groups of hospital boards. These specialists should be employed either full or part time by hospital boards. These appointments would only be a beginning and each would have to build up a team of trained personnel to establish clinics and expand the scheme.

(b) *The Medical Superintendents of Mental Hospitals* recommended psychiatric inpatient facilities at Christchurch, Hamilton, Napier, Palmerston North, Timaru, and Invercargill, in addition to those at Auckland, Wellington, and Dunedin, to serve as base hospitals on a regional basis. These units would be required to give physical treatments in selected cases and full psychiatric treatment for early and short-term inpatient cases.

The outpatient clinics already existing should be extended to service groups of hospitals with no facilities.

Child psychiatric clinics are needed in addition to the present child health clinics; to start with one in the South Island and two in the North Island.

Three suggestions were made as to medical staffing:

(1) Part-time psychiatrists seconded for duty from the Mental Hygiene Division for both inpatient and outpatient services, which would be an extension of the services already being given by the Division to many hospital boards. The Division considered that if it was adequately staffed medically it could meet most of the reasonable psychiatric needs of public hospitals.

(2) The appointment of full-time salaried psychiatrists of the larger hospitals and salaried psychiatrists to ser of smaller hospitals.

(3) Part-time psychiatric services to public hospitals b practising psychiatrists.

It was felt that public interest would be better served by (2)

The nursing staff of psychiatric wards should be menta trained.

(c) *The Medical Superintendents of Public Hospitals* subn in the larger hospitals at least the provision of an adequat of beds for psychiatric cases and the establishment of a psychiatric unit is desirable. Facilities should be made ava regular out-patient clinics.

They considered that medical staffing could be provided time psychiatrists employed by hospital boards, by part-time ps in private practice, or by Mental Hygiene Division officers c time basis depending on the size of the units and the locati hospitals. Ancilliary nursing staff should be mental hospit and seconded as necessary.

(d) *The New Zealand Branch of the British Medical A* considered that separate psychiatric wards with equal provisior and female should be established in the main centres at least. beds per 100,000 of population to be served were considered for immediate needs, excluding senile patients. Some beds sidered necessary for the observation and treatment of child p patients.

The association was divided on the need for outpatient when there are consultants in private practice in the district.

As regards medical staffing, the association advocated appointments in the same way as other specialties. It was c that a 30-bed unit would require a senior part-time psychi assistant part-time psychiatrist, and a full-time registrar wit two years general medical experience. General trained nurse ably with psychiatric training, should be in charge of the w extension of female nursing to male wards was supported. Lachlan, giving evidence on behalf of the British Medical As expressed the view that there was no objection to a Mental Division psychiatrist being head of the psychiatry depart public hospitals.

(e) *The Australasian Association of Psychiatrists (New Branch)* submitted that there should be 20 to 30 beds in wards in public hospitals in the main centres for the "sho treatment of selected cases. A continuous outpatient service s provided by a public hospital department of psychiatry in t centres. In the smaller centres an expansion of clinic facilitie therapeutic side was needed in addition to consultation and f Separate child psychiatric clinics were considered necessary.

The association advanced that the psychiatrist in charge of beds should be of specialist status and employed for a minimum of five sessions weekly. Some of the senior nursing staff should have psychiatric training.

There is a need for outpatient clinics, staffed by trained psychiatrists, clinic psychologists (non-medical), and psychiatric social workers employed by hospital boards and supplemented by Mental Hygiene Division personnel functioning as at present.

(f) *The Paediatric Society* recommended separate psychiatric ward provision for children in the four main centres. As a guide, four to six beds are needed at Auckland for immediate needs. Child guidance outpatient clinics on the basis of 1 to 100,000 of population are required. These clinics should be attached to the general hospitals.

The society also recommended that a child psychiatrist should be on the staff of the public hospitals in the four main centres. Child psychiatrists from the Mental Hygiene Division could be employed if available. Child psychiatrists are required to work at the child health clinics of the Department of Health and at smaller hospitals.

(C) Item (iii) of Order of Reference – "The need or otherwise for a type of institution intermediate between the public hospital and the mental hospital."

The consensus of opinion was not to press for an institution intermediate between the public hospital and mental hospital. However, the Advisory Committee on the Care of the Aged suggested that accommodation for the "aged confused" be provided in existing mental hospital grounds. This in a modified form was supported by the medical superintendents of public hospitals.

Some medical superintendents of mental hospitals advocated the provision in the North Island of a unit similar to Hanmer for psychoneurosis cases. The British Medical Association representatives were opposed to this, but stated that if such an institution was established it should be administered by a hospital board.

The Australasian Association of Psychiatrists stated that there was no need for any intermediate institution but pointed out that if the idea of such a move envisaged the removal of parts of mental hospitals from the provisions of the Mental Health Act it might prolong the attachment of a stigma to the remaining parts of a mental hospital rather than remove it.

