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‘A CHOICE OF DIFFICULTIES’:

NATIONAL MENTAL HEALTH POLICY
IN NEW ZEALAND, 1840-1947

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Doctor of Philosophy
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ABSTRACT

This thesis describes and analyses the main elements of national mental health policy in New Zealand from the inception of organized government in 1840 until the merger of the Mental Hospitals and Health Departments in 1947. Mental health services, in this context, refer to specialized psychiatric care and treatment. Before 1947 and for many years afterwards, that care was provided almost entirely through a network of public mental hospitals. A “top-down”, national view of mental health policy helps to explain why that system evolved, because the national policy was the legal, organizational and regulatory framework within which personal and clinical interventions occurred and specialized care was provided.

Governments set out to achieve their policy aims for mental health through regulation, funding, ownership, and occasionally through investigation. Politicians and officials who held particular responsibilities for managing the state’s interest in mental health shaped that policy within constitutional arrangements and the machinery of government. Working in a policy field of minor political importance, officials acquired a significant and powerful role in policy-making for they both advised the government on and implemented policy through a virtual monopoly on the provision of specialized services.

This thesis examines the part played by ministers, the specialized bureaucracy set up in 1876, and interest groups in the formulation of policy. The primary sources for the thesis have been the archives and published official papers of those government agencies that had responsibility for mental health policy and services. Surviving administrative records of some psychiatric hospitals have also been used. A documentary approach has been complemented by interviews.

New Zealand’s policy was shaped by the answers to broad policy questions about identifying mentally disordered persons, how they should be dealt with, and how they should be treated. Major elements of the pathway of mental health services in western Europe and the historical interpretations accorded them have been reviewed, because they influenced mental health policy in New Zealand and other countries with a similar colonial background. But “Home” ideas were adapted to colonial circumstances so that, by 1876, three foundational policies of institutional care, separate administration and state responsibility were implemented.

Local and national officials faced a choice of difficulties brought about by the intended and unintended effects of these foundational policies. Later policies were built incrementally upon these solid foundations, either in response or reaction to a complex interplay of social, political, and legal factors, therapeutic limitations and developments, or to the growth of the role of government in New Zealand society. These factors made for a pattern of short bursts of high policy activity and the injection of resources followed by troughs of stagnation or quiet incremental adjustments to the core policies.
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INTRODUCTION

Many years of work in the New Zealand Department / Ministry of Health were the catalyst to my thesis. My departmental career began in 1965 when a network of public mental hospitals around New Zealand was run centrally by the Department of Health. These institutions had their own organizational culture, traditions, legislation, long-standing problems and some historic Victorian edifices. Later, as a policy analyst in the Department's head office, I kept asking myself whether this system arose from choice or whether it was it the product of layers of decisions made over many years? Was the system unique to New Zealand? I am still fascinated by the origins and growth of this mental hospital system because recent policies of community care or “deinstitutionalization” were formed in reaction to the long shadow cast by the lunatic asylum, mental hospital or “institution”.¹

In this thesis, I will try to explain why New Zealand’s mental hospital system was set up and how it grew between 1840 and 1947. This period began with the establishment of government in New Zealand after its cession as a British colony and it concluded with the merger of two separate departments of state, the Mental Hospitals Department and the Department of Health. The system was shaped in response to a series of policy questions. Who was defined as a mentally disordered person? What should be done with such persons? How should the state intervene in the life or affairs of a mentally disordered person? These were issues that affected society generally. As such, they were questions of public policy and the answers were given through the institutions of the state. Governments developed policies about the most appropriate ways of caring for those citizens who were deemed to be mentally disordered. Throughout the period, institutional solutions were generally favoured, although other options were considered and developed. Institutional solutions begged other questions about the location and size of institutions, care and

treatment of different groups of mentally disordered persons, and the management and staffing of institutions. Answers to this series of questions will form the substantive part of my study.

I will also try to answer further questions about the way national mental health policies were made. Who was involved and how? Were national policies continuous, new, adaptations of existing policy, or was there a cycle of repetitions? Did these policies work? What were the cumulative consequences of major policy decisions, seen and unforeseen, and how did they affect subsequent policy decisions? I shall attempt to answer those questions by studying the nature of policy-making processes within the apparatus of the Crown Colony (1840-52), provincial administration (1852-76) and central government (1852-76), and the specialised department that ran mental hospitals between 1876-1947. Before proceeding further though, the key words 'national mental health policy' in the title of my thesis should be explained.

The latest lexicon of the World Health Organization contains no definition of mental health or mental health services and comments that there are no universal or timeless definitions.^{2} Freeman likens the task of defining mental health to entering a semantic slough of despond from which little that is useful may emerge.^{3} Definitions of mental health range from a negative concept (the absence of disease or illness) to a panglossian expression of complete physical, mental and social well-being. Freeman opts for a 'common sense and pragmatic' view of mental health as the absence of identifiable psychiatric disorder, according to current norms.^{4} Such a view accords with the report of a 1995-6 formal inquiry in New Zealand which chose not to define mental health. The term was left instead to ‘receive its broad, ordinary meaning’.^{5} By implication, mental health services can be considered shorthand for psychiatric care and treatment services.^{6} The notion of a comprehensive mental

\footnotesize
\begin{itemize}
\item[4] ibid., p. 6.
\end{itemize}
health "service" that protects and restores people's mental health is relatively recent.
Even now, some policy documents acknowledge mental health promotion and the
prevention of mental ill health as textual clip-ons or schematically peripheral to
treatment services. The shorthand meaning of mental health services has been
used in various official policy pronouncements.

In my thesis, mental health services refers to specialist forms of diagnosis, care,
treatment and rehabilitation that evolved between 1840-1947. These services were
mainly provided in institutions. Specialist services grew within the framework of
psychiatry, or that specialist branch of medicine that applies knowledge from
biological and social sciences to the care and treatment of persons suffering from
disorders of mental activity and behaviour. Care provided by families, social
support agencies or general medical practitioners was most important, but generally
lies outside the scope of this thesis.

