Differential Pay Scale for Psychiatric and Psychopaedic Nurses

First Report of
The Royal Commission of Inquiry
into
Hospital and Related Services

Wellington
December 1972

THE ROYAL COMMISSION OF INQUIRY INTO HOSPITAL AND RELATED SERVICES

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Royal Commission to Inquire into and Report Upon Hospital and Related Services

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ELIZABETH THE SECOND, by the Grace of God of the United Kingdom, New Zealand, and Her Other Realms and Territories Queen, Head of the Commonwealth, Defender of the Faith:

To Our Trusty and Well-beloved CHARLES PIERREPONT HUTCHINSON, Esquire, M.B.E., of Auckland, Queen's Counsel, JAMES RICHARD CROPPER, Esquire, of Auckland, company director, WILTON ERNEST HENLEY, Esquire, C.B.E., of Auckland, medical superintendent-in-chief, JOHN TURNBULL, Esquire, O.B.E., of Wellington, retired secretary, and IONA WILLIAMS, of Dunedin, married woman.

GREETING:

KNOW ye that We, reposing trust and confidence in your integrity, knowledge, and ability, hereby nominate, constitute, and appoint you, the said

CHARLES PIERREPONT HUTCHINSON, M.B.E.;
JAMES RICHARD CROPPER;
WILTON ERNEST HENLEY, C.B.E.;
JOHN TURNBULL, O.B.E.; and
IONA WILLIAMS

to be a Commission to receive representations upon, inquire into, investigate, and report upon the existing facilities and the future requirements for hospital and related services for New Zealand and the resources to provide such services, and to recommend such measures as you believe will ensure adequate provision of such services, and, in particular, but without restricting the generality of the foregoing, to receive representations upon, inquire into, investigate, and report upon the following matters:

1. The plans, policies, and programmes of the Department of Health, Hospital Boards, and other hospital and related agencies for dealing with the treatment, care, and rehabilitation of hospital patients, including the provision of specialist, out-patient, day hospital, and domiciliary services, and the need, if any, for changes in such plans, policies, or programmes.

2. The functions, powers, responsibilities, and interrelationships of the Department of Health, Hospital Boards, and other hospital and related agencies, and the need, if any, for changes in geographical areas of responsibility, or in the functions, constitutions, or powers of such bodies in relation to the said services.

3. The organisation and scope of the hospital services in relation to medical care work carried out by non-hospital agencies, including medical practitioners, and the need, if any, for changes in relationships, particularly in the light of developments such as the emergence of health centres and group medical practice, and particularly also in respect of the provision of hospital treatment for maternity patients.

4. The relationship of hospital services with the preventive aspects of medicine including the public health services, and the need, if any, for closer integration of these services.

5. The financing of hospital and related services, including those provided by private hospitals and welfare agencies, and the need, if any, for changes in the system of finance or methods of control over expenditure, including the sources from which and the means by which any such services should be financed.

6. The provision of buildings and other physical facilities for the housing or treatment of patients in all classes of hospitals, including the inter-relationship of such facilities and also their relationship with other medical care facilities, and the need, if any, for changes in policies or programmes in relation thereto.

7. The existing medical, nursing, para-medical, and other staffing provision for hospitals and the adequacy of such provisions, and the need, if any, for changes in any of these matters.

8. The administration of hospital services, and, in particular, the organisation of hospital work, the management and training of staff (otherwise than for the purpose of obtaining registrable qualifications), the provision of staff accommodation and amenities, the use of modern methods and techniques and aids to management, and the need, if any, for changes in respect of any of those matters.

9. In respect of nursing, the justification, if any, for a differential pay scale in favour of—

(a) Psychiatric and psychopaedic nurses as such over other kinds of nurses; or

(b) All nurses employed in psychiatric or psychopaedic hospitals over nurses employed elsewhere,—

on the grounds of job content or responsibility, conditions of work, or for any other reasons.

10. Any amendments that should be made to existing legislation to promote improvements in any of the aforesaid matters.

11. Any associated matters that may be thought by you to be relevant to the general objects of the inquiry.

And We hereby appoint you the said

CHARLES PIERREPONT HUTCHINSON, M.B.E.,

to be Chairman of the said Commission:

And for the better enabling you to carry these presents into effect you are hereby authorised and empowered to make and conduct any inquiry or investigation under these presents in such manner and at such time and place as you think expedient, with power to adjourn from time to time and place to place as you think fit, and so that these presents shall continue in force and any such inquiry may at any time and place be resumed although not regularly adjourned from time to time or from place to place:

And you are hereby strictly charged and directed that you shall not at any time publish or otherwise disclose, save to His Excellency the Governor-General, in pursuance of these presents or by His Excellency's direction, the contents of any report so made or to be made by you, or any evidence or information obtained by you in the exercise of the powers hereby conferred on you, except such evidence or information as is received in the course of a sitting open to the public:

And it is hereby declared that the powers hereby conferred shall be exercisable notwithstanding the absence at any time of any one or any two of the members hereby appointed so long as the Chairman or a member deputed by the Chairman to act in his stead, and two other members are present and concur in the exercise of the powers:

And We do further ordain that you have liberty to report your proceedings and findings under this Our Commission from time to time if you shall judge it expedient to do so:

And, using all due diligence, you are required to report to His Excellency the Governor-General in writing under your hands,—

(1) Not later than the 31st day of December 1972 your findings and opinions on the matters in clause 9 of the aforesaid terms of reference;

(2) Not later than the 30th day of June 1973 your findings and opinions on the matters aforesaid so far as they relate to psychiatric services;

(3) Not later than the 30th day of June 1974 your findings and opinions on the other matters aforesaid,—

together, in each case, with such recommendations as you think fit to make in respect thereof:

And, lastly, it is hereby declared that these presents are issued under the authority of the letters patent of His Late Majesty King George the Fifth, dated the 11th day of May 1917, and under the

authority of and subject to the provisions of the Commissions of Inquiry Act 1908, and with the advice and consent of the Executive Council of New Zealand.

In witness whereof We have caused this Our Commission to be issued and the Seal of New Zealand to be hereunto affixed at Wellington this 28th day of February 1972.

Witness Our Right Trusty and Well-beloved Cousin, Sir Arthur Espie Porritt, Baronet, Knight Grand Cross of Our Most Distinguished Order of Saint Michael and Saint George, Knight Commander of Our Royal Victorian Order, Commander of Our Most Excellent Order of the British Empire, Governor-General and Commander-in-Chief in and over New Zealand.

ARTHUR PORRITT, Governor-General.

By His Excellency's Command—

J. R. MARSHALL, Prime Minister.

Approved in Council—

P. J. BROOKS, Clerk of the Executive Council.

Letter of Transmittal

To His Excellency Sir Edward Denis Blundell, Knight Grand Cross of the Most Distinguished Order of Saint Michael and Saint George, Knight Commander of the Most Excellent Order of the British Empire, Governor-General and Commander-in-Chief in and over New Zealand.

MAY IT PLEASE YOUR EXCELLENCY

By Warrant dated 28 February 1972 we the undersigned CHARLES PIERREPONT HUTCHINSON, JAMES RICHARD CROPPER, WILTON ERNEST HENLEY, JOHN TURNBULL, and IONA WILLIAMS were appointed to report not later than 31 December 1972 our findings and opinions on the matters in Clause 9 under the terms of reference stated in that Warrant.

We now humbly submit our report for Your Excellency's consideration.

We have the honour to be

Your Excellency's most obedient servants,

C. P. HUTCHINSON, Chairman.
J. R. CROPPER, Member.
W. E. HENLEY, Member.
J. TURNBULL, Member.
I. WILLIAMS, Member.

Dated at Wellington this 1st day of December 1972.

Chapter I. INTRODUCTION

GUIDING PRINCIPLES

Terms of Reference

1. This report is made in accordance with that provision in our Warrant which requires us to report

> "Not later than the 31st day of December 1972 your findings and opinions on the matters in clause 9 of the aforesaid terms of reference."

Clause 9 reads—

> "In respect of nursing, the justification, if any, for a differential pay scale in favour of—
>
> "(a) Psychiatric and psychopaedic nurses as such over other kinds of nurses; or
>
> "(b) All nurses employed in psychiatric or psychopaedic hospitals over nurses employed elsewhere,—
>
> on the grounds of job content or responsibility, conditions of work, or for any other reasons."

2. Clause 9 itself gives no indication of the principles which should guide us in inquiring into and reporting on this particular matter. But the clause is only part of our Warrant, and is itself governed by the main directive clause which requires us "to recommend such measures as you believe will ensure adequate provision of [hospital and related] services".

3. This directive to ensure adequate provision of services is reinforced in clause 7 which requires us to report on "The existing . . . staffing provision for hospitals and the adequacy of such provisions, . . ." Clause 10 requires us to report on "Any amendments that should be made to existing legislation to promote improvements in any of the aforesaid matters".

4. If we except a reference in clause 4 to "the need, if any, for closer integration" of hospital services with the preventive aspects of medicine, the references quoted in the preceding paragraphs are the only ones in which our Warrant seeks to direct the course of our inquiry. We are not, for instance, specifically asked to recommend ways of providing hospital and related services economically; we are left to give such emphasis to this and other matters as the course of our inquiry may suggest. But we are specifically required to "ensure adequate provision".

5. From this we infer that in considering nursing, and what justification there may be for a differential pay scale, our guiding principle must be to ensure the adequacy of nursing services and, if possible, to improve their standard.

Wage Fixation

6. We are dealing in this report with the pay scales of nurses. There are principles which have to be observed in dealing with or determining the remuneration of employees, and as nurses in both psychiatric and general hospitals are employed in the State services as defined in the "State Services Remuneration and Conditions of Employment Act 1969" we turned to that Act for further light on the principles which should guide us.

7. The relevant provisions are contained in section 6 of the Act:

"(1) In prescribing pay scales . . .

"(a) The aim shall be to set for each occupational class a pay scale which will enable the State to recruit and retain an efficient staff, will take account of special responsibilities or conditions applying to employment in the occupational class, and will be fair to the tax paying public and to employees in the State services.

"(2) . . . the rewards of employment in the State services shall be kept broadly in line with those of employment outside the State services.

"(3) . . . regard shall be had to the following criteria:

"(a) External comparability . . .

"(b) Vertical relativity . . .

"(c) Horizontal relativity . . .

"(d) Recruitment and retention, being the need to attract, and to hold at all levels of that occupational class, enough staff of sufficient competence to ensure efficiency and the adequacy of the current pay scale for these purposes."

8. We see nothing here that is in conflict with the guiding principle which we believe our Warrant imposes—to ensure the adequacy and, if possible, improve the standard of nursing services. Indeed, the words "recruit and retain an efficient staff" and "enough staff of sufficient competence to ensure efficiency" reinforce that principle. Adequate service can be given only by a staff that is adequate in numbers and in competence. The other matters referred to, special responsibilities or conditions and fairness to the tax paying public and to employees, have also been given due weight in our deliberations.

9. Section 6 is directed to State employing authorities—in this case the Director-General of Health—and to various tribunals. But we must consider the fact that employees also are involved and that it is a well accepted principle in this country that wages shall be freely negotiated between employers and employees and be subject to arbitration if agreement is not reached. It is true that Government exercises the right to place certain restrictions on this freedom of

negotiation but the principle nevertheless stands. The 1969 Act prescribes machinery for putting the principle into effect in the State services.

10. Observance of this principle has a special implication for us. Our report and our recommendations are made to His Excellency the Governor-General. In effect our advice is to the Government which has here two functions—to provide the nursing services and to employ the nurses—both through statutory agencies. But we are well aware that before any Government decision can be translated into action it must be subject to negotiation and possibly arbitration. The implication for us is that although we must be guided primarily by the need to ensure the adequacy of the nursing services we must bear in mind that decisions arising from our recommendations will eventually be reached by different people, in different circumstances, and possibly on different grounds. We have therefore made recommendations which are intended to keep the adequacy and quality of nursing services in the foreground when decisions are eventually being made.

Other Statements of Principle

11. We have considered whether the principle accepted by the medical profession that no salary distinction should be made between the various specialties should be applied to the closely related nursing profession. But we cannot see that for our purposes it has the force of a principle; it is a consideration to be weighed in its impact on our primary aim of ensuring the adequacy of nursing services.

12. It was also put to us that to differentiate in salary scales between two kinds of nursing was to breach the widely held principle of the essential unity of the nursing profession—that "nursing is nursing". On the face of it this is an attractive proposition. But the terms of our Warrant require us to look at considerations which may or may not justify a differential pay scale; we cannot accept as a guiding principle a proposition which virtually prejudges the issue.

The Social Value of Care of the Sick

13. Being satisfied, as we are, that the primary aim required of us is to ensure the adequacy of nursing services, we still have to determine what is "adequate". This question will no doubt receive close attention in the later stage of our inquiry when we examine the whole range of hospital and related services. We will be confronted with the problem of the availability of finance and other resources. But on the question of a pay differential we received little guidance as to what should constitute an adequate nursing service.

Indeed there seemed rather to be a contest of inadequacies, with the shortage of nursing staff in both general and psychiatric hospitals being emphasised.

14. Nurses are educated, qualified, and employed to care for patients. The community decides what standard of care it wants and is prepared to pay for. We are in no doubt that the community wants the highest possible standard of nursing care for all patients. This is attested to, not only by the submissions made to us, but by the attitudes of the public and the press during recent controversies. We are convinced that the public places a very high value on the care of the sick, mainly for humanitarian reasons, but also because good health enhances the quality of life of both the individual and the community whereas ill health has adverse economic consequences for both. We are not required at this stage to determine the order of priority which the community gives to health, education, law and order, and other objectives. It is sufficient to know that the community would not tolerate any avoidable diminution of the nursing care of the sick.

15. We are thus able to translate the language of our Warrant into a statement of principle which is apposite to the limited subject of this part of our inquiry and our report. We must regard as good that which will ensure the best care of the sick, and as bad that which will endanger or detract from it.

THE CIRCUMSTANCES LEADING TO THE INQUIRY

16. The question of what relationship there should be between the salaries of nurses in general and psychiatric hospitals has only recently become an issue in New Zealand. Historically there has been no direct relationship. We have used here the term "psychiatric" as including "psychopaedic" and we adopt this practice throughout the report unless the text demonstrates otherwise.

17. General hospitals have traditionally been run on a local basis, employing and training their own nurses. Only in the last 30 years have the various hospital boards used a nationally determined salary scale for the nurses whom they employed.

18. Until the Second World War only women were employed as nurses in these general hospitals. Thus the salary scales were devised for women, and the rate offered was influenced by the attitude that nursing was a vocation which enabled women to render a service to humanity. The idea that hospitals needed to compete on the labour market for suitable staff played little part, until recent years, in the determination of the salary scales.

19. By contrast, early local authorities made little attempt to care for the mentally ill. Mental hospitals were developed and run by provincial and central governments. The emphasis was on the custody of those who could not be left at liberty in the community. Mature men, not young girls, were required for this work, and the wages paid were not even thought of as being related to "nursing". The supervision of patients doing farm or domestic work, and even their instruction in such work had only an incidental therapeutic value. Women as well as men were employed as "attendants", but the main job content was custodial and domestic.

20. Important changes took place in later years and more especially after the Second World War. Developments in medicine placed heavy demands on the general nurse and required more intensive and specialised education. In the psychiatric hospitals the changes were more fundamental. Great advances were made in the understanding and practice of psychiatry—and not least in its acceptance—while convulsive- and chemo-therapy started to change the emphasis of care from custodial to curative. The attendant became a therapist and was called a nurse.

21. In the light of these developments, the traditional separation of psychiatric from general hospitals began to be questioned. General hospitals started to treat patients for psychiatric disorders, either as agents for the State psychiatric hospitals or on their own responsibility. The possibility of integrating the two systems was examined.

22. In 1945 the Nurses and Midwives Board (now the Nursing Council) took over the responsibility for the registration of mental health nurses, a responsibility which it had exercised for general nurses since 1925. School Certificate become the minimum entrance qualification for general nurse trainees in 1966 and for psychiatric nursing trainees in 1970. The qualification age, and therefore the trainee entrance age, for the latter had earlier been lowered to correspond with that for general nurses.

23. The existence of two different salary scales for two kinds of nurses was also questioned but did not become an issue until the last 5 years. Clearly psychiatric and psychopaedic nursing now have much more in common with general nursing than ever before; they are often practised side by side. The Department of Health favours the fullest possible institutional integration and on 1 April 1972 transferred psychiatric hospitals to the control of hospital boards. It sees the continued existence of separate pay scales as a barrier to that integration.

24. Although the 1960 State Services Equal Pay Implementation Committee took regard in dealing with public hospital rates to what it

was recommending for psychiatric nurses, the State Services Commission and the Department of Health were not, even in 1963, valuing the two nursing professions one against the other. Opposing a claim made to the Government Service Tribunal for increased psychiatric nursing salaries, the State Services Commission insisted that the correlation with indentured tradesman's rates was correct, and the Government member and assessor, in dissenting from the majority decision, said "There was some evidence that the duties [of psychiatric nurses] were changing but change does not necessarily involve increased valuation—indeed, as was pointed out, new treatments and improved methods may even lighten the burden carried by nurses".

25. But by 1967-68 the emphasis had changed. The State Services Commission opposed a Public Service Association claim on the grounds "That the salaries paid to Mental Health nursing staff are already higher than warranted in relation to those paid to General nurses. It follows that the granting of any further increases to Mental Health Nurses, however small, will aggravate the present imbalance and could cause unrest in the General Nursing field." The burden of the Commission's case was that general and psychiatric nursing were closely comparable.

26. The Public Service Association claimed that a differential in favour of the psychiatric nurse was justified but opposed the State Services Commission's attitude principally on the grounds that the salary scale for general nurses was determined by the Government without proper conciliation or arbitration and that general hospital rates had "been determined by comparison with Mental Hospital Nurses' rates." This particular case was never concluded.

27. It is by no means clear to what extent psychiatric hospital rates had been taken into account in fixing general hospital rates, but the State Services Commission told us that when psychiatric nurses obtained a salary increase in 1966, "In view of the relationship . . . it is almost certain that the increase granted to the psychiatric nurses would have spread to general nurses had it been sought. However, no claim was made."

28. Whatever the reasons for making no claim in 1966, the body representing general nurses, the New Zealand Nurses' Association, made its attitude known after the State Services Remuneration and Conditions of Employment Act was passed in 1969 giving that association access to State services conciliation and arbitration machinery. In February 1970 the Public Service Association lodged a new salary claim and the Nurses' Association did likewise. Although the latter claim was based on the value of nursing as a profession, the association

disputed the Public Service Association claim for a differential in favour of psychiatric nursing. The two organisations negotiated concurrently, but separately, with the State Services Co-ordinating Committee and the Government; the Public Service Association seeking continued recognition of the "mental health lead", which it claimed had been established, and the Nurses' Association "making strong representations for salary parity with psychiatric nurses". We understand that the Nurses' Association did not pursue a claim for parity for trainees.

29. In 1971 the employing authorities offered a virtually identical salary scale for registered nurses to both associations. This gave salary increases to both groups, but larger increases to general nurses to bring about parity. The general nurses accepted but the psychiatric nurses declined the offer. Indeed in some hospitals they withdrew their services in June 1971, and although other reasons for doing so were claimed, we received some evidence that the salary development played a part in at least "triggering" this action.