(D) Item (iv) of Order of Reference – "The allocation of responsibility of hospital boards and the Mental Hygiene Division of the Department of Health for staffing psychiatric services in public hospitals."

The consensus of opinion of those giving evidence was that the provision of facilities for patients diagnosed as requiring only "short stay" therapy should be an accepted function of the general hospital service. The mental hospital staff should continue to have consultative contact with public hospital staff.

The medical superintendents of mental hospitals claime their mental hospitals were adequately staffed medically th like to and could supply most of the reasonable psychiatric public hospitals, but whatever course was adopted Mental Division staff should play a large part in public hospital p services.

The British Medical Association was unanimous that ps should be appointed by and be responsible to hospital boar same manner as other specialists, but expressed a desire that th Hygiene Division psychiatrists continue to visit public ho assist patients who may come under their future care in hospital, and to supervise those patients who have been d from a mental hospital on probation. The closest cooperatic two types of staff was considered to be essential.

The Australasian Association of Psychiatrists stated that a Board should be wholly responsible for the service. Psychia ancillary personnel from the Mental Hygiene Division should to contribute to the service as at present.

(E) Item (v) of Order of Reference – "Such other matters a to come within this field."

The Advisory Council on the Care of the Aged stressed tha units should be provided in every public hospital and the aged confused patients therein should have the assistance of domiciliary care by psychiatrists and social workers to reduce of hospital treatment.

The Medical Superintendents of Public Hospitals advocatec integration between general and mental hospital services as phy mental health are complementary in the prevention of diseas

The Paediatric Society advocated the employment of a trained child psychiatrists in the team at the main child heal of the Department of Health.

The British Medical Association stressed:

(i) The need for well trained psychiatric social worke persons being more important than the build up psychiatric outpatient clinics and additional beds:

(ii) The need for protective legislation for both patients, trists, and medical superintendents, where patie have to be temporarily detained in a public hos observation:

(iii) The allocation of more time in the medical curri training in psychiatry and the need to give adequa vation, treatment, and nursing care of mental cases hospitals:

(iv) The need for the provision of "short stay" beds i hospitals to give temporary relief to relatives who ar psychiatric patients in their own homes; these beds addition to the recommended 14 per 100,000 of po

IV. DR IRONSIDE'S PERSONAL SUBMISSIONS

Dr Ironside submitted a memorandum on the problem as he saw it from his point of view. The following is a summary of this submission prepared by Dr Ironside:

"It is generally agreed that the incidence of psychiatric disorders in countries such as Britain and the U.S.A. is about 40 per cent of the total sick population. The incidence in New Zealand is unlikely to differ much. Only a fraction of such patients would ever be suitable for mental hospital treatment.

Especially since 1945 there has been a rapid development of general hospital psychiatry in many countries, especially Britain, Canada, and the U.S.A. The trend is to treat those patients who are not suitable for mental hospital. But seemingly any psychiatric disorder can be treated in general hospital provided certain social factors in the patient's environment can be controlled. The emphasis in general hospital psychiatry is on outpatient treatment and well established units provide a continuous outpatient service. A growing trend is to provide domiciliary treatment also. In Britain particularly many mental hospitals have adopted general hospital concepts. The latest development of this is "The Worthing Experiment", which has resulted in a spectacular reduction of admissions to the local mental hospital. These current trends have prompted psychiatric authorities to predict the early disappearance of mental hospitals as now known and to advocate a stringent revision of any new mental hospital building.

In contrast to what is happening overseas, there has been but slight growth of general hospital psychiatry in New Zealand. All organisations and individuals submitting evidence to the Committee agreed that New Zealand general hospital psychiatry was inadequate. This was confirmed by returns from hospital boards which revealed that with a few exceptions general hospital psychiatry is virtually non-existent in the Dominion.

Standards for the staffing of general hospital psychiatry units have been outlined by the American Psychiatric Association. Apart from personnel work-load ratio, these standards emphasise that qualifications for personnel should be above certain level and that in psychiatric practice, team work, headed by the psychiatrist with clinical psychologist and psychiatric social worker, is essential. Eight per cent to 10 per cent general hospital beds is recommended for psychiatric casualties, and any hospital with more than 150 beds should have its own psychiatric unit.

Adopting the formula of the American Psychiatric Association, if only 5 per cent (260) of the 5,206 beds of New Zealand's Class I hospitals were set aside for psychiatric patients and an associated outpatient service established, 39 psychiatrists, 65 psychiatric social workers, and 26 clinical psychologists, all whole time and engaged only in clinical work, would be required. To achieve this would be a long-term goal.

The immediate aim in developing psychiatry in general hospitals is to establish psychiatric teams in Auckland, Wellington, and Christchurch and make some additions to the Dunedin Hospital unit.

The next step would be to establish teams in the other eigh hospitals. The third step would be the expansion of these uni they could service part-time clinics in the remoter areas, anc domiciliary care.