The language of mental health has changed in an attempt to counteract the so-called
stigma or discrimination against people living with mental illness or mental health
services. Mental health services were formerly known as psychiatric services and
before that, as psychiatric hospitals, mental hospitals, and lunatic asylums. Each
new term was intended to overcome the pejorative connotations acquired by other
terms in common parlance. Similarly, what are nowadays called mental illness or
mental disorders were once known as insanity, lunacy or madness. Each of those
terms is a medical, social and legal construct for a cluster of psychological and
physiological symptoms that cause suffering and distress and which represent a
departure from a person's normative pattern and level of functioning.

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7 E.g., Board of Health Standing Committee on Mental Health, Draft Discussion Paper:
Community Mental Health Services - Issues and Implications, 23 December 1985, Health Department
Archives, National Archives, Wellington, File H 349/18 (60590); Department of Health, Outline of
Service Development for Mental Health for Area Health Boards, Wellington, 1989, pp. 5, 14, 17;
Unpublished Ministry of Health Background Paper to the Ministerial Inquiry into Mental Health
Services, 1996, p. 8; Minister of Health, Policy Guidelines for Regional Health Authorities 1996/97,
8 Derived from Desmond Curran, Maurice Partridge and Peter Storey, Psychological Medicine:
9 Mental Health Commission, Discrimination against People with Experiences of Mental Illness,
10 Appendices to the Journals of the House of Representatives (AJHR), 1994, E-31V, p. 35.
these terms is precise. For example, in 1935 the Director-General of the Mental Hospitals Department said that there were different definitions of insanity in the law on criminal responsibility, testamentary capacity, marriage, inquisitions de lunatico inquirendo, and confinement in a mental hospital. The Director-General was also attracted by Lord Justice Dunedin’s assessment of Scots law on the definition of insanity in 1907. The judge said that in one sense no one could say what insanity was. Doctors could not agree. Medical views had altered the scientific view of insanity and the courts had followed suit. Acts of Parliament, however, could not deal with scientific opinions, so juries were left to make a commonsense determination of the matter, assisted by evidence and judicial direction.

Mental disorder has a legal as well as a clinical meaning. I shall use mental disorder to refer to persons whose clinical and behavioural characteristics rendered them liable to procedures under the relevant mental health statute of the day. Applying this definition to earlier legislation means that a mentally disordered person includes “menta defective” in the Mental Defectives Act 1911 and amendments, and “lunatic” and “idiot” in nineteenth century legislation. Mental disorder includes persons detained and treated involuntarily (committed patients and the occasional single patient) and, after 1911, “voluntary boarders” under the Mental Defectives Act 1911.

Policy is a word that is now generally held to involve an expression of general intent, rules or precedents that guide future action, a process of decision-making, a course of action to implement decisions, and the effects of the course of action. These understandings of public policy are consistent with Keisler’s definition of national mental health policy as ‘the de facto or de jure aggregate of laws, practices, social structures, or actions occurring within our society, the intent of which is improved mental health of individuals or groups.’ De jure policy is intentional and is usually

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12 Director-General to Secretary for Justice, 18 March 1935. H 30/28/21 (34252). Inquisitions de lunatico inquirendo were an ancient legal device for a court to establish a person’s sanity and commercial competence.
13 Director-General to Solicitor-General, 14 August 1935. H 30/25/9 (34231).
legislated as statutory law. De facto policy is the net outcome of overall practices regardless of whether the outcome is intended or not.¹⁶ Policy, as used in my study, includes the process, intentions and intended and unintended outcomes of sets of decisions.

Public policy is made within the legislative, executive and judicial branches of government and involves the various institutions and agencies of the state at national and local levels.¹⁷ Public policy interventions reflect three broad purposes of government. In the first place, governments are uniquely empowered to determine and enforce rules that are binding on all members of society. A second purpose of all governments is to provide those goods and services that benefit whole populations rather than individuals and which are unlikely to be produced by individual, as opposed to concerted cooperative effort. Thirdly, the governments of modern nation states have acquired the function of promoting equality of access to services and outcomes.

National policy means that policy decided upon within the branches, institutions and agencies of central government. Since it emerged as a public policy domain, mental health policy has been developed within the three branches of government, but to a lesser extent within the judicial branch than the legislative and executive branches. The roles of Parliament, Cabinet and ministers responsible for mental health services will be examined in relation to policy and service development. All ministers and departments (particularly central agencies of the Public Service) have a role but, for reasons which have been outlined, this study will concentrate upon that part of the central government’s administrative machinery which had a particular mandate for specialist mental health policy advice, service funding and management.

From this discussion of the terms national mental health policy, my thesis involves a study of the intentions, processes and outcomes of courses of action taken through the machinery of government to provide mental health services for citizens of New Zealand.

¹⁶ Cited in Donna R. Kemp, Biomedical Policy and Mental Health, Westport, Conn., 1994, p. 11.
¹⁷ Gardner, p. 9; Walt, p. 15.
I shall use a mix of thematic approaches and periodization after the historiographical review. Part One will examine the official response to lunacy in New Zealand from British annexation until the demise of the provincial system (1840-1876). In 1876, the Lunatic Asylums Department was set up as a department of state under a medically qualified Inspector [-General]. The Department advised the central government on policy matters, and it took over lunatic asylums from provincial administrations and ran them. Part Two covers policies developed through the lifespan of the separate government department that existed between 1876-1947. It was first known as the Lunatic Asylums Department and later as the Mental Hospitals Department. An inspectorate of hospitals and charitable institutions was added to the Inspector-General’s responsibilities for asylums between 1881-1907 when the functions were apportioned between two departments of state. Straddling the two parts, chapters 4-5 will look at the nature of national policy-making processes within the apparatus of the Crown Colony, provincial and Parliamentary government, and the specialised department that ran mental hospitals between 1876-1947.

Throughout this work, I will also use nomenclature of the period. Superintendents or keepers were lay managers of some early asylums before medical superintendents were appointed. An alienist can be considered a psychiatrist; a lunatic asylum the early form of a mental health service; lunatics or mental defectives as mentally disordered persons. The legal language of mental disorder has sometimes perpetuated quaint terms like these, or others such as idiots, imbeciles and feebleminded persons, long after they have acquired pejorative connotations. No disrespect is intended to persons or institutions so labelled. Minister refers to the Minister of the Crown in charge of the government department with principal and specialist responsibility for mental health policy. In the earliest times, this Minister was designated the Colonial Secretary. The Department may refer to the Colonial Secretary’s Department, Lunatic Asylums Department, Mental Hospitals Department.

