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The Role of Professional Marginalisation in the Development of New Zealand's Mental Hospital Architecture 1927-1971

Architectural historian Leslie Topp observed that institutional buildings are the result of negotiations between different personalities and professional disciplines, government policies, public expectations and the limitations that these create.¹ Between 1878 and 1971 various agendas influenced the built fabric of New Zealand's mental hospitals. Not dissimilar to developments in Britain, this typology was influenced by a lack of available finance, public fears regarding the escape of insane patients and the corresponding expectation that they would be securely confined. The political desires of a young British colony, to proclaim the nation's maturity, prosperity and benevolence further influenced this typology within New Zealand, as it did within Australia. Few of these aspects would meet with surprise. This paper will explore an agenda that is little acknowledged within the development of this institutional type: the extent to which fears of professional marginalisation influenced the design outcomes of New Zealand's mental hospitals. Specifically, it will examine how the fear of exacerbating the already marginalised position of institutional psychiatrists influenced the design outcomes of Kingseat Hospital (1927), Lake Alice Hospital (1937) and Cherry Farm Hospital (1943-48). The need felt by the administrators of New Zealand's mental hospitals to protect their professional territory motivated a number of decisions that were counterproductive to progress. This resulted in newly constructed facilities that remained firmly bedded in the past. This paper highlights an agenda that has been acknowledged within nineteenth-century asylum design but is seldom discussed within twentieth-century examples of this institutional typology.

In the early 1930s New Zealand faced a decision: to extend their existing network of nineteenth-century mental hospitals using the tried and tested villa hospital model or the newer, cutting-edge psychopathic hospital. While both models offered significant advances in patient care, the psychopathic hospital presented opportunities for closer collaboration with medical schools and general hospitals. It also sent a clear message to the public that mental illness was just another disease requiring medical treatment and that there was no reasonable basis for the stigma associated with it. New Zealand's preference for the villa hospital was driven by concerns of professional marginalisation that, unintentionally, limited patient care. This is a paper about location – the mental hospital's proximity to the city – about the messages that architecture sends and the practices it allows.

Andrew Scull has identified concerns of professional marginalisation in the formation of the psychiatric profession (mid-nineteenth century). Recognising that the expansion of Britain's asylum network was necessary for the legitimisation of their profession, practitioners overlooked glaring institutional failures in order to secure their monopoly over the treatment of madness.² Little discussed, however, is the extent to which the fear of professional marginalisation persisted into the twentieth century and obstructed progress in the architectural response created for mental illness. In 1957 the New Zealand Board of Health convened a committee to inquire into the role of general hospitals in the delivery of psychiatric services. In 1966, following the recommendations of this committee, the decision was made to construct the admission unit for the rurally located Cherry Farm (mental) Hospital on the site of the Wakari (general) Hospital in Dunedin. This decision exposed professional tensions that had previously been concealed. Archival documentation from this period provides evidence that protecting the professional territory of institutional psychiatrists was a clear concern for those charged with planning the country's mental health care facilities. The tensions revealed within the correspondence surrounding the Wakari unit can be traced through the planning of Cherry Farm Hospital (1943-48) and Kingseat Hospital planned 18 years earlier.

The villa hospital versus the psychopathic hospital

The villa hospital was developed near the close of the nineteenth century as a response to the limitations of traditional asylums that often accommodated more than 1,000 patients in a single building and where security measures were dictated by the worst behaved patients. The villa hospital accommodated patients within detached cottages, of between 24 and 50 beds, set amid gardens and farmland. Its intent was to mimic ordinary rural life for patients. Daily occupations continued to form an important part of therapy and trustworthy patients were granted the liberty to wander within the secure outer boundaries of the hospital.³ High fences, locked doors and barred windows were, in theory, to be replaced with "humane but stringent supervision" by nurses and attendants in what also came to be known as the "open-door" hospital.⁴

The psychopathic hospital typology emerged in Britain and the United States between 1906 and 1913.⁵ In 1908, British doctors Henry Maudsley and Frederick Mott announced their

intention to open a new kind of mental hospital based on the general hospital typology.⁶ It would be located within the city, in close proximity to existing general hospital and medical school facilities, and would offer outpatient and short-term, intensive inpatient care for those suffering from acute mental illnesses (those of recent onset). This new model aspired to advance the medical understanding of mental illness and to offer treatment independent of public mental hospitals and the stigma that was attached to them. The absence of chronic patients was a strategy to encourage patients to seek early, voluntary treatment, as it was widely believed, both within the psychiatric profession and by the public, that if acute patients were socialised with those suffering from chronic mental illness then their recovery would be retarded.⁷ Maudsley and Mott's ideal hospital was sited in central London, directly across the road from the King's College (teaching) Hospital (Figures 1 and 2).