30. A temporary settlement of the dispute was reached on terms which are set out in a letter dated 13 August 1971 from the then Prime Minister to the Public Service Association president. One of the terms was that "the principle of a 'lead' should be considered by a Commission of Inquiry" although the amount of any such lead, failing agreement in negotiation "is a matter for decision finally by the State Services Tribunal". Meanwhile the previous differential was restored, being paid as an allowance from 1 January 1972 until the matter is finally settled.

31. The Prime Minister's letter is silent on what would happen if it were finally decided that the "lead" was not justified. On the face of it the existing allowances would be discontinued, but this does not seem to be what is contemplated. Certainly no suggestion has been made to us that general nurses' salaries should be increased to bring about parity, but it was suggested that psychiatric nurses should have a "pay pause" until such time as general nurses' salaries came into line through the addition of, for example, cost of living increases. Thus, psychiatric nurses currently receiving the differential would not suffer an actual cut in their take-home pay but they would not receive in full the normal salary adjustments.

32. It is against this background that our Warrant requires us to inquire into the justification, if any, for a differential pay scale in favour of psychiatric and psychopaedic nurses or of nurses employed in psychiatric or psychopaedic hospitals. As we have shown, the matter could as easily have been approached in another way; we could

have been asked to inquire into the justification for the claim that general nurses should have parity in pay scales with psychiatric and psychopaedic nurses.

THE DISTURBANCE OF RELATIVITIES

33. It was strongly suggested to us during this inquiry that psychiatric nurses would be greatly disturbed if the differential in their favour were taken away. They would see this as a down-grading, and as indicating a lack of appreciation of the value of their work. Countering this it was urged that the differential was an historical accident, and had never been awarded by any wage-fixing authority. It was also suggested that removing the differential would indicate that psychiatric nursing was more highly regarded than before, and no longer needed an additional incentive.

34. Wage relativities are not sacred. No one entering a trade or profession can or should be guaranteed that the skills acquired will always be valued more or less than other skills. In a free market rates tend to adjust to supply and demand. In a controlled situation such as we are dealing with, the authorities must ensure that relativities are changed only for good and sufficient reason. Nevertheless we are aware that, to those directly affected, relativities have an importance which others may not appreciate. Their disturbance, however well justified, may have repercussions which cannot be ignored.

35. There is no doubt that a differential does exist in favour of psychiatric nurses. But it is by no means clear that this has always been so between female nurses. Comparative salary scales back to 1949 were produced, but these by themselves can be misleading. Provisions for the payment of board or rent, for overtime and penal rates, and for leave would have to be quantified before true comparisons in effective remuneration could be made.

36. As recently as 1963 the Public Service Association claimed before the Government Service Tribunal that male staff and charge nurses in general hospitals had higher wage rates than their counterparts in psychiatric hospitals. The State Services Commission countered this with the claim that the rate for the general hospital included a loading in lieu of penal time.

37. In any case we do not propose to be bound by the past. Supposing a competent wage-fixing authority had declared 30, 20, or even 10 years ago that a differential was justified one way or the other, this would not be conclusive today. The work required of both general and psychiatric nurses has without doubt become more skilled and more valuable to the community and we are concerned with matters which will affect the quality of nursing care now and in the foreseeable future.

LIMITATIONS OF THE INQUIRY

38. Our Warrant requires us to inquire into the justification, if any, for a differential pay scale. It makes no mention of the amount of any such differential, or of at what points in the scale the differential should be effective. The inference taken by the Public Service Association was "that it is the principle of the margin that is to be considered by the Royal Commission and not the quantum".

39. This interpretation is supported by the Prime Minister's letter of 13 August 1971 (*vide* para. 30) which stated that ". . . the principle of a 'lead' should be considered by a Commission of Inquiry", and that it had been agreed "that the amount of any such lead is a matter for decision finally by the State Services Tribunal, should agreement not be possible in negotiation with the employing authority". The tribunal may in fact have the final say on whether there should be any "lead", and in whose favour, irrespective of what we may say.

40. But the principle and the amount are not so easily separated as may have appeared. This, we think, is borne out by an examination of the existing effective salary scales, which show what the "lead" amounts to and where it applies (*see* table 1).

Table 1

SALARY RATES ON 31 JANUARY 1972

Position	Psychiatric/ Psychopaedic Nurses in Psychiatric Hospitals	General Nurses in Public Hospitals	Differential	Difference
	$	$	$	%
Supervising charge nurse	4,479	4,381	98	2.2
Supervising sister	4,351	4,236	115	2.7
Charge nurse	4,201	4,083	118	2.9
Ward sister	4,049	3,987	62	1.6
Staff nurse/sister	4,018*	—	N.A.‡	
Yearly increments	3,879	3,670	209	5.7
	3,729	3,550	179	5.0
	3,484	3,322	162	5.0
Student or trainee nurse	—	3,022†	N.A.	
Commencing rates vary with age and qualification	3,122	2,747	375	13.7
	2,916	2,535	381	15.0
	2,732	2,275	457	20.0
	2,438	2,015	423	21.0
	2,229	1,820	409	22.5

*Merit step after 4 years' satisfactory service on the top step.

†Fourth year step for student nurse who commenced employment with a university degree accepted by the Director-General of Health.

‡Not applicable.

NOTES—

(i) For grades above these positions for which direct comparisons can be made, there is no salary differential between psychiatric and general nurses except for assistant matrons. For example, a first assistant matron of a public hospital with 351-600 occupied beds receives a salary advantage of $97 on the first step and $110 on the second step above the assistant matron or assistant head nurse, grade I, in a psychiatric hospital. The relative rates are $5,094 against $4,997 and $5,301 against $5,191.

(ii) The salaries for registered general nurses working in psychiatric hospitals are, with minor variations, the same as those shown for general hospitals.

(iii) The position in psychiatric units in general hospitals is somewhat different and is discussed in chapter III.

41. Table 1 shows that the differential is greatest during the training period and ranges from 14 to 22.5 percent. It is reduced to between 5 and 6 percent after training is completed; it is reduced again when a charge position is obtained; and it disappears in the higher echelons.

42. What Table 1 does not show is that there is *no differential* for psychiatric hospital employees apart from psychiatric nurses. The differential does not extend to doctors, physiotherapists, occupational therapists, community nurses, hospital aides, or domestic employees.

43. We will consider these anomalies, if such they are, in chapter III. But at this stage we wish to point out that it will be difficult to justify a differential without taking some account of its application.

44. Our Warrant refers only to "a differential pay scale". As we have already observed, apparent differences or similarities in pay scales cannot be taken at their face value if other conditions vary. For example, the same weekly wage is not in fact the same if one worker receives extra for hours worked at the weekend, and another does not; and there is a difference, even though annual salaries are equal, if one person works 1,800 hours for that salary and another works 2,000 hours. Thus we interpret the words "pay scale" in our Warrant to cover remuneration generally and to include allowances and other emoluments or charges for rent or board if differences in these are great.

Differentials Other Than Pay

45. There are many differences between the conditions which applied to psychiatric hospital nurses, as State employees before 1 April 1972, and those which applied to general nurses employed by hospital boards. Most of these cannot be regarded as part of the "differential" which concerns us, but there are five that may be so regarded.

(i) Board and lodging—For nurses in psychiatric hospitals this was approximately $1 per week less than in general hospitals.

(ii) Meals—These were cheaper in psychiatric hospitals for staff on duty: 34c for dinner as against 50–80c or more; 16c for breakfast and lunch as against 35–40c.

(iii) Penal rates (at T$\frac{1}{2}$)—These applied to all ordinary hours worked on a Saturday in psychiatric hospitals, but in general hospitals applied only to hours worked after midday on Saturday.

(iv) Overtime limits—No annual limit was placed on the amount of overtime that could be earned by psychiatric nurses in psychiatric hospitals, but there were limits in general hospitals.

(v) In psychiatric hospitals these increased to T2 after 3 hours per day, whereas hospital board rates continued at T1$\frac{1}{2}$.

46. As we understand the position:

- Some of these advantages were shared by some staff in psychiatric hospitals including general and community nurses, who did not enjoy any differential in pay.
- These advantages are still enjoyed by psychiatric nurses seconded to psychiatric units in general hospitals before 1 April 1972.
- These advantages will *not* be enjoyed by staff appointed to psychiatric hospitals after 1 April 1972, even though they may qualify for differential pay.

Registration

47. Clause 8 of our Warrant specifically excludes matters pertaining to the obtaining of registrable qualifications. Although we are not required to report on these, we must take account of the existing conditions under which registrable qualifications are obtained in order to assess some of the grounds on which differential salaries are supported or opposed. We have also been asked to take note of proposed changes, and this we do in chapter IV.

THE PROPRIETY AND TIMING OF THE INQUIRY

48. The New Zealand Medical Association, through its Secretary, Dr Erich Geiringer, presented a submission which called into question the propriety of having a Royal Commission inquire into this salary differential, and, in particular, of our endeavouring to determine this single issue before examining in detail the organisation

of hospital and nursing services. We are not without sympathy with this point of view, the more so as we had already carefully considered similar, and even wider-ranging doubts which had arisen in our own minds.

49. We appreciate that our Warrant requires us to report on this matter before examining the needs of the hospital and nursing services and that a decision based on the facts as they now appear could, in the light of future information and opinions, be an impediment to the best development of those services. We also realise that we could be overruled by the State Services Tribunal or the Remuneration Authority on this point. The outcome could be embarrassing for any Government and prejudicial to the later and more important phases of our inquiry.

50. It is clear, too, that the Government did not originally intend that we should deal with this one issue in isolation from, or in advance of, wider investigations. The Prime Minister said in his letter (*see* para. 30) "It is also obvious that the question of the 'mental health lead' cannot be properly considered without an investigation of all relevant aspects in both psychiatric and general hospitals". No doubt the Government later realised that a full investigation would take considerable time. Indeed this inquiry was not ordered until nearly two months after the date when the Government originally expected that it would receive a report.

51. Meanwhile the question of relative salaries is a very live issue. It is a disturbing issue, not only in psychiatric hospitals, but also in general hospitals, and it is a possible source of friction in the assumption by hospital boards of the control of psychiatric hospitals. This is unsettling for the staff and their controlling authorities, and it cannot be beneficial for the patients and for hospital services.

52. The promise of an immediate inquiry produced a degree of acceptance and harmony. For us to have said some months later, as it was suggested we should, that we could not undertake the inquiry or that we could offer no solution, for a further two years, would have been to invite more resentment and turmoil, to the detriment of both patients and services. This we were not prepared to do.

53. The State Services Tribunal, if this issue does reach it, will have to decide it in accordance with section 6 of the State Services Remuneration and Conditions of Employment Act 1969. It must have regard for efficiency and for fairness to staff and to the public. But we can, and must, go further. We must place the most emphasis on the provision of the best possible care for the sick.

54. With this as our general frame of reference, we may be able to direct consideration of this issue along lines which might not emerge in another setting. We feel that it is at least our duty to make the effort. As a Royal Commission we have resources which are not readily available in the processes of conciliation and arbitration. The submissions and other evidence placed before us have ranged over more ground and have produced facts and opinions that would not otherwise have been available. We are not the only people to have gained from this. We are sure that the interested parties and perhaps the public have a better appreciation of what is involved and this must have enhanced the likelihood of a settlement satisfactory to them and not least to the patients.

THE COURSE OF THE INQUIRY

55. The Royal Commission of Inquiry into Hospital and Related Services was established by Order in Council, dated 28 February 1972, in the *New Zealand Gazette* on 2 March 1972.

56. The text of our Warrant and the arrangements made for receiving submissions and the hearing of evidence under clause 9 were widely advertised in the press.

57. At the formal opening session, held in Wellington on 21 April 1972, we invited organisations intending to present submissions to register, and to discuss with us procedural matters for future public hearings.

58. We held public sittings on 9 days in July and August, during which time 11 submissions were presented to us orally and 9 were written into the record.* The supporting oral evidence which was recorded verbatim, ran to 707 pages.

59. Some organisations sought, and were granted, permission to call witnesses to support their submissions. This procedure will also be followed during stages II and III of our inquiry, but in future the evidence of such witnesses must be submitted in writing at least 3 days before the date on which they will be heard.

60. Because we wished to prevent the inquiry being regarded as a contest of adversaries, we sought to create circumstances in which those contributing could work with us to explore the validity and significance of the matters canvassed in the submissions. We therefore circulated all submissions to those who were to appear before us well in advance of the public hearings so that they would have

*See appendix I for the list of organisations and individuals making submissions and the witnesses appearing on their behalf.

adequate opportunity to evaluate them and to note any points for further investigation during cross-examination of witnesses. After the presentation of evidence representatives of the participating organisations were given the opportunity to cross-examine each witness. This opportunity was generally accepted and, as a result, we are satisfied that all issues considered pertinent by contributing parties were adequately explored. Although we are grateful for the helpful information contained in the submissions and the evidence of witnesses, a feature of the inquiry was the dearth of statistical and factual data.

61. At our request the State Services Commission and the department produced additional statistics on staffing and in doing so they drew our attention to shortcomings which we have borne in mind. Shortly after the public hearings, we became aware that an analysis had been completed of certain statistical returns received from the schools of nursing. We obtained copies of this and circulated it to all parties for comment. Although we have been advised that this analysis cannot be regarded as statistically reliable, it is in some ways the most pertinent that appears to be available and we have therefore made considerable use of it, quoting from it when it appears to support and illustrate other evidence.

62. We have not restricted our investigations solely to the matters raised at public hearings or to the consideration of written material. Some or all of us have visited Oakley, Kingseat, Tokanui, Sunnyside, Cherry Farm, Porirua, Levin, Mangere, Templeton, and Lake Alice Hospitals; the Ashburn Hall private psychiatric hospital; and the psychiatric units in Kew, Princess Margaret, Wellington, Palmerston North, Hastings, and Auckland General Hospitals. We have thereby gathered first-hand impressions of the facilities available and the type of patients cared for. In this way we have been better able to appreciate the evidence presented to us.

Chapter II. JUSTIFICATION OF A DIFFERENTIAL

Terms of Reference

1. Our Warrant requires us to investigate the justification, if any, for a differential pay scale on the grounds of job content or responsibility, conditions of work, or for any other reason.

PART I JOB CONTENT AND RESPONSIBILITY

ARGUMENTS FOR PARITY

2. We examine first job content and responsibility, to see in what respects and to what degree psychiatric nursing can be distinguished from general and other kinds of nursing, and whether the nursing of psychiatric patients in psychiatric hospitals differs markedly from the nursing of the same kind of patients in other hospitals.

3. The State Services Commission and the Department of Health, in a joint submission, took the view that "Psychiatric and general nurses' responsibilities present more similarities than contrasts". They relied heavily on an assessment of the clinical, managerial, educational, and miscellaneous functions of nurses made in 1970 by a committee which they had set up and which consisted of an Assistant Director of the Division of Nursing, the then matron of Porirua Psychiatric Hospital, a senior officer of the Hospitals Division, and a senior inspector of the State Services Commission.

4. After visiting nine hospitals, including one psychiatric and one psychopaedic hospital, the committee concluded that "in terms of qualifications, clinical responsibility, nature of duties, degree of difficulty and work complexity, there should be no differentiation as between public hospital and mental health nurses". The committee emphasised that it had not been required to examine such matters as recruitment and retention of staff but had made its assessment "strictly on the basis of job content and nature of duties".

5. The committee used as its basis for assessment a schedule of nursing functions, and assigned for each function the degree of responsibility borne by a nurse in a general hospital and a nurse of equivalent rank in a psychiatric hospital.

6. The committee's report was criticised because the members were all employees of the State Services Commission or the department, which had already come to the conclusion that "There was no discernable overall difference in the job content and responsibility of

general and psychiatric nurses". Two of them were also members of a team which was negotiating with the Public Service Association on its salaries claim of February 1970. The members of the committee claimed that they had undertaken their investigation with an open mind, and so far as this is possible to any of us we accept that this was so.

7. Our reservations about the committee's conclusions are not based on any suspicion of bias or preconception of ideas, but on two other considerations. The first is the inherent improbability of two kinds of work, similar in some respects, but different in others, being found to be so exactly similar over all that they warrant exactly the same salary scale. The committee concluded that "there should be no differentiation". But if, on a careful assessment of job content and responsibility, one kind of nursing was rated at 98 points and another at 102 points, this would be a very close similarity: yet the difference of 4 percent, on a salary of $4,000, would be worth $160 per year.

8. We find it difficult to see how, on the basis of the sort of comparisons made, anyone could be so dogmatic about absolute equality. We do think, however, that it would be possible to conclude from such an exercise that sufficient difference had not been established to warrant departure from the principle that has been put to us that nursing is nursing, whether it is called general or psychiatric, and that there should be one basic scale for nurses.

9. Our second ground for reservation is that the type of question which the committee posed for itself, although suited to measuring divergences from an established base, was not suited to determining whether there are certain fundamental differences between one kind of nursing and another. For example, when comparing general hospital staff sisters with psychiatric hospital staff nurses (after 1 year) the committee carefully compared the *degree of responsibility* for observation, for assessment, for planning programmes, and for care of patients. But surely the fundamental questions relate to patient-care itself. How does it differ in the different circumstances? And consequently how, if at all, does observation differ, how does the assessment of patients differ, and how does the planning of programmes for care of the sick differ? Because these basic questions are not answered in the committee's assessment schedule, we are unable to get any assistance from its conclusions.

ARGUMENTS FOR A DIFFERENTIAL

10. We now examine the various arguments which were put to us in support of the proposition that the job content and responsibility of psychiatric and psychopaedic nursing justify a salary differential over general nursing.

11. Before doing so, however, we note that the entry qualification for psychiatric nursing is now the same as for general nursing; that the training period for registration is also the same—3 years; and that the academic content of training is greater for general nursing than for either psychiatric or psychopaedic nursing. These facts clearly provide no justification for a psychiatric "lead", except possibly that trainee psychiatric nurses give more "service" than do student nurses in general hospitals.

Observation and Interpretation

12. The committee found that all nurses at the staff sister or equivalent grade had "considerable degree of responsibility for observation of patients". The Public Service Association claimed that the psychiatric nurse had to observe moods and behaviour and then interpret her observations as a guide to action to be taken or treatment to be given. Also her observations were often the best available information on which the psychiatrist could base a therapeutic programme. The general nurse, on the other hand, could measure a patient's progress by readings of pulse, temperature, blood-pressure and the like, with much less responsibility for the interpretation of observations.

13. This is of course, an over-simplification. All nurses need to be skilled observers, and great reliance must be placed on a general nurse's ability to observe, interpret, and act promptly on her own interpretation of her own observations. Nevertheless there are notable differences. The psychiatric nurse must know not only what may be expected medically in a particular case—as would any other nurse—but she must also know and take into account the personality of each patient. In the light of this personality she must find a rationale for deviations in consistently irrational behaviour.

Interpersonal Relations

14. Great stress was placed on the importance of the personal relationship which the psychiatric nurse must establish with her patient. We ourselves, from the evidence we heard, and from our own observations, are convinced that this is indeed a very important factor. In the absence of a good relationship between nurse and patient, the nurse's attentions to her patient are unlikely to be beneficial and they may be harmful.

15. The general nurse, by her skill and care, supports whatever treatment—rest, drugs, blood transfusions, and a host of others—has been prescribed by the physician or the surgeon. The psychiatric nurse not only supports other treatments, such as E.C.T. or chemotherapy, but also, during her nursing care, personally provides a therapeutic influence which is often the most important therapy the patient

receives. Thus psychiatric nursing can be seen as a therapy comparable with physiotherapy or occupational therapy. This we believe to be the chief difference between psychiatric and other nursing.