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18 The title Inspector-General was used unofficially from the early years of the Department. F.W.A. Skae is honoured as the first Inspector-General in a memorial erected in 1881. It crept into official nomenclature later in the decade, e.g. Inspector-General to Superintendent, Hokitika, 8 May 1883, pasted inside Seaview Hospital patients' book, unclassified Seaview Hospital Records, Hokitika. Nineteenth century legislation did not distinguish between honorary officials called provincial district inspectors and the full-time national inspector. To avoid confusion with local officials, I will use the term Inspector-General consistently for the departmental head.

19 This was originally a French term, aliénation being the medical term for mental derangement, and aliéné an insane person.
or Department of Health. The head of the national mental health bureaucracy was styled Inspector-General (1876-1927) or Director-General [of Mental Hospitals] (1928-1947). My thesis also includes some references to the organisation within the Department of Health after that date. To avoid confusion, the Director-General of Health is always referred to by that title. In the merged department, the office of Director-General of Mental Hospitals became the Director [Division of Mental Hygiene / Health].

The history of mental health has fascinated a number of writers in New Zealand for a little over 50 years. A number of institutional and other studies have drawn upon official records, clinical archives, oral histories, and patients’ experiences. The corpus of knowledge remains somewhat disparate, with an emphasis on local institutions, psychiatry as a profession, and events of the nineteenth and early twentieth centuries. I hope that within its conceptual parameters and a top-down official view of national mental health policy in New Zealand between 1840-1947, my study can complement and contextualize some of these other studies.
1.

SHADOWLANDS OF THE ASYLUM:
HISTORIES OF MENTAL HEALTH SERVICES

Given the shared heritage between New Zealand and its former imperial power, the United Kingdom, it would be surprising if there were no parallels between the stories of mental health services in this country, other former British possessions, and the constituent parts of the United Kingdom and Ireland. The historiography of mental health services in industrialized countries is therefore important to help understand why and when mental health services developed in New Zealand in particular ways. In this chapter, I will outline the two main explanations historians have offered why mental health services in Britain and Western Europe developed along institutional lines. These are the so-called progressivist and traditional histories of psychiatry. Major themes of revisionist interpretations will then be explored, with some examination of their impact upon insanity among social classes, women and colonial peoples. I will then review the growing body of historical research on mental health services in New Zealand. The last part of the chapter will show how my study might contribute to this knowledge base.

MENTAL HEALTH AND POLICY-MAKING

International literature on the history of psychiatry and mental health services highlights certain common elements and a similar broad pattern of development in industrialized countries of Europe and North America.\(^1\) The literature is largely of a national, Eurocentric or Anglo-American viewpoint, although developments in some former European colonies have also been studied. Trends have certainly swept through some countries, but they may have reached other countries much later or not at all. Culture, religion, politics and imperial connections also helped to shape each

country's national policies. As a settler colony of an imperial power, New Zealand's mental health policy was heavily influenced by developments in Europe, particularly the United Kingdom.

Most histories of mental health services have incorporated a policy dimension because the building blocks of services – legislation and rules, ownership, and funding – are all expressions of policy. Attempts, however, by policy scholars to bring historical developments in mental health under their gaze are fairly rare and recent. The discussion usually forms a backdrop to modern mental health policy issues. Historical elements of mental health policy are included in works on mental health policy by authors such as Rogers and Pilgrim for Britain and Rochefort for the United States, with some trans-Atlantic references. Rogers and Pilgrim, for instance, categorize the works of some historians into different perspectives on policy formation. Rochefort posits a cyclical view of policy. Both historians and policy analysts have a contribution to make in studying the long-term causes, nature, processes and effects of mental health policy.

Leading contributors to the history of psychiatry and mental health services in Britain (particularly England), such as Jones, Scull, Porter and Busfield, identify and agree upon certain facts that are, in many respects, components of mental health policy. Why these policies arose is much more controversial than establishing the facts. The story, albeit simplified and not necessarily sequential, goes something like this.

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6 They link Scull to Marxist economic theory and Weber’s views on professional dominance. Foucault was associated with a Marxian emphasis on the need for social control. Jones’ accounts were blamed for being anti-theoretical and for uncritically accepting the views of dominant interest groups. Jones is therefore said to endorse a public relations view of psychiatry with a blend of nineteenth century humanitarianism and twentieth century technology. Rogers and Pilgrim, pp. 24-27.
8 The distinction is important. Historical literature on English mental health services is vastly larger than that on Scotland. Despite sharing many similarities with England, nineteenth century Scottish policy retained some distinctive features.
Lunatic asylums arose as special purpose institutions for the care of the insane. Asylums were one manifestation of the institutional management of deviance in the eighteenth and nineteenth centuries. Asylums became the organizational base for the practice of psychiatry, as a speciality of medicine. Certain types of medical practitioner became experts in identifying and managing people who were regarded as suffering from the disease of insanity. The asylum system helped give credence to the claims of alienists. In their early years, the promise of asylums and the aspirations of their administrators were linked to a unique system of care called moral management or the non-restraint system. This promise was not realized. Insanity became an expansive definition and by the late nineteenth century, public asylums were overcrowded and suffered from inadequate staff and resources. Institutions swelled in size far beyond the intentions of their founders and they became more custodial in reality even though they continued to project a therapeutic image. Reaction to these negative characteristics contributed to the growth of general hospital psychiatry and alternative provision for people suffering from war and other neuroses. The supremacy of institutions in the management of mental illnesses was largely unchallenged until the 1950s when psychiatric treatment was transformed by biomedical technology (especially pharmacology), and new thinking about the social effects of psychiatry and institutionalization. Community care, as a convenient name for a variety of non-institutional treatment and care options, then became fashionable.