Fig. 1 The Maudsley Hospital situated on a busy London street. Photograph by Rebecca McLaughlan, September 12, 2013.

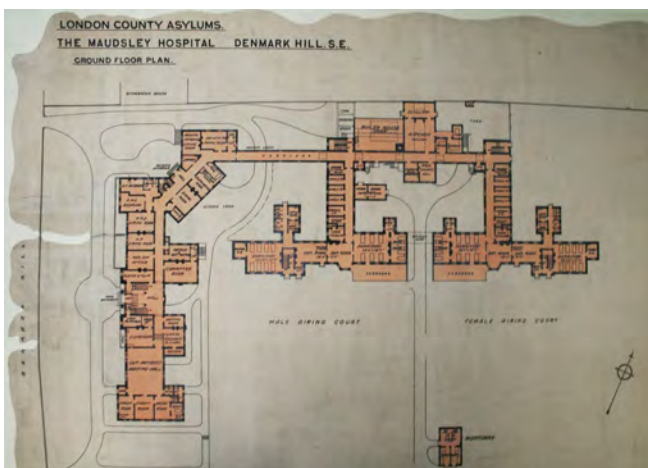


Fig. 2 Plan of Maudsley Hospital, July 5, 1913. Design by William Charles Clifford Smith. Bethlem Hospital Archive: YDP/01.

The accommodation of greater movement was a key feature of both typologies. While the villa hospital concentrated on freedom of movement, for patients, within hospital boundaries, the psychopathic hospital encouraged freedom of movement between the home, the city and the hospital for patients, medical students and practitioners. The greatest potential

advantage of the psychopathic hospital was accessibility. In 1953, the World Health Organisation (WHO) publically acknowledged that even short stays in a mental hospital could cause debilitating effects and keeping a patient “in daily contact with the members of his home and ... general social setting” would maximise the chances of a successful recovery.⁸ The psychopathic hospital, with its offering of outpatient services and shorter-duration inpatient care, addressed this concern more than four decades earlier.

In 1927 Dr Theodore Gray, director of the Mental Hospitals Department from 1927 to 1947, embarked on an international study tour to view the “most modern” institutions for mental health care in Great Britain, the United States, Canada and the Continent. This included visits to a number of psychopathic hospitals in America, including leading institutions such as the Henry Phipps Clinic (Johns Hopkins University Hospital), and the Maudsley.⁹ He also visited a number of villa hospitals. Despite the advantages of the psychopathic hospital model it was never developed in New Zealand, owing largely, this paper will argue, to concerns of professional marginalisation.

Marginalisation within the psychiatric profession

The history of mental hospital psychiatry was characterised by a lack of respect from the wider medical profession. In 1925, for example, when New Zealand’s Mental Hospitals Department began to offer out-patient clinics it was “suggested professionally” that: “it would be wiser not to have a mental hospital doctor attending the weekly clinic ... it would be better for the patients to be seen and advised only by members of the staff of the general hospitals – on account of the dread people have of facing an ‘asylum doctor.’”¹⁰ In 1925 psychiatrists were not typically employed by New Zealand’s general hospitals. The suggestion was that patients would be better off if attended by a general physician than a medical professional whose professional experience and training was in treating mental illness. Gray suggested this professional tension was owing to the lack of scientific advancement in the field of psychiatry; not until World War I did the wider profession accept that mental illness was curable.¹¹ To put this in context, the early, defining breakthroughs in general medicine occurred between 1840 and 1880, with the discoveries of anaesthesia and antiseptic operating procedures. Similar breakthroughs in psychiatry did not occur until the mid-twentieth century with the discovery of insulin-coma therapy in 1933, followed by electro-convulsive therapy in 1938 and effective psychopharmaceuticals in 1947. The creation of the psychopathic hospital model caused a division within the field of psychiatry itself. In 1908 it was thought that the cure of mental illness was only viable during the acute stages of illness; the psychopathic hospital’s proposition to remove acute patients from public mental hospitals threatened to deny the psychiatrists who administered those institutions the opportunity to *treat* mental illness. This transformed a profession who had long faced marginalisation from the wider medical fraternity to one that feared marginalisation from within its own ranks.