16. Emphasis was also placed on the difficulty of establishing a favourable relationship with psychiatric patients who are unwillingly receiving treatment, are unaware that they need treatment, or are reluctant to admit even to themselves that they suffer from an illness which carries an undesirable stigma. The attentions of the nurse, instead of being welcomed, are rejected or received with suspicion.

17. Although this is no doubt true, it is surely the sort of problem with which the psychiatric nurse is trained to deal. The general nurse has similar problems in dealing with babies, patients who are unconscious or are in great pain, or in fear of pain, operations, or other treatment.

18. Another way in which psychiatric nursing differs from other nursing is that the general nurse commonly cares for her patient in the hospital ward where she is accepted as being the person in charge, but the psychiatric nurse must often carry out her observations and treatment in a variety of places and circumstances. The patient may be in bed, in a day room, in the dining room, at occupational therapy, working in a kitchen, garden, or the industrial or training workshop, or playing a variety of games. Reactions in all of these situations are important, and the nurse must learn to rely as little as possible on the "authority" which her position gives her.

Rehabilitation

19. The psychiatric nurse is perhaps more involved in problems of rehabilitation than are other nurses, whose responsibility usually ends when nursing care is no longer necessary, even when some bodily function has been lost. Rehabilitation then rests more with such people as physiotherapists and social workers. Psychiatric conditions often result from inability to cope with life's problems, and nursing must be consciously directed towards combating institutionalisation and fitting the patient to meet the same problems again. The nurse may even have to try to modify some of the conditions which the patient will have to face on discharge. Here again, interpersonal relations are important.

Acquisition of Skills

20. It was put to us that as the skills required of the psychiatric nurse are different, so is the process of acquiring them. What might be called mechanical skills can be demonstrated, but interpersonal skills can be learned only by experience and are in effect a development of the nurse's own personality. We do not suggest that other

nurses rely only on mechanical skills or can become proficient without disciplining their own personalities, but it does seem that this plays a larger part in psychiatric nursing.

Responsibility

21. The ratio of doctors to patients is much lower in psychiatric hospitals than in general hospitals. The psychiatric nurse must therefore act on her own responsibility more often and for longer periods. The availability of a doctor for consultation or direction varies with different types of patient, but under present conditions it is quite common for a nurse to continue prescribed treatment, and to be expected to do so, for lengthy periods without reference—except for written reports—to a doctor.

22. Thus doctors have to place great reliance on the observations and reports which they receive from nurses. These frequently serve as the basis for the prescription of further treatment, for decisions on conditional release, and eventually for discharge. The observations and reports of psychiatric nurses may be an essential part of diagnosis. By contrast, a general nurse's notes, though available, are not usually referred to the doctor treating the patient.

23. There may be a considerable difference, because of staffing ratios, between the responsibilities of psychiatric nurses in psychiatric hospitals and those in psychiatric wards of other hospitals. Here, with a greater proportion of acute cases, and more frequent contact between doctor and patient, the nurse's responsibility may not be so wide. On the other hand, she may be required to take a more intensive part in positive therapeutic programmes.

24. It was suggested to us that if the psychiatric nurse carried more personal responsibility in the matters we have outlined, this was seldom of a life and death nature; the consequences of failure to observe or failure to act were unlikely to be as drastic or immediate as in general hospitals. There are, of course, possibilities of suicide, or of physical harm to other patients in psychiatric hospitals, as there are in other hospitals, and crises can arise in a moment. But it could be accepted that the psychiatric nurse does not, and should not, work at the pace and under the stress of urgency that is common in some general hospital wards.

CONCLUSIONS ON JOB CONTENT AND RESPONSIBILITY

25. In the foregoing paragraphs we have not been attempting to establish a case for elevating psychiatric nursing above other forms of nursing. To do this we would have had to go much more deeply into the subject, not only of psychiatric nursing but more especially

of other nursing, to do justice to the skills and responsibilities needed in the operating theatre, the intensive care units, the children's and geriatric wards, and many others, and the great varieties of skills which we take for granted from nurses in our general hospitals.

26. We are satisfied, however, that there are important differences between psychiatric and other nursing. To the extent that relative salaries should or can be determined on the basis of job content and responsibility, these differences are important enough to satisfy us that the dogmatic assertion that "nursing is nursing" cannot be used to determine whether there should be any differential. In any case the nomenclature of "nurse" is applied to a variety of occupations which do not have the same salary scales as general nurses, for example, Plunket, Karitane, dental, and community nurses. Conversely it could be argued that some of the present job content of psychiatric or psychopaedic nursing justifies a name other than "nursing".

27. Nevertheless we do not see the job content of psychiatric nursing as necessarily requiring that the salary scale should be higher than for general nursing. We make no attempt to evaluate the differences in money terms or to say in whose favour any differential might be. All we can say is that the salary scales need not be the same, and that on the grounds of job content and responsibility there need not be parity.

PART II CONDITIONS OF WORK

CONDITIONS COMPARED

28. The job content of a particular kind of work cannot always be clearly distinguished from the conditions under which that work is normally done. We do attempt here to distinguish content from conditions but it will be seen that they are often closely related.

Danger

29. The Public Service Association placed considerable emphasis on the psychiatric nurse's liability to physical injury, arising from the "unpredictable aggressive behaviour" with which she has to contend, and the consequent continuous stress and tension under which she works. Supporting evidence was submitted by the medical superintendents of two psychiatric hospitals and by psychiatric nurses.

30. This point was not mentioned in the report of the 1970 committee or in the assessment of functions on which the report was based. A member of the committee stated in evidence that it took into account "unpleasant situations which you might get in psychiatric hospitals or violent behaviour in some parts of psychiatric

hospitals . . ." The Committee apparently thought that this matter did not relate to all psychiatric nursing, or related in varying degrees, and had to be weighed against similar matters affecting nurses who worked in particular areas of general hospitals.

31. Although instances of injury, some serious, caused by patients were given to us, the Public Service Association was not able to submit statistical information which would enable us to assess the degree of risk or to compare psychiatric with general hospitals. Dr S. W. P. Mirams, Director of the Division of Mental Health, appearing as a witness for the department did produce some relevant evidence:

(i) A special survey of files at the Porirua Psychiatric Hospital showed that in a period of 2 years to 31 December 1971, 176 acts of aggression had been committed against staff (who numbered 272 at the beginning of the period), and in an additional 40 incidents aggression had been attempted or threatened. Many of these acts were minor, but on the other hand many minor incidents were probably not reported. As a result of assaults, four members of the staff had to take time off work—one for 1 day, one for 2 and one for 12 days, and one for 123 days. The latter was still absent at the end of the period.

(ii) At the Wellington General Hospital there were 12 acts of aggression against nurses (who numbered 839) in a period of 1 year. On the other hand, in a period of nearly 3 months to 31 May 1972, 15 members of the staff were off duty for a total of 409 days because of illnesses such as glandular fever and hepatitis due to duty.

(iii) In the 2 years to 31 March 1971, 34 injuries to staff were recorded in the psychiatric (excluding psychopaedic) hospitals in New Zealand, representing a ratio of 1.6 injuries to each 100 staff (or 0.8 percent per year).

32. Dr Mirams quoted in his evidence from a paper on this subject:

> "The fact that some psychiatric patients are prone to acts of dangerous violence is common knowledge. But what is less obvious is that the proportion of such violent patients in relation to the psychiatric population as a whole is very small, so that the average modern psychiatric hospitals contains only a handful of patients with seriously violent propensities . . . It is important to realise that the average psychiatric patient—be he psychotic or neurotic—is no more likely to violence than the population in the neighbourhood whence he came."*

*Harrington, J. A., "Violence: A Clinical Viewpoint", in *British Medical Journal*, 1972, 1, p. 231.

We note, however, Dr Mirams commented that a proportion of psychopathic patients are more likely to violence than the average member of the community and patients suffering from this condition are accommodated in psychiatric hospitals.

33. The New Zealand Nurses' Association pointed out that general hospital nurses, who are predominantly female, are also subject to violence from some patients whose behaviour may be irrational from a variety of causes including brain tumours and head injuries, high fevers, psychiatric disorders (including patients transferred from psychiatric hospitals), drunkenness, and drugs. Furthermore they were exposed to the risk of contracting serious illnesses such as serum hepatitis and acute viral infections.

34. Some witnesses suggested that psychiatric patients would not become violent if properly nursed, or that aggressive moods should be anticipated and properly guarded against. There was an inference that fewer incidents of violence would occur in hospitals where modern nursing methods are more generally adopted. With our present limited knowledge of the hospitals it would be difficult to substantiate this from the available statistics. Conversely it was suggested that by giving patients the greatest possible freedom, and by resorting as little as possible to restrictive measures, the staff knowingly accepted greater risks in the interests of promoting the recovery of their patients.

35. It would be quite wrong to minimise the risks attached to psychiatric nursing: they do exist. But they are today very much less than they were in the past, despite such developments as referrals from prisons and courts. As far as they exist, they may properly be taken into account in fixing salary scales.

36. But we are concerned here with the question of a differential against general nursing scales and we are not persuaded that danger of all kinds is greater in all wards of all psychiatric hospitals. The special circumstances of particular wards should be dealt with by special payments and not by a general differential.

37. Having come to this conclusion, we can say also that the health and well-being of the staff merit the closest attention from the responsible authorities. We were surprised to note the dearth of information on a subject which is obviously—and we think unduly—in the minds of many nurses and trainees. The staff has a right to be assured that every effort consistent with proper nursing practice is made to eliminate or minimise such risks as there are.

Unpleasantness

38. The Public Service Association and some of its witnesses referred to the often unpleasant nature of the work of psychiatric nurses. For instance, the medical superintendent of one hospital was quoted as referring to:

"a boredom factor in some situations, especially in security nursing and the nursing of chronic patients" and

"an unpleasantness factor in the care of psychogeriatrics and chronically disturbed psychiatric patients."

39. The staff of another hospital were quoted as having written:

"The majority of psychopaedic patients require sustained training over long periods, in the most elementary task, such as washing, feeding and dressing themselves. The very severely retarded never accomplish these tasks and the care of these patients is one phase of psychopaedic nursing that is at times very unpleasant and quite unlike general nursing. Psychopaedic patients are retarded but quite a number of them are mentally disturbed, and can be noisy and troublesome, agitated and aggressive. Having to nurse this type of patient for days on end can also become very unpleasant and very often nerve-wracking, and many a nurse has given up psychopaedic nursing because of this."

40. Witnesses mentioned verbal aggression, abuse, foul language, the depressing atmosphere of disturbed and geriatric wards, the loneliness of being surrounded by people with whom there could be little communication, and various other aspects of psychiatric nursing ranging from the distasteful to the revolting.

41. As with liability to physical injury, it must be acknowledged that unpleasantness does exist in psychiatric hospitals. In one form or another it is probably fairly common, occurring in more wards and therefore affecting *all* psychiatric nurses. Some witnesses referred to it as a "constant factor" and spoke of "total exposure".

42. But our immediate task is that of comparison with general nursing. It was admitted that the same kinds of unpleasantness do arise in general hospitals. They may be just as distressing in, for example, geriatric and casualty wards and may be encountered in greater or lesser degree in any ward. In addition the general hospital has unpleasantness of a kind not common in psychiatric hospitals: the New Zealand Nurses' Association mentioned the occurence of death, the care of the dying, distressing incurable conditions, and severe mutilating injuries.

43. Nevertheless it does seem to us that unpleasantness may be more prevalent in psychiatric hospitals, and that general nurses would more frequently obtain relief in wards with a brighter atmosphere and in dealing with comparatively cheerful and co-operative patients.

Legal Liability

44. Witnesses stated that some patients resented being in a psychiatric hospital and were continually on the lookout for opportunities to make allegations or lay complaints against the staff. Threats of legal action were common, and although these were seldom pursued every complaint had to be investigated and nurses were frequently "on trial" for imaginary misdemeanors.

45. Situations such as this had led to full-scale inquiries in the past. This was upsetting to the staff, as was the tendency of a few newspapers to give publicity to complaints which were seldom justifiable. The Rev. W. B. Glassey, a chaplain at Porirua hospital, thought that junior staff would have some fear of litigation but that mature senior staff would not worry about it if they knew their job.

46. In assessing this issue we must also note that general hospital nurses, although not subject to the same harassment from litigious patients, must always be fearful of making a mistake which could have serious or even fatal consequences for a patient as well as a blighting effect on their own careers.

Stress

47. Several witnesses claimed that psychiatric nurses worked under greater stress than nurses in general hospitals. This stress was attributed to a number of different causes including the unpredictable behaviour of many patients; the possibilities of violence, verbal aggression, or litigation; resentment of treatment for an illness which the patient did not understand nor acknowledge; unpleasant situations in disturbed or geriatric wards; and lack of support because of medical and nursing staff shortages.

48. The same witnesses were prepared to acknowledge that general nurses were also subject to stress from a variety of causes, but maintained that the stress in psychiatric hospitals was both greater and more continual. But on this there was certainly no unanimity of opinion.

49. The medical superintendent of one psychiatric hospital emphasised the stress and tension under which psychiatric nurses worked. Another psychiatrist with considerable psychiatric hospital experience thought that there was little stress in some parts of a psychiatric hospital but a great deal in others. Incidentally he thought that psychiatric-trained nurses tended to create some of their stress by their attitude to the patients and to their work. Two experienced psychiatric nurses holding responsible positions thought that the stress in psychiatric hospitals was greater, claiming that it resulted

from total exposure, without respite, to situations of strain. On the other hand two others, also experienced and responsible but with general nursing experience, would not agree that the nervous strain was greater in psychiatric nursing.

50. Undoubtedly situations of stress commonly arise in both psychiatric and general nursing. But it is important to realise that people differ greatly in their response to different situations, and what is alarming for one person may be no more than routine for another. Thus one person may find driving a car in traffic something to be feared while another may find it relaxing. It may be true, however, that a greater or lesser number of people may experience stress in one type of situation than in another. There is some evidence that the particular stresses and strains of psychiatric nursing are best coped with by those who are emotionally mature. This is apparently the opinion of the Department of Health which sponsors the careers information issued by the Vocational Guidance Service. The leaflet issued in July 1971 on psychiatric and psychopaedic nursing states, "This is a very useful and satisfying career, but it is arduous, and students must be physically fit and emotionally mature". Leaflets about general nursing emphasise other qualities.

Job Satisfaction

51. It was contended that nurses obtained less satisfaction from work in psychiatric hospitals than in general hospitals. Whereas patients in general hospitals are usually appreciative of the care they receive, psychiatric patients are often ashamed or resentful of their state and react to their nurses accordingly. Many patients cannot be cured or even much improved but can only be cared for. The proportion of such patients in both psychiatric and pyschopaedic hospitals was claimed to be considerably greater than in general hospitals. Consequently psychiatric nurses are denied the satisfaction associated with the rapid amelioration of their patients' conditions.

52. Against this it can be argued that with interpersonal relations so highly developed as was claimed for the psychiatric nurse even a small advance made by a chronic patient would be a source of deep satisfaction to the nurse. We were ourselves privileged to note the keen pleasure which was obviously felt by psychiatric and psychopaedic nurses in the smallest progress made by severely handicapped patients. It must be remembered, too, that not all general hospital patients improve, or even survive; and that many general hospital nurses do not have the opportunity of closely associating and therefore closely identifying with their patients.

Attitudes of Relatives

53. Some witnesses claimed that the attitude of patients' relatives made the task of psychiatric nurses more difficult and unpleasant. Relatives tend not to understand the illnesses from which patients suffer, and are disinclined to accept advice or to co-operate. Undoubtedly this stems from the distinction which is still commonly made between mental and physical illness. It was also suggested that whereas physical illnesses are only seldom the result of family or domestic circumstances, there is more frequently a close connection in psychiatric illness, and relatives do not find it easy to accept this.

Staff Ratios

54. Dr Mirams gave evidence that on 31 March 1972, 2,801 nursing staff were employed in psychiatric hospitals, caring for an average of 9,807 resident patients. The staff to patient ratio was therefore 1:3.50 (on 31 March 1967 the ratio had been 1:4.20). From the Department of Health's annual report for the year ended 31 March 1972, we note (p. 62) that the average daily bed occupancy in 1971 of institutions controlled by hospital boards (including maternity hospitals, old people's homes, etc., as well as general hospitals) was 16,382. The nursing staff employed on 31 March 1971 was given as 14,350, the staff to patient ratio being 1:1.4.

55. These figures may not be strictly comparable but they show that the psychiatric nurse has to look after approximately three times as many inpatients as the general nurse. Because the nursing services required by patients are also very different, these figures cannot be taken as indicating that psychiatric nurses have more to do than general nurses. But they do show that the psychiatric nurse in a psychiatric hospital does not have the same contact with and support from nursing colleagues as does the general nurse.

56. This lack of support is intensified by the lesser availability of the senior members of the hospital team, the doctors. These numbered 105.5 (full-time equivalents) in psychiatric hospitals on 31 March 1972, whereas hospital boards had 1,309.1 on 31 March 1971. The ratios of medical staff to nursing staff were thus about 1:27 and 1:11. However inexact these comparisons may be, they show that the psychiatric nurse has contact with medical staff less than half as much as a general nurse.

57. Therefore it appears that the psychiatric nurse may have to be, and to act, on her own much more than a general nurse. The occasions on which decisions have to be taken may be fewer and the importance of the decision may or may not be so great; we are not able to weigh these points. But most people prefer to work with others.

Staff Shortages

58. It was claimed that the staff shortages in psychiatric hospitals were such that nurses could not carry out their nursing duties as they should, and as they would wish. The shortages also aggravated other adverse working conditions such as risk of assault or other aggressive behaviour, stress, isolation, and lack of job satisfaction. Also they made the working of overtime constantly necessary, increasing fatigue and denying the staff adequate opportunities for getting away from the pressures of the hospital.

59. The Public Service Association outlined a history of staff shortages going back to 1936 and varying since then only in degree. Certainly staff shortages exist at present and have existed for a long time. Dr Mirams stated that the nursing establishment on 31 March 1972 was set at 3,379, but only 2,801 were employed. This is a shortage of 17 percent and indicates that one additional nurse is needed for every five now employed.

60. Dr Mirams stated that the nursing staff had been increased by 321 since 1967 when the number employed was 2,480 against an establishment of 2,591. On the face of it the shortage then seems small, but it is obvious that the establishment figures were unrealistic. At any rate a great deal of overtime was being worked in March 1966, more than in 1972.

61. The Public Service Association acknowledged that staff shortages exist also in general hospitals, but submitted that they could more easily be mitigated by closing wards and restricting the intake of patients. It was suggested that the burden was shifted to patients who either went to private hospitals or stayed on waiting lists. In the absence of these alternatives, the burden in psychiatric hospitals was borne by the staff working overtime or by a reduction in nursing care.

62. We acknowledge that staff shortages are accepted almost as the natural order of things in psychiatric hospitals, and that this does detract—not only by the need to work overtime—from the attractiveness of psychiatric nursing. But we are unable to say with certainty that the position is worse in psychiatric than in general hospitals. We can compare staff numbers with the establishments authorised at the time of our inquiry, but we have no faith in the latter figures. We do know that there are constant nursing shortages in many general hospitals and that, as in psychiatric hospitals, this imposes undue burdens both on junior nurses, who have to assume responsibilities for which they are not prepared, and on senior staff, who have to rely on inexperienced and partially qualified nurses.

Shifts and Rosters

63. The care of the sick continues 24 hours a day, 7 days a week, 365 days a year. Consequently a nurse's working hours cannot be limited to the general pattern of 8.00 a.m. to 5.00 p.m., Monday to Friday. Shift work is necessary to cover the 24-hour span, and rosters to cover the 7 days.