Important themes and theories of public policy literature give clues about the who and how factors in mental health policy-making. Who played what part in the formulation of policy? Did governments and government agencies have greater influence in crafting policy than other interest groups? Did a government department have greater influence because its top officials advised governments on policy and then implemented that policy directly through the same organization? I make no pretence at being exhaustive or detailed in my discussion and have relied upon Hill's elegant synthesis of the main strands of scholarship on public policy-making. Hill states that

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9 Moral management was a system of mental care and treatment associated with the Retreat, at York (1794). "Moral" involved psychological forms of persuasion rather than physical or medical means of changing disturbed patterns of behaviour. These techniques were absorbed into the wider term moral management, which relied upon organized work and recreation programmes, participation in religious worship, ordered daily routines, good staff as role models, and good interactions between staff and patients. Non-restraint was a later development in English asylums from the late 1830s. That term referred to the abolition or curtailed usage and modified forms of mechanical restraint.
thinking in this field is fairly recent. Studies of how the public policy process works were of minor concern between 1950 and 1980 since when they have really mushroomed.\textsuperscript{10}

Answers to the question of who makes public policy and the influence and power of interest groups in public policy remain divided. Pluralist writers, such as Beer, Dahl or Polsby, contended that in a participatory democracy, policy-making represents negotiated consensus among various interest groups (including government). This power shifts over time.\textsuperscript{11} In a subsequent development corporatist theories, which were advanced by Schmitter, Middlemas or Milward, argued that interest groups organised themselves into a limited number of groups to represent and advance their interests. Trade unions, professional associations, and national voluntary organisations are modern examples of corporate interests in health policy. Corporate groups are supposedly favoured over other interest groups because they become accepted as a part of the extended government system and are consulted on policy change.\textsuperscript{12} Other writers, such as Marsh, Rhodes, Dunleavy and O'Leary, have refined the corporatist view into the notions of loosely formed policy 'issue networks' and more stable 'policy communities' of interest groups in particular policy fields. Dunleavy and O'Leary regard policy communities as a vital source of innovation.\textsuperscript{13} Hill says that policy communities help to stabilize the management of policy issues, promote consultation, and fit the departmental organization of government.\textsuperscript{14}

Ideas about power in policy-making relate to my study because they describe the types and nature of pressure groups in mental health.\textsuperscript{15} Changes in the organization and relative power of key interest groups over time should indicate the possible relevance of corporatist theory to mental health policy-making. Similarly, it may be possible to establish whether or not a mental health policy community or issue

\textsuperscript{12} Hill, pp. 66-8.
\textsuperscript{15} Rogers and Pilgrim, pp. 1-18, 44-5 carefully applied a similar technique to identify various 'stakeholder' interests involved in mental health policy, past and present.
network existed in the years before 1947. The literature on power in policy-making discusses whether or not the state wields greater influence than other interest groups. Pusey argues that Australia was born as a modern state because the state assumed or acquired a major role in economic and social development.\(^\text{16}\) Bassett makes a similar point about New Zealand in the introduction to his recent historical analysis of this country's relentless 'passion for state activity'.\(^\text{17}\) Contrary to the classical pluralist view that the state is a neutral adjudicator among competing social and economic interests,\(^\text{18}\) other writers claim that the state in its various guises serves and protects its own interests. Tullock points to vote-catching concessions to pressure groups as a device by which governments maintain or increase political power.\(^\text{19}\) Bachrach and Baratz use government non-decision making on politically risky issues as another example of government self-interest.\(^\text{20}\) Public choice theorists have regarded the monopolistic tendency of public providers and bureaucrats as evidence of bureaucratic self-interest.\(^\text{21}\) Miliband takes a cue from Marxism to argue that the state helps maintain ruling class interests as part of the national interest.\(^\text{22}\)

I want to explore some of the internal workings of government in formulating national mental health policy using themes from the policy literature as a guide. Each of the state's many parts - legislative, executive and judicial institutions, numerous administrative departments and agencies, central and local levels, and officials - may influence public policy to varying degrees. The relative influence of these institutions has altered over time in line with constitutional change, and less obvious shifts in the power of the legislature, political executive, courts, and agencies of state. Hill concludes, presumably with reference to the modern industrial state, that with the

\(^{16}\) Michael Pusey, *Economic Rationalism in Canberra*, Cambridge 1991, p. 1. Strictly speaking, Pusey should have referred to the Australian states rather than to the nation of Australia to take account of patterns established before the Commonwealth was established.


gradual accretion of state intervention and direct state provision in social and economic life, policy processes evolved in which political executives (and, one may add, their advisers) are now central actors. According to Hill, the legislature now only endorses or evaluates executive initiative.23

The general thrust of histories of the constitution and public administration in eighteenth and nineteenth century Britain bears out Hill’s point about changes in the balance of power between Parliamentarians, Cabinet ministers and government officials.24 The effects of some of these changes are traced in ‘top-down’ historical accounts.25 Mellett related mental health policy-making and the ubiquitous state inspectorate to the role of the Victorian administrative state in England.26 Hervey explored the plodding nature of policy development by the English Commissioners in Lunacy.27 Suzuki examined the complicated role of magistrates in lunacy reform.28 Dorothy Porter has noted the advance of state medicine through lunacy and public health in tandem. She flagged the topic as warranting further exploration.29 Busfield included state intervention in lunacy with other social legislation that was prompted by the social effects of urbanization and industrialization in the Georgian and early Victorian era, such as factory legislation, public health, and poor law.30

23 Hill, pp. 94-95, 145-8, 155.
29 For a recent example, see Dorothy Porter, ed, The History of Public Health and the Modern State, Amsterdam-Atlanta, 1994, pp. 1-25.
Several writers on public policy may be helpful in ascertaining the position of government officials in policy-making. Between 1876-1947, the same department that advised New Zealand governments directly implemented mental health policy through its own organization. In my thesis I hope to examine whether or not this organizational arrangement gave departmental officials greater influence over other mental health interest groups or, indeed, over ministers and Parliament in the formulation of policy.