Coordinated training programmes to ensure a flow of psy clinical psychologists, and psychiatric social workers will be es the full establishment and continuation of general hospital p services. Negotiation with the University of New Zealand is

Adequate general hospital psychiatric services will have a effect on mental hospital practice. A large reduction in menta admissions can be anticipated. Discharge rates especially of chronic patients will increase. The overall result will be a co reduction of the need for mental hospital beds. Therefore, all ne hospital bed construction should cease forthwith.

The entire establishment, e.g., material facilities, advertising ments, etc., and administration of general hospital psychiatri should be solely invested in hospital boards. Hospital boards will seek close links with the Mental Hygiene Division, but this sh matter of arrangement between boards and the Division."

V. THE COMMITTEE'S GENERAL COMMENT

The term "mental illness", for the purposes of this report, is to to mean all forms of mental illness, not only the obvious su psychoses, but also the less obvious such as the neuroses, perso orders, and psychosomatic affections. It is also used to cover thc illnesses consequent upon disease of the brain from any cause.

Over the last 30 years or so, by progressive medical knowledge result of study of the human mind, it has become possible to u in a more scientific way the nature of the various particular menta from which these patients suffer and apply appropriate treatm this knowledge it is now possible, in a substantial proportion o effect a recovery, and the New Zealand Mental Hygiene Divisic of shortages of psychiatrists over these years has introduced measures with much success.

This progress has brought about a considerable modificati attitude of the public towards the mental patient as evidenc increased willingness to enter a mental hospital for treatment as tary boarder". This new attitude is dominant in the minds of came forward to give evidence.

The medical evidence accepts the fact that there will always mental hospitals to receive a certain number of mental patie environmental circumstances do not permit them to live at home outpatient treatment plus those patients who will not submit w essential care and treatment and who will therefore have to be co detained in mental hospital. There will also be those cases th a period of treatment longer than can reasonably be given in hospital psychiatric unit and can only be treated in a menta

However, this medical evidence does also indicate that a large proportion of those suffering from mental disorder of a transient type or of minor degree could be diagnosed and treated like all other types of illness either by private medical practitioners and practising psychiatrists or at psychiatric units in public hospitals without being subject to the due process of the law. Patients in this group should not need to be sent to a mental hospital, but should be properly diagnosed and then treated by all known treatment measures either as short-term inpatients or as outpatients.

The cases referred to in the preceding paragraph, which cannot be appropriately treated without admission to mental hospital, should be enabled by relaxation of the law to enter mental hospital with the least possible legal formalities. It should be appreciated that there are some legal formalities associated with treatment in general hospitals.

Education of the public mind is of first importance before schemes which may have been a success overseas are likely to be a success in this country.

A trend was referred to in the presidential address to the American Psychiatric Association in May 1958 by the president Dr H. C. Solomon when he predicted the early disappearance of the mental hospital as we know it today, urged an end to all mental hospital buildings, and advocated further development of psychiatric services based on general hospitals or small independent treatment units.

The Hon. Walter S. McClay, Senior Commissioner of the Board of Control, England, warns that a demand for example for 1,000 more mental hospital beds should be reduced immediately to 200. The Committee feels that this trend is established overseas. If adequate services are provided in public hospitals in New Zealand, it may well mean that future building for the Mental Hygiene Division would be confined to the relief of present overcrowding and to the replacement of beds which for one reason or another have become substandard to modern requirements. It is felt that if corresponding emphasis were made upon the development of psychiatric medicine based on the general hospital then the shortages of staff in mental hospitals would not be so apparent as under the present system.

There are several advantages likely to accrue from the development of this policy.

(a) The first of these advantages would appear to be that the psychiatrist, working in a public hospital in closer association with all other sections of his medical colleagues and as part of the general hospital unit, is likely to be able to put forward his best work.

(b) Secondly, the treatment in public hospitals associated with outpatient clinics enables so much more work to be done on the basis of domiciliary care. There can be little doubt that some patients who can be treated in their own homes among their own relations and in their own environment will react more swiftly to treatment than if they are under the necessity of being removed to a distant institution. The virtues of domiciliary treatment of persons suffering from mental illness are equally valid whether treatment is carried out by psychiatrists of the Mental Hygiene Division, the public hospital, or by the psychiatrist in private practice.

(c) A third advantage worthy of mention is that these propos avoid or at any rate greatly reduce the resistance which n particularly if they are sufferers themselves, exhibit towards treatment especially if committal to a mental institution is li involved.

The Committee has given some consideration to the recommen the Royal Commission in England on the Law relating to Menta and Mental Deficiency 1954/57 in which were proposed swee reforms so that mental illnesses can be treated with the same infc other illnesses. Among the recommendations (page 43) are these:

"*Para. 3.* Procedures which involve the patient's detention should not be used unless the use of compulsion is positively to provide treatment which the patient needs but is unwilling or to protect him from exploitation or neglect, or for the prc others.