64. None of those making submissions to us claimed that this condition bore more heavily on psychiatric than on other nurses, or vice versa; but, as this fact distinguishes nursing from most other work and must have a bearing on questions of remuneration, we wished to be informed of the position and asked the parties concerned to furnish agreed statements on the facts.

65. It appears that in general hospitals the usual pattern is to have three shifts, viz:

Morning	7.00 a.m. to 3.00 p.m.
Afternoon	3.00 p.m. to 11.00 p.m.
Night	11.00 p.m. to 7.00 a.m.

Staff nurses and staff sisters may work any shift; student nurses usually (but not in all hospitals) work only morning or afternoon shifts; more senior staff usually work more conventional day shifts, say 8.00 a.m. to 4.30 p.m. The usual pattern is for staff nurses and staff sisters to rotate shifts week about.

66. This is a general pattern only. Individual hospitals adopt variations, and within hospitals there are separate arrangements for special-care units. Part-time staff usually work fixed as distinct from rotating shifts, and the availability of part-time staff plays an important part in the rostering of full-time nurses.

67. In psychiatric hospitals, on 31 March 1972, a 4-shift system was in use,* viz:

A shift	12 midnight to 8.30 a.m.
B shift	7.00 a.m. to 3.30 p.m.
C shift	8.30 a.m. to 5.00 p.m.
D shift	3.30 p.m. to 12.10 a.m.

An 8-week roster is designed to give nurses 2 consecutive days off in each week. Over the 8 weeks they would have 3 Saturdays and 3 Sundays off. It will be seen that the shifts are slightly longer than those in general hospitals.

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*At the time of writing negotiations on the shift and roster system are still in progress.

Locality and Buildings

68. Some witnesses mentioned that some psychiatric hospitals are situated away from residential centres, and some are housed in old unsuitable buildings. We do not consider these facts have any bearing on the question of a salary differential.

69. We acknowledge that some hospitals are distant from residential centres, and that this may be a disadvantage to those required to work outside conventional hours or days, when public transport may not be available. But we think this is a matter more appropriately dealt with by allowances or other local arrangements.

70. As to buildings, some are old, some are new. Several of the older buildings have been renovated. The same is true of general hospitals. We do not think the degree of difference important.

CONCLUSIONS ON CONDITIONS OF WORK

71. We found, after examining job content and responsibility, that psychiatric nursing as at present practised in New Zealand in psychiatric hospitals was more different from general nursing than the "nursing is nursing" dogma suggests.

72. Now, after studying the conditions under which nursing is carried out in psychiatric hospitals, we see that there are differences here also when compared with general nursing. Some of these conditions are limited in their application and may justify local or specific allowances but not an overall salary differential. The same is true of general hospitals. Apart from these points, we find that such conditions as risk, unpleasantness, and stress apply differently; but in our opinion they do not justify a conclusion that working conditions generally in psychiatric hospitals are worse than those in general hospitals, and so justify a salary differential.

73. Even if we were prepared to place a monetary value on psychiatric nursing conditions and to say this was greater or less than the monetary value to be placed on general nursing conditions, this would not determine anything. What is important is the value placed on these conditions by the young people who are contemplating nursing as a career, by their parents, and by those who are undergoing or who have completed their training. In fact, for those who are potential recruits, and for their advisers, the actual conditions are less relevant than what people generally believe the conditions are. The real question, the question which seems important to us, is

whether the conditions in psychiatric hospitals or the public image of them, is such that adequate numbers of competent staff can be attracted and retained, so that patients can receive the best possible care.

PART III RECRUITMENT AND RETENTION OF NURSES

INTRODUCTION

74. Arguments were presented in most submissions for or against a salary differential as an inducement to recruitment and an incentive for retention of psychiatric and psychopaedic registered and trainee nurses.

75. It was suggested to us that some financial advantage was necessary to offset the stigma said to be still associated with psychiatric hospitals in the minds of the public. We were told that parents and teachers are unenthusiastic about or even actively opposed to a career in psychiatric nursing; and that psychiatric nursing has fewer prospects for a career, more limited opportunities for promotion, and far fewer avenues for specialisation or diversification than general nursing.

76. We accept the observation that there are fewer avenues of employment or opportunities for specialisation and diversification in psychiatric than in general nursing. This is a fact that should be recognised when the choice of psychiatric nursing is made.

77. The State Services Commission and the department noted a dropout rate, between 1967 and 1970, of 56.7 percent for psychiatric and 52.4 percent for psychopaedic trainees compared with 28.1 percent for student general nurses. Their submission suggested that reasons not related to salary were responsible for the higher losses of psychiatric trainees.

78. The Public Service Association submitted that the world-wide problems of recruitment and retention of psychiatric nurses were due to the nature of the work. Although agreeing that other features than remuneration were of importance in recruitment and retention, the Public Service Association concluded:

> "Compensatory pay and conditions is probably the only way to encourage people to continue working in this particular profession."

79. The Public Service Association quoted from the 1968 report of the National Board for Prices and Incomes (Report No. 60) of the United Kingdom as follows:

> "In psychiatric and geriatric hospitals there are serious shortages not only of staff nurses but of nurses of all grades. In the psychiatric hospitals there are many more male nurses than in the general hospitals, so that financial pressures operate more intensely to discourage both entry and retention. There is an urgent need to

increase both the number and the quality of recruits to this field of nursing. At present the main financial incentive is a 'mental lead' which applies to certain grades of staff."

The Nurses and Midwives Whitley Council approved the recommendation that there be an increase in the lead to £99 per annum for psychiatric and geriatric work. The Public Service Association submitted that the lead should be increased in New Zealand to encourage retention of psychiatric nurses.

80. The submission of the Medical Association of New Zealand states:

"A differential salary scale favouring psychiatric nurses *might be justified* as being necessary to attract psychiatric nursing recruits and to retain psychiatric trained nursing staff."

After analysing student nurse losses the Medical Association of New Zealand noted:

(i) That students with educational qualifications higher than School Certificate are better equipped to cope with nursing training.

(ii) That financial considerations do not appear to be a main cause in resignations of student nurses.

(iii) That, though the mental health lead might help recruitment, it does not hold trainees.

(iv) That a mental health lead does not attract a more suitable type of trainee.

(v) That attempts to improve the selection of candidates and the appeal of training and practical nursing commitments were more likely to stimulate nurses to complete their training.

After comparing shortages of nursing staff in general and psychiatric hospitals, the Medical Association of New Zealand concluded this section of its submission with the opinion that the differences of shortages of nursing staff are *not so great* as to warrant a differential salary scale for the staff of the two types of hospital. Recruitment to psychiatric hospitals away from large centres of population might be improved by an increased salary scale or some extra monetary compensation.

81. The Hospital Boards' Association stressed that the responsibility for recruitment and retention now rests with the hospital boards themselves.

"It is emphasised that whatever arguments may be put forward by other parties, in the ultimate it is the autonomous Hospital Boards themselves who have the responsibility for the recruitment and retention of staff and in the event of unsatisfactory pay scales affecting recruitment and retention, it is consequently the individual Hospital Board which is firstly criticised should hospital services not be maintained or curtailed because of staff shortages."

The association concluded that there should be no differential pay scales for psychiatric and general nurses but recommended special allowances (sufficient to attract staff) for hazardous or extremely distasteful duties in all hospitals and location allowances for service in remote hospitals.

82. The submission of the New Zealand Nurses' Association on the subject of recruitment and retention also agreed that there was little appreciable difference between general and psychiatric hospitals in shortages of staff. The New Zealand Nurses' Association made the following recommendations for the recruitment and retention of nursing staff in all hospitals:

"(a) Improved basic nursing education.
"(b) Well planned in-service education programmes.
"(c) Increased staff establishments.
"(d) Similar conditions of employment for all nurses.
"(e) Improved conditions of work (physical and other) where these are required. These would include improved accommodation and facilities for patients where up-grading is necessary.
"(f) Employment of sufficient numbers of non-nursing personnel to undertake non-nursing tasks such as clerical, house-keeping and the like.
"(g) Higher salaries for all nursing staff with those with similar job content and responsibilities being paid at the same rates in all services."

The association stressed that pay alone does not determine a nurse's choice of specialty. Nurses choose a special branch of nursing because they are attracted to it and reject another because they do not like it. Absorbing interest in the work and a sense of making a contribution are necessary for a nurse to remain.

83. The New Zealand Medical Association did not mention recruitment and retention of nurses in its original submission but included some comments in its "summary submissions" where it stated:

> "Given reliable evidence this [recruitment and retention] could form the basis for a rational decision; but before looking at the evidence the Commission should in our submission examine the implied assumption that increased recruitment and retention are in fact desirable."

After enlarging on this theme the association continued:

> "What is a psychiatric nurse? Who wants her? How many do we want? When we know this we shall know whether we should or should not worry about recruitment and the effect the *MHL will have on it.

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*MHL = mental health lead.

"When it comes to retention a further question has to be asked which we tried to highlight in our cross-examinations: Who do we want to retain? Who are the ones who give up? The uniform answer has been that those who leave are well lost. If the *MHL goes will we also lose some good ones? Conversely, is our need to keep the large hospitals so great that we must be prepared to buy even bad nurses as long as it enables us to keep the shop open?

"What evidence has the Commission had on any of these questions? None."

84. We agree that little evidence was presented to us to permit the answering of the questions raised by the New Zealand Medical Association. We certainly consider that an investigation into the required number and proportions of psychiatric nurses and trainees is needed. We refer elsewhere to the need for a more precise definition of the establishment in the group designated "basic grade nurse".

85. Nevertheless we are of the opinion that registered nurses will continue to be required for the treatment of psychiatric and psychopaedic patients and that they will be required in increasing numbers, whether the patients are treated in hospitals large or small, psychiatric or general, or in the community. The moral rectitude of "buying" bad nurses may be open to question. We believe that closer screening of applicants would exclude some who do not possess the necessary qualities.

INFLUENCES ON RECRUITMENT OF NURSES

Control

86. In the past general hospitals on the one hand, and psychiatric and psychopaedic hospitals on the other, have been to some extent at least and especially in respect of girls, in competition for a fair share of nursing recruits. We hope that the assumption of control by hospital boards since 1 April 1972 will stimulate recruitment to all hospitals by uniform methods of advertisement, publicity, and vocational guidance.

Race

87. We note from the analysis of the annual statistical returns from the New Zealand schools of nursing that entrants to 3-year nursing programmes are not distributed evenly in accordance with the proportion which their racial group composes of the total population. We shall return to this matter in the later stages of our inquiry.

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*MHL = mental health lead.

Sex

88. For the year ended 31 March 1971, there were 2,068 entrants to the 3-year nursing programmes. Of the 1,767 starting general training, 18 (1.03 percent) were male; of 205 starting psychiatric training, 62 (30.2 percent) were male; and of the 96 starting psychopaedic training, 16 (16.6 percent) were male.

89. The higher proportion of male psychiatric and psychopaedic trainees is, in our view, of great importance in recruitment. The salary differential could well be a needed inducement for this group, especially since most male entrants to the psychiatric programme are older than those entering general or psychopaedic training.

90. We have earlier referred to the fact that one of the reasons for two different salary systems developing was that general hospitals were predominantly staffed by women and psychiatric hospitals by men. The proportion of male nurses is still much greater in psychiatric than in general hospitals, a fact which must be kept in mind.

91. Women still tend to interrupt their careers for marriage and family responsibilities thus creating vacancies which are filled by the promotion of junior staff. Men, on the other hand, tend to stay in the careers for which they have been trained; promotion is therefore less rapid in psychiatric hospitals—certainly for men, and possibly also for women—than it is in general hospitals.

92. This consideration was not advanced in support of a differential but it does play a part in recruitment and retention of staff. It is probably the reason why the additional step of $4,018 has been provided for psychiatric staff nurses who have four years' satisfactory service on the top of the staff nurse scale.

Age of Entry

93. The Nurses and Midwives Amendment Act 1963 lowered the minimum age for registration of psychiatric and psychopaedic nurses from 21 to 20 years, thereby enabling nurses to start their training at the age of 17 rather than 18. The lowest age of entry is now the same for the 3-year courses in general, psychiatric, and psychopaedic nursing. Despite the identical age for entry into all three programmes, the patterns of actual age differ in each.

94. The annual statistical returns from New Zealand schools of nursing give the entry ages of 2,068 student nurses and trainees in the 3-year courses in the year ended 31 March 1971. Table 2 below has been derived from the figures given.

Table 2

ENTRY AGES OF GENERAL, PSYCHIATRIC, AND PSYCHOPAEDIC TRAINEES

Age at Entry	3-year General Percentage of Total Entrants	3-year Psychiatric Percentage of Total Entrants	3-year Psychopaedic Percentage of Total Entrants
Under 17 years	3.5	0.5	—
17 and under 18½	81.5	28.3	51.0
18½ and under 21	10.9	30.7	30.2
21 and under 25	2.8	23.5	10.4
25 and under 30	0.7	8.3	6.3
30 and under 35	0.4	2.4	—
35 and over	0.2	6.3	2.1
	100.0	100.0	100.0
Number of entrants	1,767	205	96

95. It can be seen that recruitment to psychiatric and, to a lesser extent, psychopaedic nursing tends to be more widely distributed over older age groups. Further analysis of the figures for entrants to psychiatric nursing shows a difference in the age distribution on entry between males and females.

Table 3

AGE DISTRIBUTION OF MALE AND FEMALE ENTRANTS TO PSYCHIATRIC NURSING

Age at Entry	Males Percentage of Total Entrants	Females Percentage of Total Entrants
Under 17 years	1.6	—
17 and under 18½	11.3	35.7
18½ and under 21	30.6	30.8
21 and under 25	37.1	17.5
25 and under 30	9.7	7.6
30 and under 35	1.6	2.8
35 and over	8.1	5.6
	100.0	100.0
Number of entrants	62	143

96. Table 3 shows that 56.5 percent of the male entrants to psychiatric nursing are over the age of 21 at entry.

97. Salary rates of psychiatric trainees are determined not only by qualifications but also by age at entry. It is difficult to escape the conclusion that the later entry to psychiatric nursing, particularly of males, is related to salary. An entrant aged 20 or over is paid at the fourth step of the trainee scale.

School Certificate

98. A pass in the School Certificate examination became a prerequisite for entry into general nursing training on 1 December 1966 and for entry into psychiatric and psychopaedic training on 7 September 1970.

99. The effect of the introduction of School Certificate as a prerequisite for the 3-year general nursing course was presented in evidence by the State Services Commission and the department. The educational qualifications of student nurses are set out in table 4.

Table 4

EDUCATIONAL QUALIFICATIONS OF STUDENT NURSES IN GENERAL HOSPITALS*

Qualifications	Percentage of Student Nurses in Each Group 1965	1966	1967	1968	1970	1971
Lower Sixth Form Certificate, U.E., or better	27.4	31.9	39.2	44.5	56.5	60.5
School Certificate	33.8	35.8	40.3	44.7	40.9	37.3
Less than School Certificate or other	38.8	32.3	20.5	10.8	2.6	2.2
Number of Student Nurses	4,763	4,597	4,299	4,091	4,620	4,611

*The figures for 1965, 1966, 1967, and 1968 are for calendar years: those for 1970 and 1971 are for years ending 31 March.

100. Table 4 shows a decline in numbers of student nurses for the first 3 years after the introduction of School Certificate as a prerequisite. Even more notable is the rise in the percentage of student nurses with more than the minimum educational qualifications.

101. The same source provided similar information about psychiatric and psychopaedic trainees.

Table 5

EDUCATIONAL QUALIFICATIONS OF PSYCHIATRIC TRAINEES

Qualifications	Percentage of Trainees in Each Group 1965	1966	1967	1968	1970	1971
Nursing qualifications	*N.A.	N.A.	N.A.	N.A.	6.4	6.6
Lower Sixth Form Certificate, U.E., or better	8.9	8.4	14.6	18.1	13.9	20.2
School Certificate	13.6	16.6	17.4	21.1	16.9	23.6
Less than School Certificate	77.5	75.0	68.0	60.8	62.8	49.6
Number of trainees	317	347	489	512	490	407

*N.A. = Not available.

Table 6

EDUCATIONAL QUALIFICATIONS OF PSYCHOPAEDIC TRAINEES

Qualifications	Percentage of Trainees in Each Group					
	1965	1966	1967	1968	1970	1971
Nursing qualifications	*N.A.	N.A.	N.A.	N.A.	3.6	2.9
Lower Sixth Form, U.E., or better	1.8	5.3	5.0	5.8	6.1	13.2
School Certificate	8.2	15.3	12.5	13.9	9.3	20.5
Less than School Certificate and other	90.0	79.4	82.5	80.3	81.0	63.4
Number of trainees	171	190	229	237	248	205

*N.A. = Not available.

102. We note from tables 5 and 6 the not unexpected fall in the number of psychiatric and psychopaedic trainees after School Certificate became a prerequisite for entry. There is some evidence already of improvement in the educational qualifications of trainees; it remains to be seen whether this improvement will be continued in a pattern similar to that of student nurses in general hospitals.

103. Table 7 shows the reduced number of entrants to psychiatric and psychopaedic training since School Certificate became a prerequisite.

Table 7

RECRUITS TO AND RESIGNATIONS FROM PSYCHIATRIC AND PSYCHOPAEDIC NURSING TRAINING

Year Ended 31 March	Recruits	Resignations	Ratio Recruits/ Resignations
1968	390	229	1.7/1
1969	382	259	1.5/1
1970	385	297	1.3/1
*1971	269	268	1.0/1
*1972	271	138	1.9/1

*School Certificate required.

104. We believe that the reduction in the intake is more likely to be due to the exclusion of those without a pass in School Certificate than to any sudden change in attitudes to psychiatric nursing as a career. On the other hand, we were warned that some past recruitment and resignation figures may have been swollen by the inclusion of university students employed and paid as trainees for 3 or 4 months a year, but with no intention of continuing after the end of the university vacation.

The Present Scope for Recruitment

105. We considered it desirable to determine if possible whether the shortage of nursing staff is greater in psychiatric than in general hospitals. We are aware that some hospital boards and some hospitals have no shortage of recruits. In this analysis we shall deal with establishments, appointments, and vacancies on a national basis.

Psychiatric and Psychopaedic Hospitals

106. The present staff situation in psychiatric and psychopaedic hospitals was set out in table 1 of appendix 7 of the submission of the State Services Commission and the department. The essential features are set out in table 8.

Table 8

STAFF ESTABLISHMENT, APPOINTMENTS, AND VACANCIES: PSYCHIATRIC HOSPITALS

Group	Approved Establishment 29 February 1972	Whole-time Appointment	(Number Part-time) *F.T.E.	Vacancies	Percentage of Approved Posts Vacant
Matrons/head nurse and assistants	87	84	—	3	3.4
Supervising charge/sister	48	43	—	5	10.4
Charge nurse sister	429	379	— (3)	50	11.6
Tutors	37	29	2.6 (415)	5.4	14.6
Basic grade nurse	2,636	2,003	280.2	352.8	13.4

*F.T.E. = Full-time equivalent

107. The combining of 13 groups of staff under the title of "basic grade nurse" is confusing. Some are registered psychiatric, psychopaedic, or community nurses; some are trainee nurses or student community nurses; over half are hospital aides who do not aspire to or qualify for nursing training. The absence of an approved establishment for each group prevents an analysis of what the desirable proportions of each should be and of where the "shortages" are. The only information submitted which permits some analysis of this group of "basic grade nurses" is contained in a report of recruitments and cessations of service in psychiatric hospitals from 1 March 1971 to 29 February 1972 (table 2, appendix VI, submission of the State Services Commission and the department.)