In looking at the relative contributions of politicians and public servants to policy-making, Dyson considers that politicians have a temporary or short-term view of policy. A career civil service has a long-term and institutionalized view that accommodates the ebb and flow of politicians’ concerns. Officials are said to be powerful because they often have delegated or discretionary authority to set and administer rules. Public choice theory stands within a critique of the power and seeming independence of career Whitehall style public servants in policy-making. Hill notes several works in this vein from the first half of the twentieth century. More recently, March and Olsen or Hall have also suggested that institutions of government are political actors in their own right. A career civil service ensures that officials and their departments acquire institutional memory and influence through their constant and dedicated involvement with the issues. Where technical knowledge is combined with public administration, the twin loyalties of bureaucrat-professionals may be a source of power too. Lipsky suggests that the ‘dilemmas bearing on action’ also make lower level officials policy-makers. ‘Street-level bureaucrats’, as Lipsky calls them, develop coping strategies to salvage professional service and values from the structural and resource constraints of their work. Their day-to-day decisions therefore become part of the public policies set by top

33 Hill, p. 78. Writers he mentions are R. Michel (1915), C. Mosca (1939), C.J. Friedrich (1940), J. Burnham (1942), G. Wallis (1948), and S.M. Lipset (1950).
Rogers and Pilgrim unwittingly provide an example of street level bureaucrats by noting the extent of discretionary decision-making in mental health policy. The literature is unclear about whether or not officials play a larger role in policy-making than politicians, as Hill admits, before suggesting that party politics, bargaining and administrators are all involved in different combinations and often in all stages of the policy-making process.

The facts of the story of mental health services form the 'what' of policy-making, but how were these policies made? Once implemented, did certain policies like the decision to build lunatic asylums, become so entrenched that they closed off other options for the future? Was there a grand plan for mental health in this country? The public policy-making literature may help answer those questions through interpretations of policy-making as a rational process, an incremental one, and as a melting pot of problems and solutions. Hill discusses a sequential connection that nowadays often starts with politically expressed ideological commitments, the strength of which may preclude consideration of particular policy options, certainly for big issues. Jenkins and Hogwood and Gunn identified and rationally ordered components of decision-making that drew upon Easton's systems theory. Simon's theory of 'bounded rationality' presumed that decisions are made with information that is readily available and with an incomplete range of options. Other theories recognize that rationality is subordinate to the political nature of policy-making. Lindblom is the principal proponent of a theory of muddling through. Disjointed incrementalism, as Lindblom named his theory, assumes that policy is usually adjusted marginally through negotiation and bargaining among the interested

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38 Rogers and Pilgrim, pp. 19, 37.
39 Hill, p. 123.
40 Hill, p. 114.
parties. Dror's view is similar but a little less pragmatic because he considers that policy also includes a dash of idealism. Etzioni developed such thinking with the notion of 'mixed scanning'. This theory proposes that fundamental policy (on say, defence or foreign affairs) is settled close to the heart of government. Low-politics policy areas like health rely on consultation and decisions are usually incremental. Kingdon's garbage can theory posits that policy emerges from a melting pot in which are mixed current problems, policy ideas, participants, and political opportunity.

Yet another view, specifically of mental health policy-making this time, is Rochefort's cyclical view. This theory can also be tested for New Zealand. Rochefort maintains that the mental health system has alternated historically between crests of high policy and activity and troughs of stagnation and decline. The cyclical approach also explains why past policy themes are sometimes rediscovered and recycled. Rochefort mentions how vacillating social awareness of and attention to the mental health policy field results in periodic waves of injections of resources, short bursts of policy and programme activity, before being overtaken by another wave of backsliding and indifference. He refers to factors that are either intrinsic or extrinsic to the mental health system and that are either constant over time or fluctuating with policy cycles. Policy cycles can also be linked to a strong tradition in social policy literature that points to a sequence of the translation of personal 'troubles' into social issues. Those issues are defined as problems requiring solutions. Appropriate solutions are then identified. Prevailing views of society and the nature of social pathology influence the course and form of state intervention in the issue.

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50 Ibid., pp. 101-13, Rochefort, pp. 129-51.
51 A recent example illustrates the point. Since the 1980s, the spate of public inquiries prompted by tragedies involving psychiatric patients or ex-patients, several of them with a history of crime or violence, has revealed systemic failures of mental health services. The deficiencies that were identified by inquiries were translated into recommendations for policy action and have led to increased resources or changes in procedure and practice. Warwick Brunton, 'Colonies for the Mind: The Historical Context of Services for Forensic Psychiatry in New Zealand' in Warren Brookbanks, ed, Psychiatry and the Law, Wellington, 1996, pp. 41-50; Warwick Brunton, 'Mental health: The Case of Deinstitutionalisation' in Peter Davis and Toni Ashton, Health and Public Policy in New Zealand, Auckland, 2001, pp. 181-200.
THE UNITED KINGDOM AND WESTERN EUROPE

Historians provide two main explanations for the particular evolution of mental health services in Britain and Western Europe. Progressivist or traditional histories of psychiatry suggest that changes occurred through a mix of humanitarian reform and professional and scientific enlightenment. Revisionist interpretations explain institutional development as part of a system of social control of society, primarily by the nation state. Each of these main interpretations will be explored. The historiography leaves me asking how satisfactorily does either the progressivist or social control approach explain the way mental health policy and services developed in New Zealand.

One school of thought has explained the history of mental health services as a mix of scientific enlightenment and humanitarianism. Historically conscious psychiatrists, notably Zilboorg and Henry (1941), Leigh (1961), Hunter and Macalpine (1963), Alexander and Selesnik (1966), and Shorter (1997) represent a view that might be called progressivist. Shorter sweeping asserts that before the advent of the asylum, 'in a world without psychiatry, rather than being tolerated or indulged, the mentally ill were treated with a savage lack of feeling'. This is a florid example of a style of medical history that Teigen claims helped serve the 'essential social function of creating and maintaining professional identity, purpose, and coherence'. Two other accounts contain progressivist elements although neither is the product of a psychiatrist-historian. Jones has written and twice revised a general history of mental health services in England. She dislikes being called a progressivist and distances herself from bestowing accolades for medical and scientific achievement. Jones's

work is limited by its overwhelmingly single country approach. Like Jones, Grob's works on mental health services in the United States also invested early asylums with the prospect of hope, whose unreality paved the way for a seemingly endless journey between the extremes of institutional confinement and community care. MacDonald neatly summarizes the thrust of progressivist interpretations. They are said to present the past as a transformation from superstitious ignorance to secular scientific enlightenment. Madness was transformed into mental illness and modern psychiatry. Cruelty gave way to humane care and treatment. Humanitarian ideals of institutions, the reform of lunacy legislation and policy, the professionalization of psychiatry, and the optimism of scientific and therapeutic discovery were all stepping-stones of progress. The triumphalist conclusion of Alexander and Selesnik's work, with its plea for a comprehensive psychiatry that could incorporate the insights of psychology, epitomizes the style.