Para. 4. The circumstances in which compulsory powers m and the procedures which should be followed should be laid law, but the law should not draw rigid distinctions betwee groups of patients by the 'designation' of hospitals or in other w

The general trend overseas is to ameliorate the rigidity of the la applying to mental illness and the Committee recommends that cor be given to implementing in New Zealand similar proposals suc made by the Royal Commission and minimising the extent to wh is assumed by a statutory committee of the affairs and fortunes o from mental illness. It is interesting to observe that a simila New Zealand is illustrated by the provisions of the Mental Healt ment Acts of 1954 and 1957 dealing with the establishment of intellectually handicapped children whose homes are in the count sion to these hostels are freed from the principal legal formalitie to other mental defectives.

At the present time it is difficult to make an accurate assessm one community of the number of people who may be suffering fr illnesses of some sort or another, other than those who are in hospitals, but the Committee is convinced that much less than the of attention necessary to cope with this problem is being given.

Many social problems which are now dealt with by the Co domestic unhappiness which never reaches the light of day, man maladjustments and inefficiencies are related to this very problem.

The fact that at present and hitherto there has been inadequa and insufficient staff for giving attention to these cases has tend them in the background and now renders it difficult to asses magnitude of the problem. This at least is certain, that in the s given to us by well qualified witnesses, the public hospital servic respects are wholly inadequate to give proper treatment of requiring attention.

In the course of the Committee's inquiries in respect to syste there emerged a consistent pattern of evidence that an appreciable of the population of English speaking countries is in need of

treatment of one form or another. In the memorandum presented by Dr Ironside he said: "There is a general agreement at least among the medical professions of the English speaking countries that about 40 per cent of the total sick population suffer from mental disorders".

In an article *Provision For the Mentally Ill,* by Dr Alexander Kennedy, M.D., F.R.C.P., Professor of Psychiatry, University of Edinburgh, recently published, it is written "In 1948, the National Health Service had to take over both the hospitals with more good ideas than money to implement them and those that had hardly changed since the day they were built. It was not until they started work that most regional boards realised that nearly half the hospital beds were occupied by psychiatric patients".

It appears that of the recognised total sick population (overseas) there is general agreement that something between 40 and 50 per cent suffer from some type of mental illness with or without physical illness and are in need of psychotherapy of one type or another.

The Committee noted the incidence of mental illness as assessed from studies overseas and has taken cognisance of this in the formulation of its recommendations.

This assessment shows the urgent need for much greater awareness on the part of the whole medical profession to the importance of recognising the psychiatric needs of the community.

VI. THE COMMITTEE'S COMMENTS AND RECOMMENDATIONS ON SUBMISSIONS AND EVIDENCE

Item (i) of Order of Reference – "The extent and deficiencies of the existing inpatient and outpatient psychiatric services in New Zealand public hospitals."

Having referred to the problem in a general way, it is then necessary to consider what services are actually provided by the public hospitals in New Zealand. The British Medical Association in adverting to this subject said in their submissions:

> "Psychiatric services in public hospitals are provided at the present time in the main by psychiatrists from the Mental Hygiene Division, the exceptions being Auckland, Dunedin, and Napier. Service is available at Auckland, Hamilton, Rotorua, Tauranga, Palmerston North, Napier, Hastings, Wellington, Nelson, Christchurch, Hokitika, Greymouth, Timaru, Oamaru, Dunedin, Balclutha, and Invercargill. Having regard to the staff available, reasonable coverage of the country is provided. The lesser centres are served in the main only by fortnightly or monthly visits of brief duration. Of the main centres Auckland and Dunedin have the fullest facilities. Elsewhere visiting psychiatrists undertake ward rounds (two or three times a week in Christchurch and Wellington) and conduct outpatient clinics. They are also available for consultation on inpatients. The outpatient clinics serve patients referred by general practitioners,

Pensions, and other Departments, and for follow-ups of pa probation or after discharge from mental hospitals. Little tre carried out, the service being mainly diagnostic and advi deficiencies in this service are related to insufficient atten psychiatrists in most centres, lack of beds for holding purpose observation and investigation, lack of beds for short-term tre suitable cases, lack of trained staff, and lack of continuity in th available at present, often carried out by different psychiatri same hospital.

Facilities in general at present fall far short of a reasonable m

The Committee is of the opinion that this is a fair statemen It becomes evident therefore that over a large part of the country p services in public hospitals are intermittent, limited by force of circ to diagnostic and advisory services, and that only a minimal thera is available. As the British Medical Association has pointed out, t to the community is deficient in most areas by reason of insufficie ances by psychiatrists, lack of beds set apart for the treatment of p patients, lack of trained staff, and continuity of treatment.

Item (ii) of Order of Reference – "The provision which s made in public hospitals for the diagnosis and treatment of p illness (a) for clinical facilities, (b) staff establishment."