108. In table 9 below, the whole-time and part-time recruitments and cessations in each subgroup have been summated. The figures show the number of individuals, not their full-time equivalents for service.

Table 9

RECRUITMENT AND CESSATIONS: PSYCHIATRIC HOSPITALS

(Year 1 March 1971 to 29 February 1972)

Group	Recruitments	Cessations	Gain or Loss	Mental Health Lead
A. Senior Staff—				$
Matrons/head nurses and assistants	2	5	−3	Nil
Supervisors	0	2	−2	98-115
Charge nurses (sisters)	7	40	−33	62-118
Tutors	2	2	—	
Sub-total: senior staff	11	49	−38	
B. Basic grade nurses, registered—				
Staff nurse (male)	35	59	−24	162-209
Staff nurse (female)	46	62	−16	162-209
General staff nurse (male)	12	1	+11	Nil
General staff nurse (female)	44	30	+14	Nil
Registered community nurse	29	21	+8	Nil
Sub-total (A + B) registered staff	177	222	−45	
C. Basic grade nurse, trainee or untrained—				
Trainee nurse (male)	119	69	+50	375-409
Trainee nurse (female)	151	125	+26	375-409
Student community nurse (male)	3	2	+1	Nil
Student community nurse (female)	6	11	−5	Nil
Assistant nurse (male)	2	17	−15	Nil
Assistant nurse (female)	6	45	−39	Nil
Hospital aide (male)	136	82	+54	Nil
Hospital aide (female)	469	305	+164	Nil
Sub-total trainee and untrained	892	656	+236	
Grand total A + B + C	1,069	878	+191	

109. Analysis of table 9 shows that the "net gain" of staff during the year is in mere numbers, not in psychiatric nursing expertise. There was in fact a net loss of 78 registered psychiatric nurses. There is a gain in trainee nurses but the biggest numerical increase is in hospital aides who are presumably doing work much of which would or should be done by psychiatric nurses (and present trainees) if sufficient were available. Table 9 also shows the effects of the policy of phasing out the assistant nurses. We believe that the desirable proportions of trained and trainee psychiatric nurses to registered and student community nurses and hospital aides should be clearly defined in a formal establishment for each hospital. Admittedly the establishment may not be filled but at least it would provide a standard to strive and plan for in the interests of the quality of

nursing care. The gain in recruitment and retention of trainee nurses may be due to the mental health lead: the same cannot be said for registered staff whose smaller lead does not retain them. Moreover the greatest increase is found in the hospital aide figures where the lead does not apply.

110. We conclude that there is scope for recruitment of psychiatric trainees who are to be preferred to "pairs of hands" ineligible for psychiatric training. Not only are there many nursing vacancies in the approved establishment: there is also what we consider to be an imbalance in the ratio of psychiatric nurses or trainees to other personnel doing or attempting nursing duties. A desirable, even if presently unattainable, establishment should be determined for each division of the "basic grade nurse" group for each hospital.

General Hospitals

111. To the extent that general and psychiatric hospitals share the same pool of recruits, recruitment in each will affect the prospects of the other. We have received no complete figures for shortages of nursing staff in general hospitals. Some hospital boards were uncertain of, or did not include, establishments or resignations. Excluding five such boards, we have figures for 70.3 percent of the total number of nursing staff employed by hospital boards. These figures permit an assessment of shortages in a representative sample of the whole (table 1 of supplementary information supplied by the State Services Commission and the department).

Table 10

ESTABLISHMENT, APPOINTMENTS, AND VACANCIES: GENERAL HOSPITALS

(Year Ended 29 February 1972)

Group	Approved Establishment	Whole-time Appointments	(Number Part-time) *F.T.E.	Posts Vacant	Percentage Vacant
Matrons and assistants	225	217	(1) 0.9	7.1	3.4
Supervisors	254.8	195	(9) 5.1	54.7	21.4
Tutors	231.6	178	(37) 21.8	31.8	13.7
Ward sisters	971.6	745	(45) 24.8	201.8	21.7
Staff nurses/sister	2,556	1,533	(1,218) 601.2	421.8	16.1
Registered community nurses	1,012.8	797	(81) 45.2	170.6	16.8
Hospital aides	1,671.5	1,388	(803) 427.3	Nil	Surplus
Students: 3-year course	3,702	3,450	—	252	6.8

*F.T.E. = Full-time equivalent

112. We note that the apparent shortages of registered nursing staff in general hospitals are even greater than in psychiatric hospitals. Shortages of supervisors (21.4 percent compared with 10.4 percent in psychiatric hospitals) and ward sisters (21.7 percent compared with 11.6 percent in psychiatric hospitals) are obvious. Direct comparisons below this level are not possible owing to the absence of a specific establishment in psychiatric hospitals.

113. Direct comparison of percentage shortages may be invalid without consideration of the staffing structure of nursing in the two types of hospital. With the addition of figures available from four of the five boards excluded above, the patterns of staffing in psychiatric hospitals can be compared with that of 87.2 percent of nursing staff in general hospitals.

Table 11

EXISTING DISTRIBUTION OF NURSING STAFF ON 29 FEBRUARY 1972: PSYCHIATRIC AND GENERAL HOSPITALS

	Group	Psychiatric Hospitals		General Hospitals	
		Number	Percentage of Total Nursing Staff	Number	Percentage of Total Nursing Staff
1	Matrons and assistants	84	3.0	261	1.8
2	Supervisors	43	1.5	254	1.8
3	Charge nurse/ward sister	379	13.4	976	7.1
4	Tutors	32	1.1	250	1.8
5	Staff nurse/staff sister	567	20.0	2,684	19.6
6	RCN/RM/RMN Karitane	51	1.8	1,341	9.7
	Sub-total (percent)	—	40.8	—	41.8
7	Assistant nurse	436	15.5	—	—
8	Hospital aides	586	20.8	2,251	16.3
9	Trainee or student nurse	627	22.2	4,250	30.7
10	Student community nurse	16	0.6	1,402	10.2
11	Others	—	—	136	1.0
12	Total	2,821	100.0	13,805	100.0

114. From table 11 we note that the staffing can be directly compared in the first six divisions of registered staff. There are more staff in wards of psychiatric hospitals at charge nurse/ward sister level. There are considerably more registered community nurses in general hospitals. Registered nursing staff comprise 40.8 percent of nursing staff in psychiatric hospitals and 41.8 percent in general hospitals.

115. The most important differences are in trainees: students, at 93 percent of establishment, comprise 40.9 percent of nursing staff in general hospitals compared with 22.8 percent in psychiatric hospitals. This disparity is balanced in psychiatric hospitals by hospital aides and assistant nurses (36.3 percent of "nursing staff" compared with 16.3 percent in general hospitals).

116. This suggests to us that, though comparable shortages exist in psychiatric and general hospitals, there is greater need to recruit trainees for psychiatric hospitals than student nurses for general hospitals.

117. We believe that the salary differential, *per se,* may be a strong inducement to recruitment. After the negotiated pay rise in 1966, entrants rose from 264 to 384. The annual entry has fallen progressively since 1968, but there have been contributory causes such as School Certificate and adverse publicity.

118. We are of the opinion that the salary differential may be an incentive to some good and some bad recruits and that those for whom it is the major influence in the choice of psychiatric nursing as a career may well form a high proportion of the dropouts. On the other hand, we do not think that adult males will be attracted by the salary scale for student nurses in general hospitals.

119. We hold the view that many other influences are likely to have an effect on recruitment at least equal to that of the pay differential. We would place on all the intangibles that create a good reputation for a hospital and its school of nursing as great an emphasis as on differences in pay.

INFLUENCES ON RETENTION

120. The influences which affect retention of psychiatric nurses and trainees can be considered from a positive and a negative point of view. On the positive side we have listed the influences that favour retention and on the negative those which are advanced as reasons for resignation.

121. We have reviewed the evidence which was produced to suggest that the salary differential retains trainees who would otherwise cease their training. Few facts were presented to support this contention. The assertion appears to us a matter of opinion that approximately $400 a year would persuade a trainee to accept conditions which she could not tolerate and to continue a training for which she found herself, after experience, to be unsuited. We agree that the salary differential might persuade some trainees to continue, but, if this were the sole influence, these trainees are unlikely to be of great potential.

122. The evidence presented to us on recruitment and cessations of registered psychiatric nurses for the year ended 29 February 1972 shows an excess of 78 resignations (92 recruitments and 170 cessations). Those who resign are not necessarily lost to nursing: a few may have been appointed to psychiatric units in general hospitals. It appears to us that the existing margins at staff nurse, charge nurse/sister, and supervisor level have not prevented an adverse staffing trend.

123. The view was expressed in cross-examination that the acceptance with inadequate screening, of large numbers of recruits invited a heavy dropout rate which might, in effect, be a good, rather than a bad thing. We believe however, that trainees should be carefully selected. On the evidence of a dropout rate twice that in general hospitals, it does not appear that the mental health lead is effective in retaining those who find the work or study too much for them.

124. We think it too early to judge whether the higher educational qualifications of trainees will have a favourable influence on their retention. The report on aspects of nursing in some Auckland hospitals, which was quoted by the Medical Association of New Zealand, shows quite clearly that resignation rates were substantially lower among student nurses with higher educational qualifications than School Certificate.

125. Another positive influence on retention as on recruitment, is exercised by those intangibles which produce for a hospital a good reputation. Among these we would list the attitudes of the superintendent and his medical, nursing, and tutorial staff towards the trainee, the atmosphere and "personality" of the hospital, working conditions, staff morale and interpersonal harmony, a high standard of teaching, stimulating and provoking educational programmes, and the creation for the trainee of a sense of purpose and a feeling of belonging to a team.

126. The availability of other employment in the locality affects recruitment, but we received evidence that, even where recruitment of psychiatric trainees was full, the dropout rate continued to be high.

127. We note as a favourable influence on retention the practice of some hospitals to give applicants a preliminary exposure to the hospital before selection. This, and the gradual introduction of the trainee to the more demanding work of the hospital, may help retention of recruits.

128. On the negative side we would expect to find in the reasons given for resignation some indication of the influences against retention. We accept the assurances given that such evidence is unreliable, since the statement on the resignation form may not give the real reason for resignation.

129. The annual statistical returns for New Zealand schools of nursing for the year ended 31 March 1971 gave the following reasons for the resignation of 230 psychiatric and 88 psychopaedic trainees who left during the year.

Table 12

REASONS GIVEN FOR RESIGNATIONS OF PSYCHIATRIC AND PSYCHOPAEDIC TRAINEES

Reason for resignation	Percentage of Resignations	
	Psychiatric	Psychopaedic
Marriage	8.26	12.50
Study problems	13.48	38.64
Personal/family	29.13	19.31
Dislike of nursing	8.70	4.55
Health	11.30	11.36
Dismissed	8.26	1.14
Dislike of conditions	3.48	3.41
Not known	4.35	2.27
Others	13.04	6.82

130. We believe that it is natural for a trainee to rationalise resignation in terms acceptable to herself and others. The "reasons" given are non-specific and largely uncontrollable, and they may hide rather than reveal the true causes such as emotional immaturity, depression, anxiety, truancy, lack of application, revulsion from realities, despair about incurables, and the fear, traditionally attributed to medical students, of suffering from the same disorders as the patients. Two other reasons were brought most forcibly to our attention in a discussion with a group of trainees. These were having to accept responsibilities for which they were neither sufficiently mature nor adequately trained and the effects of the shifts and roster system which interfered with social life and cut them off from their friends in other types of employment.

131. In evidence submitted to us there were other "reasons" which were alleged to make psychiatric nursing an "unfavoured profession". The patients were "different", there was lack of intelligible communication, there were danger, violence, verbal abuse, stress, contact with death, fear of litigation or of articles in the press. Many of these reasons apply equally to general nursing and all have been fully discussed earlier in this chapter.

THE MENTAL HEALTH LEAD

132. The "mental health lead" appears to have acquired a certain mystique in recent years. The State Services Commission and the department, though recognising a salary differential, denied the existence of a mental health lead.

> "Salary differentials between psychiatric and general nurses have been the outcome of the separate procedures and decisions of different wage fixing Authorities in the past. No 'mental health lead' (in the sense attached to this term in the United Kingdom health services salary scale) has ever been claimed, negotiated or conceded by any wage fixing process in New Zealand."

133. Whether the term used is salary differential, margin, or mental health lead, it is clear that some witnesses saw it not so much as a compensatory payment for poor conditions or special skills, or as a specific inducement for recruitment and retention, but as a status symbol—a recognition of value to the community. If, whether by accident or design, it has become such a symbol of status, its elimination will have more than a mere monetary effect on those who receive status satisfaction from it.

134. Even on the monetary level the Public Service Association claimed that if the differential were removed psychiatric nurses would lose something. The State Services Commission and the department suggested that psychiatric nurses would lose nothing but that general nurses would gain more than psychiatric nurses. We were made aware that for psychiatric nurses to "stand still" while others catch up would be at least a deprivation of advancement.

135. Salary rates influence, and are designed to influence, the choice of a career. For those for whom the salary differential was a potent influence in recruitment, it will remain as an incentive for retention. It will especially continue to influence those who by habit or necessity regard it as a priority.

136. We note Mr Healy's comment during cross-examination in answer to a question on recruitment and retention.

> "I think we have heard enough evidence here in the last two weeks, that I think there is a good case for a special study to be made on recruitment and retention at trainee levels in both hospitals."

137. We agree that such a study would provide at least some of the facts that were missing in the evidence presented to us.

138. In our view further study is required also of the other influences, favourable and unfavourable, which affect the attractiveness of psychiatric and psychopaedic nursing as a career. We believe that much can be achieved by positive attention to the influences which favour retention, so that these are cultivated and strengthened. The negative influences must then diminish.

CONCLUSIONS ON RECRUITMENT AND RETENTION

Influences on Recruitment

139. We have noted that in some respect the factors affecting the recruitment of psychiatric nurses are different from those affecting the recruitment of general nurses. Until comparatively recently the minimum age of entry was higher, and until 1970 the educational qualification was lower. These factors make it difficult to compare past statistics. Continuing influences are lesser attractiveness of psychiatric nursing in the public esteem, and therefore to girls and their parents; fewer opportunities of specialisation; fewer avenues of employment; and less rapid promotion, especially for men.

Influences on Retention

140. In the preceding sections of this chapter we have discussed a number of matters relating to job content and conditions in which psychiatric nursing differs from general nursing. Although we could not say that of themselves these differences justified a salary differential we recognised that they could be potent influences in the minds of young people and thus on the retention of psychiatric nursing entrants. It is not necessary to refer to all of these matters again, but it needs to be emphasised that some of them, such as the greater social (and often geographic) separation of psychiatric hospitals from the community, unpleasant and unfamiliar aspects of the work and premature assumption of responsibility may affect the acceptability of an occupation to a much greater extent than is generally realised.

The Statistical Picture

141. Having regard to these various differences it is not surprising that such statistics as are available show different patterns of recruitment and retention. We find a much higher loss of psychiatric trainees than of general nursing students, despite the presumably countervailing effect of the high salary differential. We find that even after the minimum age of entry has been made the same, psychiatric entrants come in at higher ages, and on the male side, very markedly.

142. After registration we find that although the salary differential is less, proportionately fewer psychiatric nurses leave than general nurses. This however must be considered in the light of two important factors—the greater proportion of male nurses in psychiatric hospitals and the greater propensity for general nurses to travel overseas. This latter point is illustrated by a Department of Statistics analysis of declarations made by persons entering and leaving New Zealand. In 2 years to 31 March 1972 there were

approximately 20,000 departures and arrivals of persons declaring themselves to be registered general nurses, and only 200 persons declaring themselves to be registered psychiatric or psychopaedic nurses.

143. What the available statistics could not demonstrate—because of unrealistic and uncategorised establishment figures—was the extent of the shortage of psychiatric nurses and whether it was greater than the shortage of general nurses. It was indeed suggested to us that there might not in fact be a shortage but we are in no doubt that measured by the needs of the patients there is a shortage and it is considerable.

144. Factual information on all matters relevant to assessing the importance of a salary differential in recruitment and retention was singularly lacking. We were given some information about the educational qualifications of psychiatric trainees from a source which in all other matters we were advised to ignore. In the absence of any others, we have had to use the figures collected from New Zealand schools of nursing to get some indication of the sex and age of psychiatric trainees and their "reasons" for resignation.

145. Shortages of psychiatric nurses have existed for many years. Shortage of staff was the cry on all our visits to hospitals. Yet no retrospective nor prospective analysis of the extent, the trend, and the relief of the shortages appears to have been made.

146. If the salary differential is an influence favouring the recruitment of trainees (and we believe it is, particularly of males), it is obviously desirable to know the extent of the problem of recruitment before recommending the removal of a favourable influence on it. The following information is necessary if an objective assessment is to be made:

(i) An assessment of the optimal bed occupancy of existing psychiatric hospitals and of the qualified staff required to service these beds.

(ii) An assessment of the planned outpatient, day-care, and domiciliary services to be provided by existing psychiatric hospitals and of the nursing staff required to run such services.

(iii) An assessment of the psychiatric nursing staff required to staff existing and planned psychiatric units in general hospitals.

(iv) A nursing staff establishment for all psychiatric hospitals with a clear indication of the desirable proportions of qualified psychiatric nurses, trainees, community nurses, and hospital aides. In one hospital we were informed that the trainees were one-third of the nursing staff, yet the national average is one-fifth.

(v) The future pattern of retirement on age or after 40 years' service of present psychiatric nursing staff.

(vi) The rate of resignation of qualified psychiatric nursing staff for reasons other than age or 40 years' service.

(vii) The number of qualified psychiatric and general nurses required to replace nurses retiring or resigning and to maintain the existing and planned services.

(viii) The number of recruits required to yield, after dropouts, the qualified staff necessary.

Staff Shortages

147. We are forced to conclude that shortages of nurses in psychiatric hospitals have been accepted rather than analysed, tolerated rather than attacked, and submitted to rather than overcome. Recruitment and retention of psychiatric nursing staff offer a challenge for action.

148. We are convinced that the most important factor in providing psychiatric care is the availability of suitable staff. There is among nurses a very strong desire to give the best possible psychiatric service. The service which psychiatric hospitals have been able to give in the past has been seriously affected by staff shortages despite efforts to improve the position. We expect that in stage II of our inquiry, further submissions will indicate the degree of urgency of recruitment and the measures proposed to ensure retention of trainees.

Chapter III. THE APPLICATION OF A DIFFERENTIAL

Psychiatric and Psychopaedic Distinguished

1. Our Warrant refers to psychiatric and psychopaedic nurses, and to psychiatric and psychopaedic hospitals. The assumption is that they should be regarded as equal, or at least so similar that if a differential salary scale is justified for one, it is also justified for the other. Moreover the submissions made to us did not seek to make a distinction between them. For these reasons we have generally used the term psychiatric to include psychopaedic.

2. Nevertheless the two terms need to be distinguished. A person may in New Zealand be registered as a psychiatric nurse (R.P.N.) or as a psychopaedic nurse (R.Pd.N.). The curricula differ, the total theory hours being 600 for the psychiatric and 500 for the psychopaedic course, and the latter course appears to lean more towards basic nursing while the former has a greater psychiatric content. The essential distinction is that psychopaedic hospitals are designed "for the care and training of mentally subnormal patients"* and psychiatric hospitals "cater for all types of psychiatric disorders"†. They are different kinds of hospitals, and call for different kinds of nursing skills.