In 1959, a British Royal Commission investigating mental health care recommended an even more challenging proposition: that it was now necessary to move away from mental hospital care toward the delivery of psychiatric care within general hospitals.¹² While the

WHO report on the future of mental health care, released in 1953, acknowledged that some mental illnesses could be treated within the general hospital environment it did not support this idea outright.¹³ Perhaps in response to the release of the British report, Dr Daniel Blain, who had been a contributor to the WHO report, warned that treating recoverable patients in general hospitals would turn public mental hospitals into “madhouse[s]” deprived of their therapeutic role. He claimed this concern was shared by the WHO’s expert committee who felt that general hospital care should not be allowed to occur “to the detriment” of the mental hospital. Blain urged members of the American Psychiatric Association that general hospital care was only appropriate where mental hospital staff would be given the responsibility for administering the psychiatric wards of general hospitals.¹⁴ Contributors to the 1953 WHO report were primarily mental hospital physicians and the fear of losing professional ground was the likely reason that this report did not go as far as the Britain’s Royal Commission in recommending general hospital care for mental illness.

Cherry Farm, Wakari and Queen Mary: Fears of professional marginalisation exposed



Fig. 3 Cherry Farm Hospital. *Otago Daily Times*, February 3, 1972. Photograph courtesy of *Otago Daily Times*.

When the Cherry Farm Hospital was designed, in the late 1940s, the paradigm shift towards the diversification of mental health care was just beginning to gather momentum but the approach it encouraged was not a significant step forward from the ethos that the Maudsley and the Phipps Clinic had been operating under for decades. Despite Gray’s knowledge of these institutions, the architecture created for Cherry Farm was similar in its concept, composition and administration to the Kingseat Hospital, designed 18 years earlier along villa hospital lines (Figures 3 and 4).

Both hospitals were comprised of a number of 50 patient villas that included dormitories of 12-16 beds and a limited number of single or two-bed wards. Each villa included its own kitchen, dining and day room spaces (Figure 5). Additional patient amenities were envisioned for these hospitals: occupational therapy centres, recreation halls, libraries, canteens, swimming pools, tennis courts, bowling greens and rugby fields. Over the course of 18 years, no re-evaluation of the fittingness of this typology occurred.



Fig. 4 Kingseat Hospital for Auckland Hospital Board, 1972. John Thomas Mair was the Government Architect at the time this hospital was designed (little archival information about the design of this hospital has been found). Photograph by Whites Aviation. Alexander Turnbull Library: WA-71752-G.

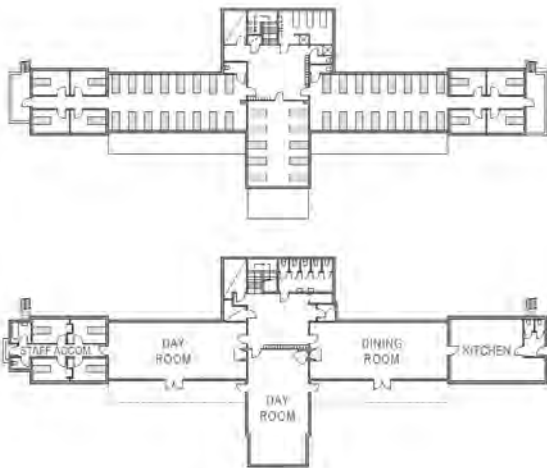


Fig. 5 Kingseat Hospital villa plan, 1927; ground and first floor (top), veranda shown dotted. Plan reconstructed from site visits and archival drawings (dated 1974) held by Archives New Zealand: W-33-6-26452. Reconstruction by Rebecca McLaughlan.