Several writers have objected to progressivist interpretations. Vandermeersch criticizes the myths of origin. He accuses psychiatrists of trying to legitimate and extend the present domain of psychiatry by inappropriately projecting their discipline into the far past. Micale and Porter claim that progressivist interpretations are simplistic and problematic. The approach is said to overlook psychiatry's halting pathway, its multiple disciplinary origins, and its lack of a stable and consensual theoretical vantage point. Dorner criticizes most psychiatrist-historians for their unfamiliarity with historical methods. In his view, their works demonstrated a humanitarian philosophy to compensate for unconscious guilt feelings about a mechanistic, impersonal orientation. Allderidge criticizes the continuous pathway of progress as a retrospective projection of the present, and suggests instead cyclcal

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59 Jones, Asylums, pp. 165, 193-6, 200-1, 213.
62 Alexander and Selesnik, p. 7.
64 Micale and Porter, p. 5.
patterns in the care of the insane. Grob also sees a cyclical pattern in the care of the mentally ill, one that alternates between enthusiastic optimism and fatalistic pessimism.

The limitations of older accounts have been generally accepted, but there the interpretive consensus ends. In 'The Great Revision', as Micale and Porter call it, psychiatry's benevolence was challenged by scholarship that exposed the contradictory social purposes served by institutions. Revisionist scholars reinterpreted the history of madness in terms of paternalistic, legal, institutional, therapeutic, and commercial power relationships. Psychiatric power, so long medicalized and normalized, masked and idealized, was itself laid bare, claim Bynum, Porter and Shepherd. MacDonald compared the intensity of the debate between progressivist and revisionist schools to 'shouted imprecations', or contesting lineages at an African wedding. Revisionism is the manifestation of Teigen's second model of medical history, in which professional historians wrote for their peers, using social, political and cultural theories.

The Great Revision began in the early 1960s and was inspired partly by historical research. The attack was also rooted in the intellectual assault of radical social scientists and psychiatrists such as Goffman, Szasz, Scheff and Laing on institutions and medicine in general and psychiatric institutions and psychiatry in particular. Micale and Porter claim that by highlighting some of the darkest aspects of institutional psychiatry, revisionist accounts served as the 'historical branch of the anti-psychiatry movement'. Social control thinking was manifest in streams of research on the psychiatric management of poverty, women and colonised peoples.

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67 Grob, p. 309.
68 Micale and Porter, p. 4.
69 Micale and Porter, p. 7.
70 Bynum, Porter and Shepherd, I, p. 2.
71 MacDonald, p. 208.
72 Teigen, p. 354.
74 Micale and Porter, p. 12.
Foucault pioneered this alternative understanding with *Madness and Civilization*, first published in French in 1961. He credited leprosaria as the origin of asylums in western society. When they outlived their original purpose, leprosaria were said to have become places of confinement for latter day outcasts - the poor, vagabonds, criminals and mad people. Like their archetypal forbears, the lepers, mad people were portrayed as objects of fear and ritually excluded from society. Under the 'Grand Confinement' of seventeenth and eighteenth century Europe, the state controlled and disciplined deviants by institutionalizing them. According to Foucault, institutions served both moral and custodial purposes through planned coordination, hierarchical observation, expert power structures and organized systems. Deviants were classified then organized into efficient and productive units. State-sanctioned juridical committal cemented this framework in which doctors played a central role as ‘Father and Judge, Family and Law’. Asylums thus provided the environment for the emergence of expert power in the form of scientific psychiatry. Foucault later elaborated similar views on expert power in theories about prisons and clinics.

Despite Foucault's methodological limitations as an historian, he set a new historiographical agenda that was based on the reasons for the birth of the asylum and other residential institutions. Unlike Foucault’s grand account of European developments, Rothman's *The Discovery of the Asylum* (1971) was a closed, one country analysis of the emergence of institutions in the early nineteenth century United States. Rothman used 'asylum' as a generic term for residential facilities for social control, be they penitentiaries, lunatic asylums, orphanages, poor houses or reformatories. Rothman attributed the sudden appearance of such institutions both to anxiety about social cohesion and to the quest for new ways to manage deviance. By acknowledging the perfectibility of humankind, reform was possible in institutions of special purpose, design, organization, routine and discipline. These Jacksonian
ideals were undermined when institutions lapsed into a custodial regime in the late nineteenth century. Continuing this study in *Conscience and Convenience* (1980), Rothman explains that the state tried to reform asylums with personalized and alternative programmes, but reform was impeded by institutional dominance.

Scull's studies have focussed upon the rise of the English asylum until the late nineteenth century, which he associated with the growth of institutions more widely as a class-based response to economic change from Elizabethan times. Institutions appealed to the upper classes as a way of managing distress among the lower classes. Residential care was an efficient alternative to outdoor poor relief. Institutions could also provide oversight, moral purpose (the work ethic), and deterrence. According to Scull, state authority facilitated mercantilism and underpinned the new capitalist order by policing society. Policing may have sparked the expansion of institutional care for social misfits in Victorian England. Social reformers (whom Scull considers to have been either conservative props of the old social order or asylum administrators with a vested interest) successfully advocated a coherent national lunacy policy based on asylums. So 'more and more the asylum was presented as a technical, objective, scientific response to the patient's condition, an environment which provided the best possible conditions for his recovery,' claims Scull. Incarceration in asylums preserved social order while moral treatment helped to remodel lunatics into socially acceptable and economically productive people. Institutionallization was locked in as a policy by the state regulation of madhouses, and by the successful pleas of competence and expertise made by institutional medical superintendents. Rapid expansion of an efficient system of publicly funded asylums augured their future failure. Asylums were beset by an

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83 David J. Rothman, *Conscience and Convenience: The Asylum and its Alternatives in Progressive America*, Boston, 1980, pp. 12, 43-44, 360-73. Alternatives included “psychopathic” hospitals for acute cases, outpatient clinics, after care, mental health education, and social workers. These ideas were also fashionable in Britain and New Zealand.
86 Ibid., pp. 43, 89, 94.
87 Scull, *Museums*, pp. 40-44.
accommodation supply / demand spiral. A custodial regime left them as 'museums of the mad', full of paupers and incurable people.  