3. Thus the case for a salary differential on the grounds of job content and responsibility or conditions of work, is not necessarily the same for psychiatric as for psychopaedic nursing. From our own observations we suspect that in these respects they differ from one another as much as either differs from general nursing. But on difficulties of recruitment and retention we do not think that they can be distinguished at the present time and on the evidence available. Consequently, as it is on this point that we base our conclusions, we do not propose to differentiate between them. It would in any case be difficult to do so, as we have noted that many subnormal patients are cared for in psychiatric as opposed to psychopaedic hospitals.

Psychiatric Nursing in General Hospitals

4. As our Warrant requires us to report on the justification, if any, for a differential pay scale in favour of psychiatric and psychopaedic nurses as such over other kinds of nurses, we must have regard to

*Department of Health: *Review of Hospital and Related Services in New Zealand*, 1969, p. 32.
†Ibid. p. 31.

the fact that all such nurses are not employed in psychiatric or psychopaedic hospitals. Some are employed as pychiatric nurses in psychiatric units of general hospitals.

5. Before 1 April 1972 such nurses received the differential pay rate only if they had been seconded from psychiatric hospitals. If they had obtained these positions independently, they were paid on the general hospital scale, as were general nurses who might be employed in the psychiatric unit. We have not been told whether this situation has changed for nurses seconded after 1 April 1972.

6. The Public Service Association originally submitted that the principle of a pay differential should apply "where there are psychiatric wards in general hospitals", but later modified this to the extent that, although the principle would still apply, it could not be assumed that the full margin in psychiatric hospitals would apply to the units.

7. If it can be assumed, and even this is arguable, that the psychiatric nurse is required to exercise the full range of her skills in a general hospital unit, it certainly cannot be claimed that she does so under the same conditions as exist in psychiatric hospitals. Thus she could not claim whatever portion of the differential, if any, is thought to be justified by those conditions. Moreover she requires no incentive to recruitment, as she is already qualified; and she needs no greater incentive to retention than the general nurse with whom she is working. Consequently we cannot see that any differential which might be thought necessary for psychiatric hospitals is justified on these grounds for psychiatric nurses employed in general hospitals.

8. We do, however, qualify this conclusion by saying that a differential may be justified by some agreement or assurance. But we do not believe it is our responsibility to inquire into or interpret any such agreements or assurances.

Other Nurses in Psychiatric Hospitals

9. Our Warrant refers to "all nurses employed in psychiatric or psychopaedic hospitals over nurses employed elsewhere". We have in the main directed our attention to the points which might be thought to distinguish psychiatric and psychopaedic nurses employed in psychiatric hospitals from general nurses employed in general hospitals. But we are required to go further than this.

10. Even accepting what some might regard as a narrow definition that "nurses" means "registered nurses", we are faced with the fact that registered nurses (R.N.) and registered community

nurses (R.C.N.) are employed in psychiatric hospitals. There is no differential in their favour against similarly qualified nurses employed in general hospitals.

11. The Public Service Association considered that the principle of a pay differential should apply to all staff of the nursing team in psychiatric hospitals. The association apparently considered that all of the grounds applied in whole or in part—job content and responsibility, conditions, and recruitment and retention.

12. General nurses, working in a psychiatric hospital, have presumably chosen to do so, whether because of locality, preference for the work, the desire to obtain wider experience or a further qualification, or some other reason. Of 146 female staff nurses in certain psychiatric and psychopaedic hospitals, 42 were registered general or general and maternity nurses without a psychiatric qualification. It is difficult to see how the argument of recruitment and retention can justify a differential in their case, except that their promotion prospects may be limited by their lack of the psychiatric qualification. On the other hand, to give them a differential pay scale would be to offer nurses an incentive to move from general hospitals. We heard no evidence or submissions to justify this.

13. Certainly the general nurse in a psychiatric hospital shares substantially the same working conditions as the psychiatric nurse, but to say that her job content and responsibilities are the same would be to say that psychiatric nursing is no different from general nursing. If we are to put any weight on the interpersonal relations and other psychiatric nursing skills which were urged on us, we cannot say that these are acquired merely by transferring from a general to a psychiatric hospital.

14. Community nurses may be trained in general hospitals or in some psychiatric hospitals. They play a valuable part in the staffing of general hospitals. The group RCN/RM/RMN/Karitane accounts for 9.7 percent of the nursing staff (*see* table 11, page 51), and we understand that the greater part of these would be community nurses. But the same group accounts for only 1.8 percent of the psychiatric hospital nursing staff. An even greater disparity appears in the figures for student community nurses, the percentages here being 10.2 percent and 0.6 percent.

15. It cannot be inferred from this that the problem of recruitment and retention of community nurses is greater in psychiatric than in general hospitals, and we heard no evidence to this effect. The disparities may be due to the fact that psychiatric hospitals, having a substantial number of assistant nurses, have been slower

to accept the Nursing Council's plans to establish the community nurse programme. Only three psychiatric hospitals have training programmes for them. Their turnover rate in general hospitals is high; of the 3,769 qualified for registration in the 5 years to 1971, it appears that only about 1,300 were employed in *all* hospitals on 29 February 1972.

16. Community nurses in psychiatric hospitals no doubt share whatever comparative disadvantages there are in that work, but it has not been argued that they share any advantage in job content and responsibility over those working in general hospitals. Their comparatively short training (18 months) and average working life would scarcely enable them to develop the psychiatric nursing skills which might justify a pay differential on these grounds.

17. The arguments applying to assistant nurses and hospital aides are much the same as apply to community nurses. They share, at least to some extent, psychiatric hospital working conditions, but in general they are not expected to exercise psychiatric nursing skills. We understand that assistant nurses are not now being recruited, and the figures for recruitments and cessations of hospital aides (table 9, page 49) do not indicate a need for any differential.

Trainee Nurses

18. Although on a narrow definition students or trainees could be excluded from the terms of our Warrant, which refers to "nurses", we do not think that this was intended, especially as it is this group which enjoys the greatest pay differential (*vide* table 1, page 19).

19. Although trainees in psychiatric hospitals have probably always enjoyed a salary advantage over student nurses in general hospitals, we were informed by the Public Service Association that the present rates were negotiated in 1966. The reasons for the Public Service Association seeking, and the State Services Commission conceding, higher margins in the lower grades was said to be to attract and retain trainees. This was not contested.

20. Certainly the trainee nurse shares the disadvantageous conditions which are claimed to distinguish psychiatric hospitals. Because of her youth and emotional immaturity some of these conditions may affect her more than they would a more experienced and mature nurse, unless special care is taken to protect her from the full impact of them. On the other hand, the trainee cannot claim to have those nursing skills which are said to distinguish the psychiatric nurse from all others.

21. It could be argued, however, that psychiatric and psychopaedic nurse trainees, having to devote fewer hours to theoretical learning—600 and 500 hours respectively, as against 918 hours for student general nurses—give nursing service for many more hours during the 3-year training period and should therefore be paid more. If this were conceded, a salary differential of 5-6 percent of salary could be justified.

Anomalies in Existing Differentials

22. It will be obvious from the foregoing discussion that the current pay differentials seem to present a number of anomalies. These may be briefly summarised as follows:

(i) The differentials are not enjoyed by all psychiatric and psychopaedic nurses; those working in psychiatric units in general hospitals may or may not receive the differential. This does not depend on whether they are exercising their psychiatric nursing skills, but on how they came to be in the unit.

(ii) They are not enjoyed by all nurses in psychiatric or psychopaedic hospitals. General nurses (R.N.) and community nurses (R.C.N.) do not receive a differential. Nor do qualified psychiatric or psychopaedic nurses in administrative positions. It might be regarded as an additional anomaly that the pay differential is not extended to groups such as doctors, occupational therapists, or domestics. Our Warrant, however, restricts us to the consideration of nurses.

(iii) They are not equally spread over the scale, but are greatest in the lower brackets, reducing with promotion, and finally disappearing.

(iv) The enjoyment of other differentials than pay scales (overtime, board, and meal charges) extends to some who do not enjoy the pay differential but does not extend to others who do.

23. The differentials are claimed to be based on three grounds:

(i) Job content and responsibility.

(ii) Conditions of work.

(iii) Recruitment and retention.

The apparent anomalies could therefore be due to the fact that not all of these grounds apply in each situation, or with the same weight. We received little guidance on this, possibly because the Public Service Association considered that our function was merely to decide on the principle of a differential, leaving it to other processes to

determine the amounts. But we find it difficult to interpret "justification" so narrowly, particularly as we are required to determine whether there is justification, not only when a differential is now paid, but also when it is not now paid.

24. It seems that any rational consideration of this problem requires some weighting of the three items, even if this need not go so far as quantifying them. The Public Service Association advocate was not able to assist us much on this. He thought "that the job content or the full elements of psychiatric nursing is the principal factor". On the other hand, he emphasised recruitment and retention for trainees, and conditions of work for general nurses working in psychiatric hospitals or psychiatric units.

25. The situation in respect of the different categories may be summarised as follows:

(i) *Trainee Nurses*—Justification for a differential can rest only on the recruitment and retention and the conditions of work arguments.

(ii) *Community Nurses*—Reliance must be placed on the recruitment and conditions arguments, but it has not been shown that the absence of a lead has affected recruitment.

(iii) *Assistant Nurses and Hospital Aides*—The conditions argument alone seems to be relevant.

(iv) *General Nurses (in psychiatric hospitals)*—The conditions argument supports a differential; the recruitment argument does not.

(v) *Psychiatric Units*—Neither the conditions nor the recruitment arguments support a differential. The job content item cannot support the general nurse in such a unit, and has not been shown to give any strong support to the psychiatric nurse, having regard to the medical treatments which patients may require.

(vi) *Psychiatric Nurses (in psychiatric hospitals)*—All three arguments apply; but recruitment and conditions less so with those who are used to the conditions and trained to cope with them, and have qualified for a career.

(vii) *Senior Nurses*—Those in administrative positions, having less contact with patients, are less affected by conditions and have fewer opportunities of exercising psychiatric nursing skills. They have less need of a retention incentive, but higher salaries at these levels could make a psychiatric nursing career more attractive to recruits and junior registered staff.

26. We conclude that there is no strong case for extending the existing pay scale differentials to categories of nurses not now receiving them. Even if the case were stronger in respect of any particular category we would think it preferable to deal with the matter only in the context of a general review of nursing salary scales.

Administrative Problems

27. It occurred to us that the existence of the salary differential could pose administrative problems particularly now that the control of psychiatric hospitals has been assumed by hospital boards. Accordingly we asked the State Services Commission and the department to comment on this point.

28. The relevant extract from their submission reads:

"46. It is known that where a special differential or allowance is granted, which yields higher remuneration, undesirable features may emerge.

"46.1 Staff resent being moved from these areas or denied opportunities to work in them.

"46.2 Pressures are brought to bear on hospital administrations to roster staff on equal terms to enable all to share in the increased remuneration. Such actions take no account of the special qualities and competence required of nursing personnel in certain wards or services or of the particular needs of their patients. This problem is already manifest in relation to weekend and night duty work for which substantial penalty payments are made.

"46.3 Long standing staff insistence on strict rotation through the roster limits continuity of staff involvement in patient treatment programmes. As well as adversely affecting therapeutic endeavour, the lack of continuity may also restrict the opportunities of student nurses to observe the practical application of sound nursing principles.

"46.4 Pressures such as the above may well divert the primary concern of a hospital administration from its therapeutic function to the maintenance of equalisation of staff remuneration.

"47. The administrative complications caused by the different salary scales and conditions of employment which now exist will gradually be overcome by the development of common salary scales and conditions of employment for all nurses employed by hospital boards. To preserve a salary differential for one class of nurse would perpetuate these complications."

29. The State Services Commission's advocate did not lay any great stress on administrative problems. When questioned on the matter he said:

"No, quite frankly I don't think this is a real issue . . . the system is so complicated already that a few more complications are not going to make much difference."

30. Having heard comment on this matter, we agree that if a differential can be justified, any administrative difficulties do not affect the issue.

Differentials Other Than Pay Scales

31. In chapter I we referred to certain differences between conditions which apply or applied before 1 April 1972 to psychiatric hospital nurses and those which apply or applied to general nurses employed by hospital boards. In paragraph 45 of that chapter we mentioned a number which might be regarded as "differentials" in favour of psychiatric nursing.

32. We received little in the way of evidence or submissions on this subject, and we are of the opinion that in general these differences have arisen from the fact that different employers and different employee organisations using different negotiating machinery were associated with the determination of conditions. We have no reason to suppose that it was ever decided that the differentials were "justified".

33. Nevertheless some of them may be justifiable by conditions which apply to one sort of hospital and not to another. For example, the occupancy of a house in the grounds of a psychiatric hospital may have certain disadvantages that warrant a lower rent being charged than would be charged for a similar house adjacent to a general hospital. If specific factors justify a difference of this sort, then we see no reason why the rental or other charge or condition should not be different. On the other hand, we are not aware of any argument which would justify the different overtime and penal rate conditions which are referred to. If we understand the position correctly, and some of these psychiatric hospital conditions are in fact public service conditions, then it would seem that there is a good case for extending them to the staff of general hospitals. We certainly do not see the fact that hospital boards are the nominal employers as being any reason for differentiating. Indeed we understand the department is moving in this direction and we trust this matter will be quickly resolved.

Chapter IV. FUTURE DEVELOPMENTS

Training

1. The evidence presented to us during this inquiry extended to subjects outside our terms of reference. We did not exclude such evidence because it could well have relevance in determining if, and if so *when,* a salary differential should be abolished.

2. The submissions of the Medical Association of New Zealand drew attention to the Carpenter Report on nursing education. We are aware that Dr Carpenter's report has been under consideration by a special committee whose recommendations are expected soon*. We express no opinion as to which of Dr Carpenter's proposals should or can be implemented in part or in whole. What seems to us important is that the basic principles and structure of nursing education are being examined and that, as the outcome of that examination, there may be changes which could influence our recommendations on salary differential.

3. For instance, if the balance of evidence presented to us supported the continuation of a salary differential under present conditions, our recommendation might be the opposite of the one which could be justified if all or some nursing trainees had student status without clinical responsibility.

4. Moreover, the Nursing Council of New Zealand (formerly the Nurses and Midwives Board) reported to us that it has had, since 1964, a plan to reduce the present seven nursing programmes (community nurses, general nurses, male nurses, maternity nurses, midwives, psychiatric nurses, and psychopaedic nurses) to three. Their proposal is that there should be only three basic courses.

(a) A degree programme.

(b) A general 3-year programme.

(c) A community nurse programme.

All three basic programmes will be designed to give adequate experience in maternal and child health, community health, psychiatric nursing, and medical and surgical nursing. In short, instead of general, psychiatric, and psychopaedic nurses, there would be just "nurses". The plan provides for post-basic specialist registration in fields including psychiatric and psychopaedic nursing. The community nursing programme would continue with little change. The programme for midwives is designated post-basic.

*It has since been announced that pilot schemes will be commenced in 1973.

5. We note from the Nursing Council's submission that this change is already behind its scheduled date (1970) for introduction. It may be that discussion of the issue of student status for student nurses, raised in the Carpenter report, has delayed the introduction of these proposals.

6. There would clearly be no justification for a salary differential for any group of nurses while they had student status and were giving no clinical service, or even while they were participating in a programme having the same course, the same experience, and the same registration as the Nursing Council proposes. Only experience will demonstrate whether some form of monetary inducement will be necessary to attract sufficient nursing staff to the psychiatric hospitals after registration.

7. While these fundamental changes are afoot, we consider a final decision on the mental health lead difficult to make and liable to change.

8. We shall refer again to this subject in our final summary. We believe that training, present and future, is relevant to the matter of a salary differential and, especially, the timing of any change.

Psychiatric Units

9. One or more members of the Commission have visited the psychiatric units in these general hospitals: Kew, Princess Margaret, Wellington, Palmerston North, Hastings, and Auckland. We do not think that the omission of visits to other units invalidates our conclusion that these units have the same atmosphere and facilities as the other wards of the hospitals containing them. Many of the units are new and show evidence of careful planning for the effective practice of modern psychiatry.

10. We do not believe that work in these units has a job content any more difficult, a responsibility any greater, or conditions any worse than in the other wards of a general hospital. No evidence was presented to support the proposition that a salary differential is essential to recruit and retain psychiatric nurses in psychiatric units of general hospitals. Such evidence as we have suggests that psychiatric nurses are willing to transfer from psychiatric hospitals to psychiatric units in general hospitals with or without a salary differential.

11. The Director, Division of Mental Health, outlined in his evidence the changes which have taken place in psychiatric services in recent years. One such change was the growth of psychiatric units in general hospitals and the decline of occupied beds in

psychiatric hospitals. The average number of occupied beds in psychiatric units of general hospitals in 1971 was stated to be 131 compared with 9,807 occupied beds in psychiatric hospitals. Dr Mirams was asked in cross-examination to predict the rate of future growth in psychiatric units in public hospitals and the rate of decline of use of psychiatric hospitals. Though he was not confident that psychiatric hospitals would be phased out completely, he expressed the opinion that it would be 10–20 years before psychiatric units in general hospitals were providing half the psychiatric services as they do in certain areas in the United Kingdom.

12. It was argued that the case for a salary differential for psychiatric nurses in psychiatric hospitals was weakened as the proportion of psychiatric services in public hospitals grew. However, this proportion is at present small, and we received no factual evidence on the likely rate of change.

13. Although we received no evidence on the subject, we observed that domiciliary services are being developed from psychiatric hospitals and from psychiatric units of general hospitals. This is a trend which is likely to grow, but not sufficiently fast to alter greatly the character of psychiatric hospital nursing in the immediate future. We note, however, that it would be difficult to make any distinction, warranting a salary differential, between domiciliary nursing based on a psychiatric hospital and that based on a psychiatric unit.

Court Referrals

14. Several witnesses asserted that working conditions in psychiatric hospitals were adversely affected by the presence of patients on remand, admitted under sections 39B and 47A of the Criminal Justice Act 1954.

15. Figures for all hospitals receiving such people in 1970 show that of the 617 "special" admissions, 524 (84.9 percent) were remand patients. Of the 9,644 registrations by legal definition (informal, committed, special) in 1970, the remand patients constituted 5.4 percent.

16. Some witnesses stated that remand patients were difficult to manage and liable to be violent. It was claimed that they were a bad influence on psychiatric patients with whom they were associated and that a psychiatric hospital was not the proper place for their treatment or observation.

17. We do not intend, at this stage of our inquiry, to express any views on these contentions; this is a problem for consideration in stage II. The matter is relevant at this point only because the presence of remand patients has been advanced as a justification for a salary differential.

18. On the evidence before us to date we do not believe that the presence of difficult patients and non-patients on remand (up to 12 percent of the total registrations in some hospitals) justifies a salary differential for the nursing staff of the whole hospital. An extra allowance for dealing with such patients in certain security areas has already been approved.

19. This subject is introduced under the heading of future developments because, if remand patients were in the future ever dealt with in other institutions, the justifications of a salary differential based on their presence in psychiatric hospitals would disappear.

Treatment of Alcoholics

20. The extent to which alcoholic patients increase the stress and challenge the skills of psychiatric nurses was not enlarged on in evidence submitted except that of Dr Moore.

21. We raise the matter under the heading of future developments because we are aware that there is a body of opinion that alcoholics, other than psychotic, should be treated not in psychiatric hospitals but in special institutions or in general hospitals.