In 1966, 13 years after the WHO report was released, the decision was made to diversify Cherry Farm's facilities in order to provide day hospitals, increased outpatient services and short-stay psychiatric treatment within the general hospital environment. This decision did not come from the administrators of New Zealand's mental hospitals but as a result of pressure from New Zealand's Hospital Boards. The public demand for increased psychiatric services within general hospitals and greater access to psychotherapy was mounting and, collectively, Hospital Boards requested an inquiry into the provision of these services.¹⁵ Echoing Blain's response, the director of New Zealand's Division of Mental Hygiene (the administrative body that succeeded the Mental Hospitals Department), R. G. T. Lewis, concurred that an inquiry should be held but was of the opinion that services provided within general hospitals be administered only by mental hospital staff.¹⁶ As a result of the 1957 inquiry, three Admission Units were planned for construction on the grounds of general hospitals in Dunedin, Invercargill and Palmerston North, while outpatient facilities were to be incorporated within the grounds of existing mental hospitals in Auckland and Christchurch – urban sprawl had repositioned these rural nineteenth-century facilities within city boundaries (Figure 6).



Fig. 6 Location of the hospitals discussed relative to major cities and medical schools. Drawing by Rebecca McLaughlan.

In 1966 the decision was made to construct the Admission Unit that was originally intended for construction at the Cherry Farm site at the Wakari (general) Hospital in Dunedin. While the intent was for the Wakari unit to be staffed and administered by Cherry Farm, staff were generally unsupportive of having this unit located within the city, 36km away. Removing curable patients from the Cherry Farm site constituted a threat to their medical practice. In 1969, the hospital's superintendent alerted the Deputy-General of Health to the "considerable danger" that mental hospitals could become "divorced from acute facilities," stating that the staff of Cherry Farm should not be "banished to the country asylum."¹⁷ Lewis' submission to the Board of Health Inquiry, a decade earlier, foreshadowed this concern, he wrote: "it is most important that mental hospitals should not be relegated to the care of only long stay and most difficult patients."¹⁸ Lewis' response is unsurprising; the clear picture provided by various submissions to the Board of Health Inquiry was that the ongoing presence of acute patients within the mental hospital environment was anything but assured.

As part of the Board of Health Inquiry, general hospitals were sent a questionnaire that asked how psychiatric services within their hospitals should be administered and "whether more assistance should be given by Mental Hygiene Divisional staff?"¹⁹ Most responses acknowledged the need for some cooperation with the Division of Mental Hygiene but submissions were almost unanimous in the view that psychiatrists working within general hospitals should be employed by those hospitals and not associated with New Zealand's mental hospitals.²⁰ The British Medical Association suggested that mental hospital staff be allowed to consult, by invitation, specifically on those patients who were likely to require future care within a mental hospital.²¹ There was almost no admission that mental hospital staff could contribute valuable skills to the general hospital treatment of psychiatric illness. One contributor even suggested that the Division of Mental Hygiene might be disbanded altogether.²²

By the time the Wakari admission unit was under construction, little effort was made to hide professional tensions. On three separate occasions the Otago Health Board approached the superintendent of Cherry Farm with suggestions for closer collaboration on the Wakari site, between Cherry Farm and the independent professorial unit run by Dr Wallace Ironsides,

Senior Lecturer at the University of Otago and director of Psychiatry for the Otago Hospital Board. The medical superintendent of Cherry Farm exhibited an outright reluctance to collaborate, a response which is not surprising given the history of animosity between Ironsides and the division.²³ Only a year prior to these requests for collaboration, Ironsides, alongside his Otago University colleague Harold Bourne, had appeared within a televised current affairs programme and stated that rural institutions “must be replaced with urban psychiatric units and mental hospitals must be bought under general hospital control.”²⁴ Within his submission to the Board of Health inquiry, Ironsides had accused the division of offering little more than diagnostics in their outpatient clinics and working too much in isolation.²⁵

The collaboration with Ironsides was not the first to be resisted by the administrators of New Zealand’s mental hospitals. In 1948 the Queen Mary (neuropathic) Hospital tabled a proposal that would have aided the division with two of its most pressing concerns: staff recruitment and encouraging patients to seek early, voluntary treatment. Queen Mary was administered by the Canterbury Hospital Board, took only voluntary admissions and was largely free of the stigma associated with treatment in a public mental hospital. Patient waiting lists were often three months long²⁶ and medical graduates perceived that training at Queen Mary would avert the “largely custodial” training they were likely to receive in a public mental hospital.²⁷ Despite the clear benefits offered to the Division of Mental Hygiene, subsequent directors of the division advised against the further development of Queen Mary. J. A. Russell wrote: “in our hospitals we deal with psycho-neuroses [Queen Mary’s predominant patient load] and I have no doubt that experience in this sphere is just as extensive in our department as at Queen Mary Hospital.”²⁸