The Committee has given consideration to attempting to d respects in which the present service is deficient and to determ measures which ought reasonably to be considered with a view t these criticisms.

(1) *Psychiatric Units in Public Hospitals*

In certain public hospitals, having regard to centres of popul location and availability of staff, there should be established psychiatric departments modelled very largely on a pattern suc functions, according to the dictates of local circumstances, at Wellington, or Dunedin. The principal characteristics of these dep which would have equal application to other suitable areas, wou provision of beds for inpatients of both sexes in a self-contained p unit under the attention of a psychiatrist with suitably trained and a regular and more frequent outpatient service.

As an indication of the size of the psychiatric units envisaged, mittee is of the opinion that in the first instance the number of apart for psychiatric patients should be a minimum of 14 per of the regional population to be served by each unit (as recomm the British Medical Association).

For psychiatric departments operating outside metropolitan area provincial regional areas, it is considered that at first, according to one part-time psychiatrist (or preferably one whole-time psychiatri were sufficient need) would staff the department and visit other in the regional area as required.

Having regard to the degree of supervision needed it is considered that a part-time psychiatrist would need to be on at least five sessions per week which probably represents a higher sessional allowance for this type of case than for the normal run of medical and surgical cases.

In each department, whether metropolitan or provincial, it would be necessary to conduct an outpatients' service. This the Committee considers to be of a first importance. The question as to whether or not in any particular hospital the sessional allowance previously mentioned would cover the outpatients' attendances, would depend on circumstances and on demand.

In attention to persons suffering from mental illnesses, the outpatients' department assumes an increased importance in that it links in with a very desirable measure of domiciliary treatment. It obviously has the effect, too, of keeping out of hospital many who, if neglected, would ultimately find their way there. It also assists in accelerating discharge from hospitals and mental institutions and in rehabilitation.

In some hospitals a certain amount of structural adaptation to the existing outpatients' department would be involved.

On the subject of staffing, in addition to the psychiatrist, the desirable team set-up, particularly in the metropolitan areas, would include also a psychiatric social worker and a psychologist. It is scarcely practicable, and in any case uneconomic, for the psychiatrist to be under the necessity of attempting psychological investigations for which he may not be fitted and to have to indulge in time-absorbing social work. Nevertheless, these two ancillary lines of staffing are of distinct importance in the proper treatment and rehabilitation of the patient and must be provided for if possible.

(2) *Child Psychiatric Clinics*

The attention of the Committee was drawn to the needs of the emotionally disturbed child and it does appear that some anti-social behaviour on the part of children could be related to some type of mental illness, not often recognised as such.

The child presents a special problem and the Paediatric Society recommended that separate beds be established for children suffering from psychiatric illnesses and that outpatient clinics be availabe under the supervision of adequately trained child psychiatrists, psychologists, social workers, and play therapists. A certain amount of recognition of this problem has already been evident in that child health clinics have been established in six centres in New Zealand, but in some respects their staffing and administration falls short of what is recommended to the Committee by the Paediatric Society. It may well be though, that by reason of lack of trained personnel, it will not be possible for some time to provide special child psychiatric clinics at public hospitals, or to provide specially trained child psychiatrists who can devote their attention to this type of establishment. Wherever possible, further efforts should be made to understand and provide for the psychiatric needs of children who require skilled attention.

(3) *Specific recommendations arising from (1) and (2) above*

(a) *Clinical Facilities.* It is recommended that:

(i) *For Auckland, Wellington, Christchurch, and Dunedin*: bed provision be brought up to a minimum standard c per 100,000 of the population to be served (exclusive of beds).

(ii) *For Other Centres:* Psychiatric units should be establish when the necessary staff becomes available, in the first the following hospitals:

Waikato.	Palmerston North.
Napier.	Timaru.
New Plymouth.	Invercargill.

These units should be of such a size as to allow oth boards to use the base facilities, with a minimum of 1 100,000 of the regional population to be served.

On this basis the approximate psychiatric bed provis would need to be made in the various centres on popu the hospital district as at 31 March 1958 would be:

Auckland - - -	64 beds
Christchurch - - -	35 beds
Wellington - - -	33 beds
Dunedin - - - -	17 beds
Waikato - - - -	30 beds
Palmerston North - - -	12 beds
Southland - - -	12 beds
Napier - - - -	9 beds
Timaru - - - -	7 beds
New Plymouth - - -	7 beds

These figures are based on the population of the hosp in which the unit is established. Where, as would be t most instances, the unit would also serve the contiguou districts, additional provision to the extent of 14 beds pe of population of the additional areas to be served by the need to be made. It is realised that the psychiatric b probably have transferred to them some of the patien receiving attention in the general wards of the hospital. mean that there would be a reduction in demand fc general beds so that it may be that some beds now takir and/or surgical cases could be set aside for psychia Consequently, it may not be necessary to build furthe psychiatric cases in every centre to the full extent of 14 p of population to be served.