22. We do not propose to comment on this matter at this stage. We raise it merely to indicate the possibility of change in the management of alcoholism. If the treatment of alcoholics is removed from psychiatric hospitals, the contribution made by alcoholics to the adverse conditions alleged to exist in these hospitals will be removed.

Drug Addiction and Abuse

23. The problems of dealing with drug addicts were not specifically mentioned in the submissions.

24. We raise the matter here to say that we expect plans for their proper treatment and rehabilitation to be submitted in stage II of our inquiry.

25. In the meantime, drug addicts and abusers continue to be admitted to both psychiatric hospitals and medical and psychiatric units of general hospitals. Outpatient services of both types of hospital provide a follow-up service.

The Care of Psychogeriatric Patients

26. The problem of the care of the old and mentally infirm was referred to in some submissions. One said:

> ". . . they require assistance with everyday physiological functions. They represent a heavy continuing nursing task for which it is difficult to get devoted staff. The limitations that exist to any marked progress as a result of treatment tends to make some people see this as a revolting treadmill rather than a romantic call to humanitarian duty."

27. We are aware that elderly patients in psychiatric hospitals create a heavy nursing load. From our observations and from the information supplied by medical superintendents on our visits to hospitals, it seems clear that some patients in psychiatric hospitals are there because they are old and require some help in the activities of daily living. They are geriatric rather than psychogeriatric. Also, in geriatric hospitals of hospital boards there are some patients who are psychogeriatric rather than geriatric. The borderline is difficult to define: the disturbance of mental function may be transient, intermittent, or permanent.

28. We await submissions in stages II and III of our inquiry into the whole problem of future provision for psychogeriatric and geriatric patients. Some patients are in one or other hospital mainly because they are old and because their families cannot or will not give them the care they require. Others are in hospital to give their families a rest.

29. At this stage of our inquiry we do not wish to consider the problem of the care of psychogeriatric patients as an issue separate from the care as a whole of geriatric patients in the hospital and the community.

Implications of Future Developments for this Inquiry

30. The foregoing sections of this chapter have indicated that our inquiry into clause 9 of our Warrant is being conducted when psychiatry, psychiatric nursing, and nursing education are facing changes which are as yet not fully defined.

31. In addition, the psychiatric hospitals, recently amalgamated with general hospitals and now controlled by hospital boards are in the process of settling down under new management.

32. To make a final decision about the justification of a salary differential for psychiatric nurses and trainees without regard for actual or impending changes appears to us ill advised. We consider that the decision cannot be responsibly made until the nature of likely changes is better known.

33. We have received evidence that there are to be changes in nursing education aimed at unification. We expect in the next stage of this inquiry further submissions on psychiatric services in psychiatric, psychopaedic, and general hospitals. We expect discussions of policy on court referrals and the treatment of alcoholics, drug addicts, and psychogeriatric patients.

34. We believe that future developments have an important bearing not only on the nature of our recommendation on clause 9 but also on the timing of its operation. On the other hand, we are unable to accept the suggestions made to us that the salary differential should be abolished either to pave the way for proposed changes—such as the integration of hospital services or the unification of nursing education—or because adverse conditions in psychiatric hospitals are likely to be removed or ameliorated by projected developments. We do not consider that the existence of a differential will be a major obstacle to the introduction of changes, if and when they are approved. The various developments which are now taking place or are projected are unlikely greatly to change psychiatric hospitals in the immediate future and their effect can only be weighed when they do take place.

Chapter V. OVERSEAS OPINIONS AND PRACTICES

WORLD HEALTH ORGANISATION

1. Both the Public Service Association and the Nurses' Association sought to strengthen their case by an appeal to the authority of the World Health Organisation and quoted from its publications. The Public Service Association referred to sections of "The Nurse in Mental Health Practice" (Report on a Technical Conference; Public Health Papers No. 22, WHO, Geneva, 1963). The Nurses' Association quoted from the fifth report of a WHO Expert Committee on Nursing (WHO Technical Report Series No. 347, Geneva, 1966).

2. We have studied both documents in order to relate the quoted extracts to their contexts. In doing so we have acquired some useful background information which will serve us well in the later phases of our inquiry. But we do not think the issues raised in either document assist us in determining whether psychiatric nurses in New Zealand should receive a salary differential.

OTHER COUNTRIES

3. At our request the State Services Commission obtained information from some overseas countries on whether differential pay scales existed elsewhere. Our interest was mainly in the United Kingdom where we knew a salary lead of £99 was paid to nurses in psychiatric hospitals.

4. In providing this information about the United Kingdom, the State Services Commission commented:

> "The 'lead' which exists in the United Kingdom should not be regarded as justification for similar treatment in New Zealand without a full knowledge of the recruitment and retention problems in the United Kingdom and a comparison of the socio-economic background of the two countries."

5. We appreciate this warning, but we could not exclude the possibility that an examination of the opinions and practices of other countries might shed some light on the matters we are required to consider.

6. From the limited information given to us, we record the practice in five countries.

*Australia**

New South Wales: We were informed that psychiatric nurses "have always enjoyed an advantage over general nurses, both in terms of salary, conditions of employment, and annual leave". It may also be worth noting that a comparison of the 1971 salary agreements shows that the basic salary scale for male registered nurses in general hospitals is exactly the same as for (male and female) registered psychiatric nurses. The latter, however, have an additional allowance of $104 a year and gain a further advantage in senior positions such as deputy charge and charge nurses. A separate geriatric qualification carries lesser salaries than do either the general or the psychiatric qualification, but registered general nurses working in geriatric hospitals receive $104 a year more than they would in general hospitals. In a letter dated 12 July 1972 to the Department of Health, the Director of State Psychiatric Services said:

> "The main salary advantage carried by psychiatric nurses was achieved for female staff when they were granted equal pay with male psychiatric nurses. As a substantially female profession, general nursing has been denied the same parity, and this heightens the differences in salaries. It is our view that there is no longer any justification for this differential pay scale, which was based, in the past, on the objectionable and arduous nature of the duties associated with psychiatric nursing. We believe that the character of our mental hospitals has changed, both in terms of the physical surroundings and the content of nursing, and that there is only a marginal difference between the two branches of nursing. In recent years we have been encouraging the nurses' associations towards the view that all nurses should be paid the same. There has been, in fact, a steady lessening of the difference in each salary agreement during the last two or three years. Our principal reason in seeking parity for the various branches of nursing, and the argument we advanced to the profession, is to open up employment opportunities in general hospitals for psychiatric nurses by reducing the industrial barriers to their free movement from one hospital system to the other. We regard this as particularly important, in the light of the proposal to establish a single health authority—the Health Commission of New South Wales—in 1973."

All simplifications carry in-built distortions, but essentially the first paragraph of this quotation describes the way in which the mental health "lead" arose in New Zealand, and the second contains the nub of the submission put forward by the State Services Commission and the Department of Health.

Victoria: The Public Service Board of Victoria stated that salary rates for psychiatric and general trained nurses employed in the

*After writing our report we received further information about all Australian States but this was not such as could lead us to modify any conclusions.

public service are reviewed independently of each other. The level of salary rates at any given time might favour one group and, at another time, the other group.

Canada

The general pattern is that psychiatric nursing is part of the basic nursing education programme and there is a common salary scale for nurses whether they work, after registration, in general or in psychiatric hospitals. In four provinces some nurses are trained solely in psychiatric nursing. Graduates of these programmes are not eligible for registration as nurses in other provinces but are regarded as auxiliary workers and receive a lower salary than that paid to registered nurses employed in psychiatric hospitals.

Norway

Until a few years ago psychiatric nurses had a salary advantage but now both groups of nurses are paid the same basic rates.

Sweden

Both groups of nurses are on a common salary scale.

United Kingdom

The National Board for Prices and Incomes (Report No. 60) recommended in March 1968, *inter alia,* "The 'mental lead' of £50 to be increased to £100, extended to all grades in psychiatric hospitals and introduced for all grades in geriatric and long-stay hospitals". The reason ascribed for this recommendation was a serious staff shortage and a consequent "urgent need to increase both the number and quality of recruits to this field of nursing". The recommendation resulted in a £99 per annum salary "lead" being implemented. We have no official information on whether this salary differential has led to an increase in the number and quality of recruits. We did, however, have our attention drawn to a report by the Department of Health's Deputy Director (Administration), Hospitals Division, prepared as a result of a WHO fellowship awarded in 1971, in which referring to a visit to Edinburgh, he comments:

> "We discussed with the Deputy Physician Superintendent (Psychiatric Consultant) and the Chief Nursing Officer of a prominent psychiatric clinic the question of preferential salaries for staff employed in Psychiatric Hospitals. Neither favoured such payment and expressed the view that the current £100 'recruiting differential' is harmful to mental hospitals as such and has an adverse effect on recruitment."

To what extent either person quoted was competent to assess the effect of the salary differential we are unable to judge.

CONCLUSIONS

7. Save for the considerations canvassed in the United Kingdom report referred to above (which we have studied), the information available to us was insufficient to allow us to determine whether the opinions and practices of countries overseas could assist in reaching a conclusion on this clause of our Warrant. Nor do we think that the opinions of witnesses who had nursed overseas and had drawn their own conclusions as to the need and effects of the presence or absence of a mental health salary "lead" can help us in deciding this issue in New Zealand.

Chapter VI. ALTERNATIVES EXAMINED

Introduction

1. Some of the submissions placed before us, although opposed to a general salary differential for psychiatric and trainee nurses, suggested alternatives. In the main these were for the payment of allowances to meet special circumstances, although the State Services Commission and the Department suggested a review of staff establishments and gradings. In this chapter we examine these ideas and suggest a co-operative approach of our own.

2. The allowances proposed fell into two main groups—allowances to compensate for special or abnormal working conditions and an allowance to attract staff to isolated hospitals.

Allowances for Special Circumstances

3. The Medical Association of New Zealand said "We would recommend the overall mental health lead be abolished but that certain selected groups of nurses be selectively compensated by extra pecuniary remuneration where this is deemed just and compensation for danger is one such justification".

4. The Hospital Boards' Association of New Zealand recommended "Because there are hazardous, unsafe, and extremely distasteful duties in some areas of psychiatric hospitals, and because there are equally hazardous and unpleasant areas in general hospitals, special allowances . . . should therefore be paid for these duties".

5. The New Zealand Nurses' Association, though primarily advocating higher salaries for all nurses, commented "that where there are important but abnormal circumstances affecting only a portion of nurses in any field of nursing, that these be compensated for in special payments by way of allowances".

6. The Auckland Hospital Board submitted "It is recognised that in some places within some hospitals and in some circumstances conditions can exist that unless some extra emolument is offered for service in those environments it is unlikely that nurses would be forthcoming in sufficient numbers to fulfil service requirements". The board went on to advocate allowances above standard salary rates in certain conditions.

7. The Tauranga Hospital Board also suggested that there were justifications for allowances in certain circumstances.

8. The view of the State Services Commission, however, was firmly opposed to the payment of allowances, its contention being that the nature and circumstances of the job should be reflected in the salary scales payable.

9. The advocacy of allowances by so many groups, including the Nurses' Association, is interesting, as it appears to be a proposal to revert to a practice which was abandoned some years ago. We note that para. 13 of the report of the "Lythgoe" Committee, dated 6 November 1964, states:

> "The Hospital Employment (Nurses) Regulations provide a basic salary and a number of additional allowances. They are of a varied nature covering theatre duty, duty in a tuberculosis ward or unit, duty in extended treatment institutions, the possession of additional qualifications, the post-graduate nursing diploma etc. *Representations were made to us by the nursing representatives that these payments should be abolished, the rate for the job to be such as to incorporate them.* The Committee agree . . ." (our emphasis).

10. In the event, these allowances were abolished except for a theatre duty allowance which the committee recommended should be retained because of "the difficulty of adequately staffing operating theatres in hospitals". It was, however, represented to us that the allowance was to compensate for the circumstances in which theatre duties had to be carried out.

11. As mentioned in chapter IV, we believe any administrative difficulties implicit in a system of allowances should not impede their payment if they are justified. We do, however, foresee difficulties associated with devising an equitable basis on which such allowances could be paid.

12. Although some of the recommendations quoted above specifically mention danger and unpleasantness, these features are clearly not intended to be exclusive of other working circumstances which might justify special allowances. A consideration of these two points will, however, suffice to illustrate the difficulties we foresee, especially as both topics were featured by some witnesses appearing before us.

13. In chapter II we conclude that danger and unpleasantness are more likely to be prevalent in psychiatric than in general hospitals. But clearly either element *may* also be present in certain wards or departments of the general hospital. For instance, we learnt from Matron Grattan that nurses in the emergency department of Wellington Hospital frequently, and especially at weekends, have to treat patients who may be disorderly or aggressive. The common feature in this situation with, say, a disturbed ward at a psychiatric hospital is an element of danger from physical assault. How is the relative danger in each situation to be weighed and evaluated in monetary terms?

14. Yet danger is not an immutable condition of any ward situation. Some witnesses claimed that if the right psychiatric nursing technique is adopted and appropriate precautions taken the risk of assault in psychiatric hospitals is small. Similarly unpleasantness is not an objective characteristic which can be measured and given a compensatory monetary value, although there was fairly general agreement that psychogeriatric wards are unpleasant places in which to work. In them, many patients are doubly incontinent, physically unable or unwilling to feed, bath, or dress themselves, and have lost self-respect and self-control. Yet appropriate training of these patients can improve their condition and mitigate, at least to some degree, the essential unpleasantness of serving in these wards.

15. If certain special features of work in a hospital call for special allowances, these features have not only to be defined. They have to have a monetary value placed on them. But it must be difficult to determine the relative money value of the possible, and spasmodic, risk of danger in a disturbed psychiatric ward when compared with the certain, and continuous, unpleasantness of an acute psychopaedic ward where nursing staff must care for all the bodily functions of children with multiple physical handicaps as well as severe brain damage.

16. Matters such as these call for complex value judgments which can scarcely take account of the great variation in individual responses. It is, for instance, apparent to us that some nursing staff derive intense satisfaction from working in wards which other staff avoid whatever the financial gain.

17. These are the sorts of difficulties we foresee in translating these recommendations into monetary terms, difficulties which multiply as the list of "special circumstances" increases until virtually no one is receiving only the basic salary. Consequently even if an allowance system such as has been advocated is justified (and we have reservations about this), it might be difficult to avoid injustices and inconsistencies which could well lead to staff dissatisfaction. In this matter we agree with the State Services Commission advocate that the nature and circumstances of the job should be reflected so far as possible in basic salary.

Locality Allowance

18. The submission of the Medical Association of New Zealand stated "Many of the psychiatric hospitals are located away from large centres of population and for some of these hospitals an increased salary scale or some other form of extra monetary compensation *might well be necessary* to recruit staff or to compensate staff for time and expense involved in travelling to the hospitals".

19. The Hospitals Boards' Association commented "There are hospitals (both psychiatric and general) where, because of their location away from the usual town amenities, consideration should be given for a sufficiently large location allowance to insure that staff are attracted to these areas".

20. Dr Franklin, Director of the Department of Psychiatry, Southland Hospital, said, "There is a strong case for weighting the scales to favour hospitals in isolated or unattractive areas".

21. Dr Moore made the point that "The locality of many hospitals produced difficulties with secondary school education of children. Either father has to live in Dunedin and commute 24 miles to work or the children have to spend a large part of their time in travel to and from the city and are unable to participate in many school activities".

22. It was not seriously suggested that the isolation of some psychiatric hospitals justified a salary differential for all psychiatric nurses or hospitals. We could therefore regard it as a matter with which this report need not be concerned.

23. Nevertheless it could hinder the recruitment and retention of staff in more isolated hospitals, and so prejudice care of the sick. There was little evidence from which we could judge what effect there has actually been, but it must be a point of some importance particularly when staff work on shifts and rosters. It is a problem which can best be met by local arrangements and allowances.

24. We are aware that there are arrangements for free transport in certain circumstances or allowances in lieu, and that remote locality allowances are sometimes payable in the public service. We assume that machinery is available for negotiating whatever provisions may be adequate to meet different circumstances and we hope that "adequacy" will be interpreted primarily in relation to the objective of the care of patients.

Gradings and Establishments

25. The joint submission of the State Services Commission and the department invited us to "support the proposal for a review of staff establishments and senior nursing staff structure to assess a need for:

"(i) More highly graded positions within the existing salary scale, where appropriate.

"(ii) Increased staff/patient ratios where required."

26. This proposal was not further described in the submission, and the explanation given to us of its intent and application was

sketchy. We were told it was not put forward as an alternative to the psychiatric salary "lead" but in recognition that there were special nursing circumstances warranting special consideration and the proposal was an alternative to the payment of allowances.

27. In brief, the department is reviewing the establishments of psychiatric and psychopaedic hospitals and expects that roughly 1,000 additional positions (of all staff categories) will be added to establishments of these hospitals. Associated with this review, consideration would be given to the replacement of nursing staff by other employees, the division of wards into smaller units and the consequent creation of a greater number of "graded" supervisory positions, and the introduction of a more flexible salary scale.

28. In the absence of any detail about this proposal we can comment only in very general terms. It is evident that the scheme would need to be introduced progressively, probably hospital by hospital: it would mean structural alterations for many hospitals; its execution would be governed by the availability of suitable staff; and its cost would clearly be substantial. It is a long-term project, which, as was admitted, could take 4 years to implement.

29. In view of the evidence that both general and psychiatric hospitals are already staffed well below existing nursing establishments (see tables 8 and 10), and have been for a long time, this proposal has about it an air of unreality. It is clearly incapable of achievement unless many more qualified nurses can be obtained. Of itself the proposal offers no inducement to recruiting, although it could help to retain staff by offering better promotion opportunities and the hope of better working conditions and greater job satisfaction.

30. In spite of the vagueness of the proposals and reservations about their implementation, we do not doubt that more realistic staff establishments and more graded positions are needed. Any improvements achieved will produce benefits for both patients and staff. We, therefore, accept the invitation to support the proposals but again emphasise that they do not in any way relieve us of the responsibility of determining whether or not there is justification for a differential under existing conditions.

Adapting of Terms of Employment

31. The emphasis in this inquiry has been on monetary rewards. But when stress and other working conditions lead to mental fatigue, the better solution may be to adapt the terms of employment by granting extra leave, early retirement or similar concessions.

32. The Public Service Association has been negotiating for an additional week's leave for psychiatric nurses but has not considered earlier superannuation or earlier retirement.

33. We note that, in Britain, mental health officers have a special benefit of a minimum retiring age of 55 years compared with the normal minimum retiring age of 60 years. They may also count as 2 years' service each further completed year of service after completing a total of 20 years' mental health officer service.

34. Alternatively the terms of employment could be adapted by modifying the shift and roster systems to bring about shorter working weeks or years and to suit the hours worked to the care of patients in particular hospitals or wards and to the requirements of staff. We can see possible advantages in this approach, but it has to be remembered that an arrangement made to compensate for adverse conditions is not easily changed when the conditions themselves are eliminated.

35. Although these suggestions may not be acceptable alternatives to the salary "lead", they should be considered. We are convinced that it is not in the best interests of either staff or patients if mental and physical weariness arise from inadequate breaks from the somewhat trying environment of psychiatric hospitals. We are conscious, of course, that any moves of this kind could, initially at least aggravate staffing difficulties and might necessitate the working of more overtime, a result which we would deprecate.