Professional protection and the psychopathic hospital

When a new villa hospital was opened near Auckland in 1931 staff recalled that this was considered “very modern thinking!”²⁹ Although still popular in Britain, and widely used within America for the accommodation of chronic patients, by 1931 the villa typology was now more than 50 years old. The redevelopment of the Royal Bethlem Hospital, around the same time as Kingseat, highlights the recognition that this model required some extensive additions in order to deliver up-to-date acute mental health care. In 1930, London’s oldest institution for the treatment of mental illness was relocated from its nineteenth-century building in Southwark to a rurally located, purpose built villa hospital. A key driver in the reconstruction of Bethlem was the provision of facilities for research and teaching in order to increase their existing programmes.³⁰ Included within the brief were “bacteriological, pathological and chemical laboratories,” x-ray and dental departments, hydrotherapy and electrical treatment, consulting rooms and a 100-seat lecture theatre.³¹ Many of these facilities replicated those provided by the Maudsley. Archival records suggest, that had the resources been available, “modern forms of treatment” were to have been included at Kingseat: “massage, continuous baths, light, electricity (treatment) and X-rays ... a laboratory ... and operating theatre.”³² In the planning of Kingseat Hospital, however, little thought was given to offering outpatient clinics, conducting research or teaching – all would have been

impractical given the hospitals distance from Auckland's residential population, its general hospitals and the University's medical school. In the planning of Lake Alice Hospital (1937), near Marton, and subsequently, Cherry Farm, New Zealand decision makers persevered with the traditional, rurally isolated hospital model. It was 1945 before the value of integrating teaching facilities within mental hospitals was recognised, and even then, this was provided for the education of nurses, not medical students.³³ Not until 1959 was there any evidence of the consideration of integrating research facilities within the grounds of New Zealand's mental hospitals.³⁴

Gray was unimpressed by the psychopathic hospital model and unmotivated to integrate aspects of this model into the villa hospital. He perceived that it "subordinate[d patient care] to the teaching of students and to research."³⁵ He labelled the Boston Psychopathic Hospital a "clearing station" where only the interesting cases were kept and intimated a similar sentiment regarding the Phipps Clinic.³⁶ He was sceptical that shifting acute mental health care out of traditional mental hospitals would succeed in reducing the stigma of mental illness and advised the Prime Minister that the high costs associated with the psychopathic model were "well beyond" New Zealand's resources. Gray concluded that the rural, villa hospital was the best option – it provided for the full spectrum of the country's mental hospital population in a cost effective way.³⁷ Aspects of Gray's argument are plausible; within the history of New Zealand's Mental Hospitals Department there was never sufficient funding to provide even adequate accommodation for the number of patients under their care, let alone modern forms of treatment.³⁸ Yet other aspects of Gray's approach raise questions. Warwick Brunton, who worked within the Division of Mental Hygiene and completed his doctoral thesis on mental health policy in New Zealand, claims that Gray was weary of collaborations with general hospitals and opposed the establishment of a university chair based upon the "high falutin' theories" it might subject the Department to.³⁹ In 1908, when Maudsley announced plans for his new hospital model in *The Lancet*, the risk of losing professional ground must have been clear. Although these concerns were not openly voiced within Gray's report, or by the psychiatric profession itself until the late 1940s,⁴⁰ Gray must have recognised this risk in his evaluation of the psychopathic hospital. The geographical location of the villa hospital offered a degree of professional protection but it came at a high cost.

Assessing the cost of professional agendas

Gray stated that the construction costs of a psychopathic hospital were well beyond New Zealand's resources,⁴¹ but what were the long-term costs of writing off the psychopathic hospital in New Zealand? This typology was far more sustainable than the villa hospital. Institutions such as the Phipps Clinic and the Maudsley weathered the storm of deinstitutionalisation and are still regarded as leading institutions for treatment and education. However, it is the accessibility and visibility offered by the psychopathic hospital that we should most lament the absence of. The practices we have come to associate with this institutional typology, namely, harmful staff cultures and management regimes that stripped patients of their autonomy, dignity and self-esteem,⁴² were allowed to occur, in part, because of the geographically and professionally isolated nature of mental hospitals. This isolation

perpetuated stigma around mental illness that, in turn, made difficult staff recruitment and forced these institutions to make do with staff shortages and aging, insanitary buildings that would not have been tolerated in a more visible location. To put some of these issues in context, when District Health Boards were asked to take over the management of mental hospitals within their locality (1966-72), Brunton reports that the West Coast District Health Board required a 49 per cent increase in staff at the Seaview Mental Hospital before they would assume control.⁴³ The permeable boundaries of the psychopathic hospital, its visibility and the proximity of general hospital staff may not have allowed these practices to occur to the same extent. The mental hospital was a product of political and social conceptions of madness but it was also a tool for improving public perceptions towards mental illness. In terms of the public's acceptance of mental illness, we have to ask, had the psychopathic model been adopted in New Zealand in 1930, would we, in 2015, still be watching media campaigns where former All Blacks tell us that mental illness is okay?