Foucault and Scull each regarded the institutionalization of insanity as a corollary of a market oriented and industrialized society that was intolerant of idle or unproductive members. Dorner propounds a similar view by referring to England, France and Germany. Dorner posited that institutions and scientific psychiatry were inevitable consequences of economic and industrial revolution. He suggests that psychiatry and asylums arose as an easy solution to the social problem of insane paupers when other demands precluded home care of non-productive members of society.  

Families colluded with this phenomenon and so less productive members of society simply disappeared from sight. They were ignored as workers became self-absorbed by their own working conditions. Public indifference continued until psychiatry, wearing the mantle of social engineering, was assigned the task of eliminating social anxiety.  

Bynum, Porter and Shepherd declare that Dorner has a point and that the last two centuries of psychiatry can be seen as a response to 'the phobias of the polite and the propertied' in which the mad joined other scapegoats to help define and reinforce normalcy.  

Social control thinking influenced feminist critiques of the history of psychiatry, although a review by Tomes notes that there is no agreed-upon feminist orthodoxy on that subject. Early feminist interpretations presumed that science, psychiatry and psychology played a crucial historical role by providing intellectual justification for female subordination. Ehrenreich and English and Easlea, for example, saw the significance of and criticized the supposed predominance of women among the patients of male doctors. In Women and Madness (1972), Chesler contended that psychiatric symptoms followed prevailing stereotypes of masculinity and femininity in
a patriarchal society. Smith-Rosenberg argued that women used the sick role or hyste-
ria to protest against supposedly feminine virtues of passivity, dependency and weak-
ness manifest in neurasthenia, hysteria, and psychosomatic conditions. In the
1980s, Showalter, in particular, depicted domination as a widely diffused and all
pervasive system of perception and thought that caught up both male doctors and
female patients. Dwyer, McGovern and Tomes, however, played down these
views by drawing attention to that fact that insanity in either sex threatened family
order. They suggest that the therapeutic regime reflected contemporary gender roles
and patriarchal relations. Indeed, they suggest that women welcomed asylum care
as a refuge from overwork or domestic abuse.

COLONIAL EXPERIENCE

Some interpretations of the history of mental health services in former European
colonies reveal a third strand in social control thinking. Dorner has attempted to
place European and North American developments into a global context. He
suggests that colonization was the conceptual frame from about 1890.
Institutionalization of insanity can thus be considered ‘a colonization, a creation of
internal colonies’. Porter picks up the same term in describing the nineteenth
century asylum as a ‘self-sufficient colony’, but he does not associate that usage
with European imperialism. The application of the colonization model of insanity from
colonies of occupation to settlement colonies is a promising field for further research.

95 Phyllis Chesler, Women and Madness, New York, 1972, pp. 56, 66-75. Tomes in Micale and
Porter, pp. 348-9, 352.
counter argument that Victorian ideals of masculinity were equally as oppressive as the feminine ideal,
see Janet Oppenheim, ‘Shattered Nerves’: Doctors, Patients and Depression in Victorian England,
women as ‘befuddled and contradictory’.
98 Tomes in Micale and Porter, pp. 359-61.
99 Klaus Dorner, ‘The Role of Psychiatry in Solving the Social Question 1790-1990’ in Leonie de
Goel and Joost Vijnseelar, eds, Proceedings of the First European Congress on the History of
Psychiatry and Mental Health Care, Rotterdam, 1993, p. 335.
100 Roy Porter, ‘Madness and its Institutions’ in Andrew Wear, ed, Medicine in Society: Historical
Dorner’s assessment does not seem to have been taken up by scholars of the history of psychiatry and colonialism in Africa or India. Ernst hints at the possibility in her works on European insanity in pre-Mutiny British India but does not explore it. She thinks that insanity among Europeans was hidden from colonized Indians in the interests of a colonial ideology premised upon racial superiority and the civilizing mission of imperialism. Vaughan also considers that the colonial medical discourse was preoccupied by racial difference. In Africa, British colonial medicine helped construct ‘the African’ as an object of knowledge, and elaborated classification systems and practices that were intrinsic to the operation of colonial power. By working backwards from psychopathology to normal psychology, the African was pathologized and rendered different. On the other hand, Finnane’s study of nineteenth century Irish asylums notes the ‘especially powerful position of the state’ and the ‘colonial colour’ of the British government in Ireland that facilitated a comprehensive system of asylums. Garton and Lewis paid little attention to psychiatric colonialism of the aboriginal population in early Australia. Eldridge’s useful study of mental illness in colonial America does not consider interaction with the indigenous population. It must therefore be assumed that mental illness was a ‘white’ problem. Grob, however, discusses inherent colonialism in the antebellum south of the United States, where some states provided separate quarters in asylums for blacks and some excluded them altogether.

Little comparative work has been done on patterns of insanity and service development in settlement colonies. Mitchinson has compared asylums in Ontario and New South Wales. Like New Zealand, these British colonies were receptive to

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107 Grob, p. 89.
prevailing English ideas on moral management and beset by the same deficiencies and changing public attitudes.  

**RECENT INTERPRETATIONS**

By looking at different dimensions of social control, the revisionist school offered important insights about the use of state power, institutions and medical power in understanding historical aspects of mental health policy. Rothman is worried lest the debate oversimplify the complex links between institutions and humanitarianism or social control. Subsequent scholarship has revisited some of the major social control themes, using in some cases what Ingleby calls bottom-up accounts of the 'third world' of patients and studies of individual institutions. MacDonald made a similar plea to study both the 'great tradition' of the educated experts and the 'little tradition' of the common people to show how they were related to each other.

A third, moderate or post-revisionist viewpoint, can be found in the writings of, say, Bynum, Porter and Shepherd who are concerned lest slogans of social control become latter day chants in place of the 'war-cries of the march of scientific psychiatry'. They consider that the revisionist outline is incomplete. Busfield's account is also a solid middle of the road account. She considers that no single perspective currently provides an adequate understanding of psychiatry. Wright maintains that the historiography of the nineteenth century asylum has been written in the long shadow cast by the emergence of modern psychiatry. He considers that

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110 D. Ingleby, 'Mental Health and Social Order' in Cohen and Scull, p. 144.