A Co-operative Approach

36. We are faced with the situation that there is a "mental health lead" or, as our Warrant expresses it, a "differential pay scale" in favour of psychiatric nurses and trainees in psychiatric hospitals. We cannot say that this is "justified" on the grounds of job content or responsibility or conditions of work in the sense of being able to say that psychiatric nursing is worth so much more than general nursing. On the other hand, these are matters which affect the acceptability of psychiatric nursing as a career and contribute to the shortage of nurses, so preventing patients being cared for as well as they should be.

37. We feel that a situation in which one section of the nursing profession vies with another over salary parity or gain is bound to be harmful to both sections, and must create an unhealthy atmosphere throughout the profession. It could lead to denigration by one section of the other, and it certainly has led to one section stressing and

publicising its own disadvantageous features. What effect this has had on recruitment and retention we cannot say, but it can scarcely have been beneficial.

38. Although we believe that it would be in the interest of nursing as a whole, and of benefit to patients, if psychiatric nursing were recognised and accepted as the peer of general nursing deserving equal treatment in every way, we cannot delude ourselves that this would be achieved merely by abolishing the present mental health lead. The factors which we have referred to above would remain; the existing incentives to recruitment and retention of nurses would be reduced; and existing staff dissatisfaction in psychiatric hospitals would almost certainly be exacerbated.

39. Alternatively, we could recommend that the "lead" be retained until such time as the staffing position has improved. It is quite possible that in the later stages of our inquiry we may be able to suggest measures to mitigate those conditions which now adversely affect the staffing position, and consequently prejudice the care of patients. But there are good reasons for not relying on this approach. In the first place, we cannot contemplate with equanimity any avoidable delay in moving towards improvement. In the second place, we believe—and past history supports this—that some at least of the adverse conditions will not be cured by recommendations or decisions from outside the hospitals. They call for a co-operative approach from within.

40. For us, and we are quite certain for the New Zealand people, this is not primarily a matter of whether one nurse should receive more money than another. It is primarily a question of removing or improving conditions which militate against the best standard of care for the patients who are the community's responsibility.

41. Consequently the salary-fixing process, adequate for its own purpose, is inappropriate here. Yet it is true that the main parties remain substantially the same—the staff who care for the patients and those who employ them to do so. Are we too naive in hoping that a staff organisation can go beyond its primary duty of protecting the interests of its members or that an employer can go beyond his primary concern for relativities and costs? We do not for one moment think so.

42. Industry today accepts that there is common ground between employers and employees. Each must have some regard for the interests of the other. This must be at least equally true in an undertaking which seeks to provide a community service. Conditions which hinder recruitment or impose undue stress must reduce the quality of the service given. The improvement of conditions

must improve the quality of the service and, by removing stress and enabling the employee to do her job better, must improve the quality of her life.

43. Thus we can expect that enlightened self-interest will encourage a co-operative approach. Certainly there should be no lack of able persons with the requisite knowledge and experience to make it work. We were ourselves impressed with the ability of many of the staff of psychiatric hospitals—and this extends to all groups—and with their obvious desire to improve the service given to patients.

44. There are various formats for a co-operative approach and we do not wish to be dogmatic about this. However, the approach which commends itself to us and which we are recommending is that the Minister of Health should authorise and facilitate the setting up of a working party of those who are involved in the problems to be solved, to isolate and examine those problems. But whatever the format adopted it must have as its main concern the creation of conditions under which patients can receive the best possible care.

45. Many questions will arise and, to stress that this is no easy task, we mention some:

(i) Why do so many trainees leave during the training period?
(ii) If it is because of conditions, how can these be improved, and how can trainees be prepared for and enabled to accept conditions which cannot be changed?
(iii) If there is dissatisfaction with the actualities of nursing as compared with what is taught, can the teaching, and the actualities, be improved?
(iv) If too many entrants are unsuitable, how can selection procedures be improved; what sort of people are in fact most suitable; how are they to be attracted?
(v) What would be realistic staff establishment figures, at all levels?
(vi) How can registered nurses in psychiatric hospitals best be relieved of non-nursing duties and so enabled to carry out their nursing duties more effectively?
(vii) What scope is there for adapting conditions to prevent undue fatigue?
(viii) What conditions can best be compensated for by local or specific allowances?
(ix) How could existing differentials be phased out as the situation improved?

46. Perhaps a question which we have not listed may overshadow all others. Where does nursing stand and where should it stand relative to other occupations in the matter of remuneration? Is it

realistic to align psychiatric nurses in some way with prison officers—as is apparently the comparison now made—and then to align general nurses with psychiatric nurses? We do not consider that this question falls within the scope of our proposed working party, but it is surely a question which needs to be answered.

47. It goes without saying that the success of the proposed co-operative venture will depend on the people who take part in it. But if the right people are chosen they will have a great advantage over any Royal Commission or other body set up to adjudicate from outside. They will have intimate knowledge and experience not only of the needs of the patients but also of the demands on and reactions of staff. They could no doubt make use of subsidiary committees working in separate hospitals or on specific issues.

48. We suggest, however, that there should be an independent chairman, chosen for his personal qualities, and acceptable to the participants. There should also be adequate secretarial service. There might be advantages in constituting the working party as a committee of the Board of Health.

49. The list of questions which we have posed indicates the many sides to the problem. We do not intend that one grand solution should be sought, but that the working party would concentrate on identifying areas where practical improvements can be made. It would then make recommendations as conclusions were reached on matters large or small and should have the opportunity if necessary to discuss these with the parties who have to decide on their implementation.

50. Even if in the end the problem of the mental health lead is not entirely solved, this will be a matter of only minor importance if the staffing of hospitals and the care of patients have been improved. We are sure that such a working party's reports will be of considerable value to this Royal Commission if they are available while our inquiry is still proceeding.

Chapter VII. SUMMARY AND CONCLUSIONS

SUMMARY

1. In our approach to our task, we have adopted the principle that we regard as good that which will ensure the best standard of care of the sick, and as bad that which will endanger or detract from it.

2. We have been conscious that we are required to report before we have examined the needs of the hospital and nursing services and that a decision based on the facts as they now appear could conceivably prove to be an impediment to the best possible development of those services seen in the light of further information and opinion.

3. The statistics available have been less complete or reliable than we would have wished. They have, however, indicated trends and enabled us to check impressions and opinions gathered from witnesses and from our own investigations.

4. Despite these difficulties it has been possible to identify the important issues and to reach conclusions upon them.

5. It is apparent that the existing differentials in favour of psychiatric nurses are in a sense historical accidents. No wage-fixing authority has ever specifically awarded these differentials in the sense of valuing psychiatric nursing more highly than general nursing. Nevertheless, psychiatric nursing has been paid at a higher rate than general nursing was known to be paid. This position has existed since the implementation during 1961–63, of equal pay in the State Services. The State Services Commission has knowingly determined rates of pay for psychiatric nurses which were higher than were determined by other Government agencies for general nurses. The position has been known to both psychiatric nurses and to general nurses.

6. Because the present differential has developed without a rational basis, much of the evidence presented to us both for and against the continuance of the differential was of doubtful validity or relevance to the issue to be decided.

7. Such information as we were able to obtain about overseas practice was of little assistance to us. The fact that psychiatric (and geriatric) nursing is more highly paid in the United Kingdom than is general nursing is certainly noteworthy; but we do not know whether this results in better care of psychiatric patients than would otherwise obtain, and this is our main concern.

8. There is nothing in what we have learned to suggest that psychiatric hospitals are likely to change dramatically in character in the near future. An increasing proportion of patients may be nursed in general hospitals. More geriatrics may be accommodated elsewhere. The trend to extra-mural care will no doubt be accentuated. And it is possible that separate provision will be made for the treatment of alcoholics or drug addicts, or for psychiatric assessments to be made for the courts. But whatever changes there may be, they cannot take place overnight, and, for some years at least, psychiatric hospitals and the nurses who staff them will continue to care for much the same sort of patients as at present.

9. Changes in nursing education are contemplated and may come about relatively soon. But we do not see that we would be justified in recommending changes in the existing salary differentials in anticipation of these changes or for the purpose of facilitating them. If they do come about, and are on the lines indicated to us, they will themselves necessitate changes in salary scales. This suggests to us that a more appropriate time for changing or abolishing the existing differentials would be when other changes are made, and not now when so much appears to be in doubt.

10. We are reinforced in this opinion by the fact that psychiatric hospitals have only recently come under hospital board control, and it will be the boards who will have to cope with any changes and with any changed arrangements which may be found to be acceptable alternatives to the present differentials in pay scales.

11. Administrative difficulties in the payment of differentials are not of such magnitude as to affect the issue.

12. Our examination of the job content and responsibilities of psychiatric nurses convinces us that these are different from those of general nurses, and it is clear that psychiatric nursing has developed not so much as a branch of general nursing as a separate evolution from custodial care. There seems therefore to be no reason, based on the nature of the job, why the remuneration must be the same, but we are not prepared to say that the job content and responsibilities of either are more valuable than the other.

13. Similarly, although no attempt was made in the evidence presented to us to differentiate between psychiatric and psychopaedic nurses, we are inclined to the view that they differ from one another as much as either differs from general nursing. Nevertheless they share certain features, especially difficulties of recruitment and retention, and we cannot differentiate between them on this issue at the present time.

14. On the other hand we do distinguish psychiatric nursing in psychiatric hospitals from psychiatric nursing in units of general hospitals. We see no reason, either on the basis of job content or conditions or recruitment and retention, why psychiatric nurses working in these units should be paid at a higher rate than general nurses employed in these units or elsewhere in the hospitals. Existing rights of present staff must however be considered.

15. For registered general nurses working in psychiatric hospitals, there are insufficient grounds in job content or conditions to justify a differential, and we would be opposed to creating conditions which might entice registered nurses from general hospitals.

16. The evidence given to us does not justify extending differential pay rates to community nurses, student community nurses, assistant nurses, or hospital aides in psychiatric hospitals. This is not to say that there could be no justification. The position of the community nurse in these hospitals does not appear to have been established, and we would want to feel sure that she can and should take a proper place there, and that a sound foundation has been laid for her to do so, before we expressed an opinion on a pay differential.

17. Some of the conditions under which psychiatric nursing is carried out differ sufficiently from the conditions under which general nursing is generally carried out and reinforce the conclusion that the rates of pay could well be different. However, the major emphasis to be given to the working conditions is either to justify local or specific allowances for different conditions or to affect the attractions of the job and thus become considerations of recruitment and retention.

18. Finally we are left with the problem of recruitment and retention. The factual and statistical information available from which to make a comparison between the recruitment and retention of psychiatric and general nurses is far from adequate, largely because there are no realistic establishments determined from which accurate figures about staff shortages can be deduced. It is clear that the proportionate losses of psychiatric nursing trainees have been much greater than those of general nursing students. The existing pay differentials have not been very effective in retaining trainees, even though the differentials have been greatest at the trainee levels. On the other hand, registered general nurses appear to have left the profession in greater proportionate numbers than have registered psychiatric nurses.

19. It seems quite clear that psychiatric nursing does not have such an attractive image in the eyes of the public, and more especially in the eyes of prospective recruits and their parents and advisers,

as does general nursing, with its traditional position as an acceptable profession for women. It is difficult to decide how much this less-favourable image is due to misconception and prejudice and how much it is due to real differences in the two branches of nursing. We conclude that the effects of this less-favourable image have in the past been partly overcome by the higher salaries, because the recruitment figures of trainees have been quite good. However, this may have been partly due to the lesser educational qualifications required. There can be no doubt that psychiatric nursing has failed to retain an adequate proportion of those who, despite the unfavourable public image, were recruited. Thus we are driven to the conclusion that part of the job content or conditions of psychiatric nursing repelled trainees, despite the high pay differential.

20. The removal of the differential will do nothing to improve the adverse parts of job content or conditions. It could improve the public image of psychiatric nursing by removing a signpost which may suggest to prospective trainees that this is so unpleasant an occupation as to require special inducements. On the other hand, psychiatric nurses might regard it as a blow to their status and take it as an indication both that their profession was not so highly valued as before and that their services were not adequately appreciated. Although we must interpret the submissions of the State Services Commission, the Department of Health, the Hospital Boards' Association, and the New Zealand Nurses' Association as expressions of confidence that the staffing position of psychiatric hospitals would not be prejudiced by the removal of the differential, we are unimpressed by these assurances. Although psychiatric hospitals have long been chronically understaffed, those responsible for staffing nursing services have not presented us with any adequate survey of the position or of the problems which have to be overcome to remedy it.

21. This is particularly so for the recruitment and retention of male psychiatric nurses upon whom the adequate staffing of psychiatric hospitals is so much dependent, in contrast to the needs of general hospitals.

22. We are convinced that the psychiatric services are in a vicious circle, with undesirable conditions militating against adequate staffing and the lack of adequate staffing aggravating these conditions. In the face of this, it would seem unwise to recommend any step which could—whether it should or not—worsen the staffing position, at least until greater efforts have been made to overcome other unfavourable conditions.

CONCLUSIONS

23. Turning therefore to the specific matters which were put to us in item 9 of our Warrant, our conclusions are:

(a) That a differential pay scale in favour of psychiatric and psychopaedic nurses as such over other kinds of nurses is not justified on the grounds of job content or responsibility or conditions of work; but

(b) That the continuation of the existing differential pay scale in favour of psychiatric and psychopaedic nurses and of psychiatric and psychopaedic nurse trainees in psychiatric and psychopaedic hospitals is justified at the present time in order to facilitate the recruitment and retention of adequate staff and thus provide for the adequate care of patients.

(c) That there is no justification for a salary differential for general nurses, community nurses, or hospital aides employed in psychiatric or psychopaedic hospitals.

(d) That there is no justification for a salary differential for psychiatric or psychopaedic nurses employed in the psychiatric units of general hospitals.

RECOMMENDATIONS

24. We accordingly recommend:

(1) That the existing pay differentials be continued and be provided not in the pay scale itself, but by way of allowances, such allowances:

  (i) To be subject to review as to amounts in the light of any changes in the conditions affecting the staffing position, and the adequacy of the care of patients; and

  (ii) To be treated as part of salary for the purpose of interim adjustments under the State Services Remuneration and Conditions of Employment Act.

(2) That all possible steps be taken to improve the staffing position of psychiatric hospitals so that salary differentials in their favour may no longer be necessary.

(3) That, as outlined more fully in chapter VI, the Minister of Health authorise and facilitate the setting up of a working party consisting of persons who are themselves involved in the care of psychiatric and psychopaedic patients and who are representative of others so involved, with an independent chairman chosen for his personal qualities, to examine those conditions in the hospitals which adversely affect the staffing position, and consequently the care of patients, and to make recommendations for improvement.

(4) That existing differential conditions other than in pay scales be re-examined, with the view of equalising those which are not justified by differing circumstances.

(5) That, in view of the maturity required in psychiatric nursing and of the importance of male nurses in psychiatric hospitals, the Nursing Council consider whether prospective entrants over, say, the age of 21 (as in the case of entrance to a university) might be accepted for training as psychiatric or psychopaedic nurses without School Certificate as a pre-requisite, subject to such conditions as may be deemed necessary.

(6) That as it appears from what we have learned during this phase of our inquiry that there is a shortage of nursing and other personnel in both general and psychiatric hospitals; that this shortage is inimical to the best care of patients; that this shortage places an extra burden on nursing staff especially in view of the overtime which has to be worked; that the position may be further worsened by the implementation in industry of the equal pay legislation; and that this Commission will therefore find it necessary to pay particular attention to the question of staffing in the second and third phases of its inquiry, those responsible for the staffing of hospitals should give particular attention to such matters as are referred to in paragraph 146 of chapter II and paragraph 46 of chapter VI of this report.

APPENDICES

Appendix I

ORGANISATIONS AND PEOPLE WHO MADE SUBMISSIONS

(Those submissions not presented orally at a public hearing are distinguished by an asterisk.)

Organisations

*Ashburn Hall Private Psychiatric Hospital, Dunedin.

*Auckland Hospital Board.

Department of Health
State Services Commission } Joint submission.

Advocate: Mr A. J. Healy, Assistant State Services Commissioner.

Witnesses: Miss N. J. Kinross, Assistant Director, Division of Nursing, Department of Health; Mr B. Laity, Principal Nurse, Buller Hospital; Dr S. W. P. Mirams, Director, Division of Mental Health, Department of Health; Mr D. E. Topp, Chief Executive Officer, Department of Education.

Hospital Boards' Association of New Zealand.

Advocate: Mr P. C. Ryan, Executive Director.

Medical Association of New Zealand.

Advocate: Dr Arthur Lewis, Medical Secretary. (Dr K. E. D. Eyre presented the Association's submission.)

New Zealand Medical Association

Advocate: Dr E. Geiringer.

New Zealand Nurses Association (Incorporated).

Advocate: Miss T. Burton, National Secretary.

Witnesses: Mrs M. C. Bazley, Principal Nursing Officer, Sunnyside Hospital; Miss G. A. Grattan, Matron, Wellington Hospital; Miss J. M. Stewart, Immediate Past President, Student Nurses' Association; Mr S. H. B. Symons, Economic Welfare Consultant.

New Zealand Public Service Association (Incorporated).

Advocate: Mr A. J. A. White, Deputy General Secretary.

Witnesses: Mr R. J. Flahive, Assistant Head Nurse, Porirua Hospital; Dr R. J. Graham, Registered Medical Practitioner; Sister A. Wix, Acting Supervising Sister, Porirua Hospital.

Nursing Council of New Zealand.

Advocate: Miss D. R. Newman, Chairman.

*Southland Hospital Board.

*Tauranga Hospital Board.

Vocational Guidance Centre, Wellington.

(Mrs D. E. MacDonald presented evidence at our request.)

People

*Bull, D., Charge Nurse, Child Psychiatric Unit, Auckland Hospital.

Chaplains of Porirua Hospital—

Canon Stote-Blandy; Rev. Boyd Glassey; Miss D. Goss.

*Dornan, P. C., Charge Nurse, Ngawhatu Hospital, Nelson.

Franklin, L. M. (Dr), Director, Department of Psychiatry, Southland Hospital.
*Maddock, A. C.
Moore, C. S. (Dr), Medical Superintendent, Cherry Farm Group of Hospitals.
*Sullivan, L. I. (Miss), Charge Tutor, Oakley Hospital, Auckland.
*Thompson, J. J., Head Nurse, Cherry Farm Group of Hospitals.

Appendix II

GLOSSARY

The department means the Department of Health.

E.C.T. means electro-convulsive therapy.

Neurosis—A psychological reaction to anxiety-ridden conflicts. Except in rare instances, the observed behaviour of the neurotic person does not differ greatly from that of the normal person. Neurotic behaviour is oriented towards avoiding a recurrence of the anxiety. There may be associated "physical" symptoms and complaints, usually without organic basis.

Psychiatric denotes mental disease or disorder.

Psychopaedic is a term used principally in New Zealand denoting mental retardation. Its application is *not* confined to children and it is used as if synonymous with the older term "mental deficiency".

(NOTE—"Psychiatric" has been used to include "psychopaedic" unless the text demonstrates otherwise.)

Psycho-geriatric is frequently used to denote any form of degenerative mental disease or disorder among the elderly, but may also be applied to all patients in the geriatric age range who develop psychiatric illness.

Psychopathic behaviour is egocentric, impulsive, asocial, undertaken without regard to the consequences for self or others. Psychopaths are not deterred by punishment or other unpleasant consequences from seeking instant gratification of their wishes.

Psychosis is an acquired mental disorder of organic or functional origin. It is marked by some degree of detachment from reality. Behaviour is often obviously abnormal, and characterised by delusions, hallucinations, and withdrawal, sometimes to the point of lessened self-control or self-care.

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