Conclusion

A greater willingness to collaborate and to build facilities closer to the city could have resulted in beneficial outcomes for mental health care in New Zealand with regard to research, education, recruiting psychiatrists and reducing the stigma around mental hospital treatment. The fear of losing professional ground motivated successive administrators of New Zealand's mental hospitals to favour traditional, rurally located hospital models whose geographical isolation helped to safeguard the professional territory of mental hospital psychiatrists. This resulted in newly constructed facilities at Kingseat, Lake Alice and Cherry Farm that, although a vast improvement on New Zealand's nineteenth-century asylums, remained firmly bedded in the past. The influence of professional concerns within the architectural decision making process reaches further than architectural history; it has had a lasting impact on the social and institutional histories that accompany it.

1 Leslie Topp, "Otto Wagner and the Steinhoff Psychiatric Hospital: Architecture as Misunderstanding," *The Art Bulletin* 87, no. 1 (2005): 131.

2 Andrew Scull, *Museums of Madness: The Social Organisation of Insanity in 19th Century England* (London: Allen Lane, 1979), 93-96, 179-180, 171, 258. It should be noted that Scull's perception of the psychiatric profession has become more moderate in more recent publications.

3 Theodore Gray, *The Very Error of the Moon* (Ilfracombe & Devon: Arthur H. Stockwell Ltd, 1958), 64.

4 Leslie Topp, "The Modern Mental Hospital in Late Nineteenth-Century Germany and Austria: Psychiatric Space and Images of Freedom and Control," in *Madness, Architecture and the Built Environment: Psychiatric Spaces in Historical Context*, ed. Leslie Topp, James E. Moran and Jonathan Andrews (London and New York: Routledge, 2007), 244.

5 In 1906 the University of Michigan opened the first psychopathic hospital in the US and in 1913 Johns Hopkins University Hospital opened their Henry Phipps clinic. These appear to be unrelated developments, motivated by similar concerns.

6 "Proposed New Hospital for Mental Diseases," *The Lancet* 171, no. 4410 (1908): 728-729.

7 Director, DMH, to the Commissioner of Works, undated but filed between March 17, 1954, and February 1, 1954. Archives New Zealand (hereafter ANZ): R16195940.