(iii) *Necessary Outpatient Facilities* to be provided in ea psychiatric units as they are established.

(b) *Staff Establishments:* It is recommended that for:

(i) *Main Centre Units*

Medical { 1 senior psychiatrist – part time on five-tenths basis.
1 assistant psychiatrist – part time on five-tenths basis.
1 psychiatrist registrar – whole time.

or the equivalent staff on a whole-time basis should be able to cover a 30-bed unit and outpatient service.

It is appreciated that some additional staff is required at Dunedin to cover teaching duties.

Nursing: That the requisite nursing staff be employed with, preferably, psychiatric registration certificates.

Psychiatric Social Workers: As per demand.

Psychologists: One as available for each unit on a part-time visiting consultant basis.

(ii) *Provincial Regional Units:* One whole-time or part-time senior psychiatrist with ancillary staff available to conduct outpatient and consultative clinics at contiguous hospital outpatient departments as well as at their respective base units.

(c) *Child Psychiatric Units:* It is recommended:

(i) *At Main Centres:* That additional and specific bed accommodation be provided for children suffering from mental illness to the order of three beds per 100,000 of population, together with outpatient facilities.

(ii) *At Other Centres:* The child psychiatric service to be incorporated within the adult service at the hospitals mentioned in (3) (a) (ii) above (page 18).

(iii) *Specialist Child Psychiatrists* should preferably staff these units in main centres on a part-time basis (additional to the psychiatrists for adult patients).

If accepted, these suggestions imply and would demand the recruitment of a minimum of 10 part-time psychiatrists and four whole-time registrars, additional to the present psychiatrists employed by hospital boards, and at least 40 psychiatric trained nurses and psychiatric social workers, and in addition part-time consulting psychologists.

Item (iii) of Order of Reference – "The need or otherwise for a type of institution intermediate between the public hospital and the mental hospital."

After considering all the submissions on this subject, the Committee is of the opinion that there is no need for any institution intermediate between the public hospital and the mental hospital except for the special hospitals for inpatient neuroses cases, such as Queen Mary Hospital at Hanmer. There may be a case for the provision of special units in the environs of mental hospitals for elderly confused patients.

The Committee has already made recommendations as to the ment of psychiatric units within public hospitals. It is felt that i psychiatric treatment is required the treatment should be afforde a public hospital, psychiatric unit or in a mental hospital, excep cases which can more appropriately be treated in a special psyc hospital.

Item (iv) of Order of Reference – "The allocation of respon hospital boards and the Mental Hygiene Division of the D of Health for staffing psychiatric services in public hospita

For some years past, the Mental Hygiene Division has second trists to hospital boards for the treatment of both inpatients and and these have acted as consultants to the hospital staff. This has b valuable service, especially in provincial areas where but for thi there would have been no psychiatric services available to the com those areas. It is in every way desirable that this happy and relationship should continue, but at this point your Committee against a difficult problem; one that concerns the difficulty of into the proposed expanded public hospital psychiatric service, of number of psychiatrists, whether whole time or part time, and a time recruitment of sufficient psychiatrists to maintain an adeq for patients in our mental hospitals.

It is estimated that a period of several years must elapse be hospitals are able, even if they so wish, to staff these proposed u the needs of their patients independently of the Mental Hygien Therefore many hospitals in this country for some time to com to continue to depend upon the Mental Hygiene Division sta limited service they can afford.

While the Committee supports the idea of psychiatric unit hospitals, it is conscious of the fact that even if the Division relieved of much responsibility in this respect, the present staffi of the Division is such that this relief would merely enable t reasonably to give more time to patients under its immediate con

In considering the allocation of responsibility between pub and mental hospital staff in the operation of these psychiatric Committee was mindful of the need to provide the service w be most beneficial to all persons suffering from mental illnes Zealand, as previously stated, officers of the Mental Hygiene D have endeavoured to keep in close contact with overall trends in medicine by treating patients in general hospitals as well as under their direct control in mental hospitals. It must also be that a case being treated in the first instance at a public hospita unit may not respond or may later relapse and exhibit symp demand therapy in a mental hospital. The reverse may also a a patient discharged from mental hospital may later be treated hospital unit.

It seems to your Committee, therefore, that it is neither pr desirable either in the interest of patients or in the broad

psychiatric medicine to divorce the two services. It is considered essential that the officers of the Mental Hygiene Division should continue to share in the work of public hospital psychiatric units, and the Committee is also of the opinion that psychiatrists employed by hospital boards could, with advantage, share in the work of the Mental Hygiene Division.

The question then is how can this desirable integration of the two services best be accomplished to give a comprehensive service to patients as one unit. The key to any future development of psychiatric services in this country is staff, medical and ancillary, both in mental hospitals and general hospitals. Although public hospitals may recruit their own medical staff, this does not imply any departure from the principle already recommended of integrating the services of Mental Hygiene Division psychiatrists with the general hospital service. However, it is obvious that little can be achieved until a far greater number of psychiatrists are available to work in the New Zealand psychiatric field. It is therefore imperative that conditions of employment in the Mental Hygiene Division and the public hospital service be such as to jointly attract New Zealand graduates for training.

To summarise, the implementation of all of the foregoing recommendations must depend on the provision of additional qualified personnel. Unless more psychiatrists become available, either through training in our own medical school or by importation from abroad, the present serious deficiencies in these services must remain and even become more serious than they are at present. Doubtless there are several measures which could be adopted with a view to encouraging more graduates to specialise in psychiatry, such as the award of more special bursaries and more provision for overseas training and other measures. Collaboration between the medical school on the one hand and the Division of Mental Hygiene on the other could very well assist in this urgent problem.

It is recommended that this matter be referred to the University of Otago and the Director-General of Health for study and for the formulation of proposals which may assist in this matter.

Item (v) of Order of Reference – "Such other matters as appear to come within this field."

(a) *Appreciation of the Needs of Those Suffering from Mental Illness:* Believing that there is an insufficient appreciation throughout the country and even in the medical profession of the true needs of the psychiatric patient, living in his own home or a patient of a public hospital, and of the magnitude of this problem, the Committee recommends that much more should be done through the British Medical Association, by popular broadcasts and by any other means available to bring home firstly to the profession and secondly to the community generally a more realistic knowledge of the needs of those suffering from mental illness.

It is hoped that newly formed mental health associations will help to nurture this awareness as such organisations as Alcoholics Anonymous, the Intellectually Handicapped Childrens' Parents Association, and the Tuberculosis Association have done in their spheres. Much help can be given by

the Department of Health and the British Medical Associatio
tunately there is still a stigma attachable to mental illness and a
to accept any mental basis for illness.

On the other hand, care must be taken not to allow the com
become psychiatrically over conscious and find itself in the p
regarding simple psychological problems as indicative of illness.

(b) *Psychiatric Social Workers:* There is also a marked neec
trained psychiatric social workers. It appears that the course in
at the Victoria University of Wellington aims at training soci
rather than psychiatric social workers. This deficiency is recogni
object of the university is merely to produce a social worker. T
such a student into an adequately trained psychiatric social work
one further year's training is required, but at the present time the
to be no educational facilities available for such a purpose in Ne
This type of training in Britain is associated with selected universi
under the organisation and administration of the Association of
Social Workers. It is very desirable that this type of training
provided through one or other of our university colleges assist
using the psychiatric department of a metropolitan hospital and/o
mental hospital in the neighbourhood of the university.

(c) *Clinical Psychologist:* To complete the team of specialists
referred to there is the clinical psychologist. The Committee u
that in one of our university colleges a course of training in clinic
ogy has recently been undertaken.

(d) *The Worthing Experiment:* In the course of our inquiries
ing experiment, an English scheme, was explained to us and
interested and attracted by what it has set out to accomplish. The
is a two-year pilot scheme which commenced on 1 January
mental hospital of the area, Graylingwell Hospital, is responsib
ducting the scheme. The object is to test the possibilities of pr
outpatient and domiciliary treatment service for psychiatric patie
view to cutting down on the necessity for admission to mental ho
headquarters of the service are housed in a 20-bed unit which i
treatment centre and day hospital. No patients are resident. Care
ment is also given to patients in their home by way of a domicilia
nursing, and social worker visiting service. Through this unit all
patients from the area are screened to determine the necessity fo
to the mental hospital. The unit is staffed by the Graylingwe
but the staff are resident in Worthing itself. This experiment se
to be a success and preliminary reports show a marked decline, al
60 per cent, in admissions from the area to Graylingwell Menta
The catchment area of the experiment has a population of 160,0
tant prerequisites for success are good public relations with full
by the community of mental illness as just another type of
nothing else, cooperation from the patients, full support from
practitioners of the area, and full support and understanding in
The Committee feels that the Board of Health will wish to
interesting experiment under its observation with a view to a

New Zealand such elements of the experiment as may appear to be suited to the needs of this country.

(e) *Care of Senile Patients:* The Committee draws attention to the fact that it has regarded senile patients as falling completely outside its inquiry, except to the extent that such patients, in the ordinary course, if confused mentally, come under the attention of the public hospital psychiatric unit.

VII. SUMMARY OF CONCLUSIONS AND RECOMMENDATIONS

(1) It is obvious that there are serious deficiencies in the psychiatric services available in New Zealand, as indicated in this report.

(2) As a first step, subject to staff being available on an equitable basis, it is recommended that immediate steps be taken to establish psychiatric beds in Auckland, Wellington, Christchurch, and Dunedin of a minimum of 14 beds per 100,000 of population of the area to be served.

(3) It is recommended that psychiatric inpatient units should be established in certain other centres, again subject to availability of staff, to cover their own and contiguous hospital districts. These units should be of a minimum of 14 beds per 100,000 of the regional population to be served.