- 8 World Health Organisation (hereafter WHO), *The Community Mental Hospital: Third Report of the Expert Committee on Mental Health* (Geneva, 1953), 14, 18, 20.
- 9 Theodore Gray, "Report of Visits of Inspection to Various Institutions in Great Britain, America and the Continent," 1929, 46. ANZ: R16195841.
- 10 *AJHR* 1925, H-07, 4.
- 11 Gray, *The Very Error of the Moon*, 76-77. Scull has discussed the difficult professional transformation of men who were considered "custodians of lunacy" forming a legitimate medical specialty that arose owing to the fact that the physical space of the asylum preceded the practice of psychiatry. Scull, *Museums of Madness*, 93.
- 12 "A Charter for Mental Health," *New Statesmen*, January 10, 1959.
- 13 WHO, *The Community Mental Hospital*, 9-12, 31.
- 14 Daniel Blain, "The Function of the General Hospital Psychiatric Unit: Some Observations by the WHO Expert Committee on Mental Health," in *Psychiatric Architecture*, ed. Charles E. Goshen (Washington: American Psychiatric Association, 1959), 48.
- 15 Director, Division of Hospitals, to the Minister of Health, December 4, 1957. Subject: Psychiatric Services in Public Hospitals. ANZ: R20960744.
- 16 Director, Division of Hospitals, to the Minister of Health, December 4, 1957.
- 17 Medical Superintendent, Cherry Farm Hospital, to the Director, Division of Mental Hygiene (hereafter DMH), January 4, 1967. ANZ: R18458555.
- 18 R. G. T. Lewis, Working Notes based on replies to questionnaires [Psychiatric Services in Public Hospitals], 1958. ANZ: R20960748
- 19 Questionnaire – Psychiatric Services in General Hospitals, 1958. ANZ: R20960747.
- 20 Refer various submissions to the BOH, Psychiatric Services in Public Hospitals Committee, 1958. ANZ: R20960748.
- 21 British Medical Association, New Zealand Branch, Submission to the BOH on Psychiatric Services in General Hospitals, 1958. ANZ: R20960748.
- 22 Various submissions to the BOH, Psychiatric Services in Public Hospitals Committee, 1958. ANZ: R20960748.
- 23 Meeting minutes: Acute Psychiatric Unit at Wakari, May 16, 1968, and June 7, 1968 (undated by filed near June 7); Director, DMH to the Secretary, Otago Hospital Board, March 3, 1967. ANZ: R18458498.
- 24 New Zealand Broadcasting Commission, *Compass: Mental Health*, 1967. TVNZ Archive: P48593.
- 25 W. Ironsides, Memorandum on General Hospital Psychiatry, submitted to the BOH's Committee on Psychiatric Services in General Hospitals, 1958. ANZ: R20960748.
- 26 Robert Crawford, *The Queen Mary Hospital Hanmer Springs, 1916-2003. Hanmer Springs* (Hanmer: Queen Mary Reserve Trust: 2005).
- 27 Medical Superintendent, Queen Mary Hospital, "Survey: Queen Mary Hospital ... the Advancement of its Contribution to New Zealand Psychiatry," March 12, 1948. ANZ: R16195957.
- 28 Director, DMH, to the Director-General of Health, June 24, 1948; Director, DMH, to the Medical Superintendent, Queen Mary Hospital, July 14, 1948. ANZ: R16195957; Director, DMH, to the Director-General of Health, June 1, 1950. ANZ: R16195957.
- 29 L. B. Thompson, ed., *Kingseat Hospital, 50 Years, 1932-1982* (Papakura: Kingseat Jubilee Editorial Committee, 1981), 4.
- 30 Ironically, the importance of proximity was a lesson that Bethlem came to learn – within a few years of the move to Kent postgraduate teaching ceased to be delivered by the hospital and undergraduate teaching was transferred to locations within the city. Jonathan Andrews et al., *The History of Bethlem* (London: Routledge, 1997), 571-3, 599.
- 31 Bethlem Hospital Superintendent's Report 1926, 8. Bethlem Hospital Archive: BMO-10 B10/1.
- 32 *AJHR* 1937, H-7, 2.
- 33 A lecture theatre was included in the brief for Lake Alice, however, this was located 480km from the nearest medical school (Auckland). From 1939 efforts intensified to raise the professional status of mental hospital nurses through education and state exams. ANZ: R22502230.
- 34 Medical Superintendent, Cherry Farm Hospital, to the Director, DMH, May 18, 1959. ANZ: R18458498.
- 35 Gray, "Report of Visits of Inspection," 26.
- 36 Gray, "Report of Visits of Inspection," 24-25.
- 37 Gray, "Report of Visits of Inspection," 20-1, 34.

- 38 Rebecca McLaughlan, "One Dose of Architecture, Taken Daily: Building for Mental Health in New Zealand" (PhD thesis, Victoria University, 2014), 199-202.
- 39 Warwick Brunton, "Gray, Theodore Grant," *Dictionary of New Zealand Biography*, <http://www.teara.govt.nz/en/biographies/4g19/gray-theodore-grant> (accessed January 21, 2012).
- 40 J. J. O'Reilly, "The Planning of Modern Psychiatric Units," *Journal of Mental Science* 94 (1948): 107-133.
- 41 Gray, "Report of Visits of Inspection," 20-1, 34.
- 42 Ivan Belknap, *Human Problems of a State Mental Hospital* (New York: Blakiston Division McGraw-Hill: 1956); Erving Goffman, *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates* (New York: Doubleday, 1961); Janet Frame, *Faces in the Water* (Auckland: Random House, 2005).
- 43 Warwick Brunton, *Sitivation 125: A History of Seaview Hospital, Hokitika and West Coast Mental Health Services, 1872-1997* (Hokitika: Seaview Hospital 125th Jubilee Committee, 1997), 58.