In the first instance the Committee suggests that provision for base psychiatric units be included in the hospital development plans of Waikato, Napier, New Plymouth, Palmerston North, Timaru, and Invercargill hospitals.

(4) In the above centres a psychiatric outpatient service should be established concurrently with the inpatient unit, as one unit, to relieve pressure on both public hospital psychiatric beds and mental hospital beds by providing outpatient treatment, and ultimately domicilliary care, in appropriate cases.

(5) Staffing establishment of these psychiatric units is recommended in Section VI of this report (pages 15–16).

(6) In the four centres specified in (2) above separate child psychiatric units providing both inpatient and outpatient facilities should be established as child psychiatrists become available. In other centres it is envisaged that separate child psychiatric units will not be possible for some time to come.

(7) In order to obtain the necessary staff to administer the services recommended a vigorous staff recruitment programme will need to be added to the staff recruitment scheme of the Mental Hygiene Division.

(8) A close integration of mental hospital and public hospital staff within the public hospital psychiatric units is essential. The administration of the units should be a function of the hospital boards, but the Mental Hygiene Division staff should play a full part in the operation of the service on secondment to the hospital board either on a full-time or part-time basis. Similarly, public hospital psychiatrists should take part in the activities of the Mental Hygiene Division.

(9) There is a definite need for a more realistic understanding by the public and the medical profession itself of the needs of persons suffering from mental illness. A dissemination of knowledge of the various types of

mental illness should lead to an early and more accurate diagnosis
illness by general medical practitioners. Such a general understanc
felt, may even prevent the onset of mental illness and contribu
maintenance of good mental health. Some suggestions in that re
made in Section VI (pages 16–17).

(10) As the Committee recommends the establishment of publi
psychiatric units, it is considered that, except perhaps for psychc
hospitals, such as Queen Mary Hospital at Hanmer, there is no
institutions intermediate between the public hospital and the menta
There may, however, be a case for the provision of homes for the
confused", but the care of senile patients has not been taken
within the Committee's order of reference.

(11) If at all practicable, and the Committee does not feel com
make firm recommendations in this respect, the compulsory leg
over-riding the normal personal rights of the mentally ill should b
while still preserving essential safeguards.

(12) Reference is made to the Worthing experiment on the
of mental illness in Section VI (pages 22–23). It is suggested
Board of Health might well keep this experiment under observa
a view to the adoption of such proven elements of it as may be
the needs of this country.

P. V. E. STAINTON, Ch
W. E. BATE, Member.
W. IRONSIDE, Member.
R. G. T. LEWIS, Membe
C. A. TAYLOR, Member.

APPENDICES

APPENDIX A. Statistical Summary Showing the Extent of the Present Psychiatric Services Provided in Public Hospitals

Hospital Area and Population	Psychiatric Inpatient Beds	Number of Inpatients Discharged		Number of Outpatient Clinics per Month	Outpatient Attendances, 1957		Number of Psychiatrists Employed	Number of Hours of Psychiatric Attention Each Month
		To Home	To Mental Hospital		Number of Patients	Number of Attendances		
Northland (83,000)	..	..	..	½	*	*	1	..
Auckland (450,510)	24	315	32	20	408	580	5	124
Waikato (204,000)	..	*	*	8	167	174	1	*
Tauranga (34,000)	..	*	*	1	10	14	1	*
Taumarunui (14,810)	..	..	..	..	..	..	..	..
Cook (34,310)	..	15	7	..	..	..	..	..
Wairoa (11,850)	..	15	*	..	..	..	..	..
Waipawa (13,340)	..	12	3	..	..	..	..	..
Dannevirke (13,000)	..	10	5	..	..	..	..	..
New Plymouth (51,000)	..	94	14	8	120	432	*	*
Patea (6,800)	..	..	4	..	..	..	..	..
Nelson (46,710)	..	6	10	4	176	176	1	14
Wanganui (60,000)	..	*	6†	..	..	..	..	..
Palmerston North (86,372)	..	75	30	4	203	276	1	14
Wairarapa‡ (40,000)	..	..	..	..	..	..	..	..
Wellington (232,900)	15	283	162	12	239	452	3	40
Marlborough (26,000)	..	21	7	..	..	..	..	..
Inangahua (3,500)	..	..	..	..	..	..	..	..
Grey (20,000)	..	40	30	2	150	*	1	7
North Canterbury (250,000)	3	11	15	8	177	334	1	12
Ashburton (21,000)	..	*	*	1	45	67	1	4
South Canterbury (55,000)	..	*	*	1	*	*	1	3½
Waitaki (20,000)	..	1	7	1	44	102	1	3½
Otago (120,000)	25	273	130	56	525	3,883	5	224
Southland (86,000)	10	*	*	1½	*	*	1	11

*No information. †Approximately. ‡Return not completed.

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