113 Busfield, pp. 143-5.
paradigms of social control and professionalization were based upon mutually supporting but basically incorrect assumptions.\textsuperscript{114}

Post-revisionist scholarship has unpicked key tenets of the revisionist argument. National studies have dispelled Foucault's notion of a European grand confinement.\textsuperscript{115} So much of the groundwork in single countries has been done, Digby thinks, that comparative essays should be encouraged.\textsuperscript{116} Next, Grob has challenged the narrow understanding of social control. Social control was not 'invented' by institutional care because society regulates behaviour through socialization, social values and 'primary groups' as well as welfare institutions.\textsuperscript{117}

Grob also questions whether labelling systems were manufactured to maintain existing social order. He rightly points out that disturbed behaviour has existed in every society. The historical issue is therefore the classification of deviance\textsuperscript{118} and the roles played by various participants in labelling others.\textsuperscript{119} Local studies, say in mid-Victorian Devon, dispute the extent of uniform coercive state policing in asylum admissions.\textsuperscript{120} In that vein, Porter stresses social understandings of insanity because of the important part played by families and lay magistrates in committal proceedings.\textsuperscript{121} Walton's work on the records of the Lancaster Asylum also identifies family breakdown as the key factor in committal – very different from the idea that officials used asylums to mop up vagrants and loafers.\textsuperscript{122} Wright thus suggests that

\textsuperscript{114} Wright, pp. 139, 145. He summarizes these as the supposed central role of medical superintendents in the process of confinement, the professional incompetence of these officials that led to long-term incarceration of patients, the definition of madness a medical illness, and the asylum as the primary locus of care.

\textsuperscript{115} Mickle and Porter, p. 20; Porter in Wear, pp. 292-3.

\textsuperscript{116} Anne Digby, [Review of Bynum, Porter and Shepherd], Social History of Medicine, 3, 3 (1990), p. 475.

\textsuperscript{117} Bynum, Porter and Shepherd, I, p. 6.

\textsuperscript{118} Grob in Mickle and Porter, pp. 275-6.


\textsuperscript{120} Bill Forsythe, Joseph Melling and Richard Adair, 'The New Poor Law and the County Pauper Lunatic Asylum - The Devon Experience 1834-1854', Social History of Medicine, 9, 3 (1996), pp. 353-4; Jones, Asylums; Larry Gostin, Mental Health Services – Law and Practice, London, 1986.

\textsuperscript{121} Roy Porter, 'Madness and its institutions' in Wear, p. 179.

a household economics approach is needed to understand the complexity of the problem. Such evidence tends to support Luckin's idea that the phenomenon of institutionalized insanity was the product of a social process in which state, ruling classes and the dominated working classes participated.

The revisionist portrayal of nineteenth century asylums as large, continuous and universal is inaccurate. Institutional histories show that early asylums came in 'all shapes and sizes, big and small, good and bad'. Tyor and Zainaldin think that the institution must be examined from within to help explain the pattern of growth. Digby's work is a reminder that smaller privately run institutions provided a niche market to control the moneyed mad. Although the average size of public institutions increased undeniably until the mid-twentieth century, some histories of hospital architecture, such as those by Thompson and Goldin or Taylor note how the limitations of earlier style institutions were recognized in the late nineteenth century. Awareness of a depersonalized environment and the capital cost of building large asylums led to adaptations in building design.

The impression created by social control writers that the latter day asylum was a long-stay institution has been queried by Wright's study of the databases of six British asylums. Bynum, Porter and Shepherd point to the folly of equating the rise of

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46; John Walton, 'Poverty and Lunacy: Some Thoughts on Directions for Future Research', Social History of Medicine, 38, 15 (1986), pp. 64-67.
124 B. Luckin, 'Towards a Social History of Institutionalization', Social History, 8 (1983), pp. 87-94.
126 Anne Digby, Madness, Morality and Medicine, Cambridge, 1985, pp. 8-9.
129 Wright, pp. 143-4. He concluded that between 40 and 60 per cent of patients stayed for 12 months or less. He notes a comparable pattern elsewhere. Wright concludes that if the rate of
psychiatry with the asylum because substantial numbers of lunatics were held in non-specialist institutions and under family or parochial care.\textsuperscript{132}

Research on the professionalization of psychiatry has been preoccupied with specialist doctors at the expense of other occupations. Smith attests the neglect of research in that field and says that the crucial role of other types of asylum worker has been eclipsed by studies of medical superintendence.\textsuperscript{133} Bynum, Porter and Shepherd argue that 'nineteenth century asylum doctors [were] not so much conscious agents of social control and professional aggrandizement as medical men trying to cope with difficult circumstances.'\textsuperscript{134} Elsewhere, Porter is even more pointed: 'Asylums were not instituted for the practice of psychiatry; rather psychiatry was the practice which developed once the problem of managing asylum inmates arose.'\textsuperscript{135} Busfield attributes the professionalization of psychiatry to a post-Enlightenment 'liberal-scientific conception' of society. Medicine and psychiatry took advantage of the prevailing values of reason and scientific rationality to claim that psychiatric knowledge was scientific, unlike other forms of treatment. Because science was the 'linchpin of psychiatric practice', 'expert' psychiatrists with suitable knowledge, authority, status and altruism stood to win.\textsuperscript{136} Mellett has demonstrated the lack of a single psychiatrists' perspective or a particularly loud voice.\textsuperscript{137}

\textsuperscript{132} Bynum, Porter and Shepherd, III, p. 1.
\textsuperscript{133} L.D. Smith, 'Behind Closed Doors; Lunatic Asylum Keepers, 1800-60', Social History of Medicine, 1, 3 (1988), pp. 300-27.
\textsuperscript{134} Bynum, Porter and Shepherd, II, pp. 4, 7-8.
\textsuperscript{137} Mellett, Prerogative, Chapter 4. cf. Bynum, Porter and Shepherd, I, pp. 15-6; Oppenheim, p. 16.
NEW ZEALAND

New Zealand has shared in the international interest in the medical, social and administrative history of psychiatry since the 1970s. Dow's historiography of health in New Zealand included several paragraphs on mental health services to demonstrate that this field shares in the coming of age of the history of medicine in New Zealand. The fruits of this research are mainly confined to theses and research essays, conference papers and short articles. The continuing absence of a general history of mental health services in this country, however, still dogs historians, as it did Ernst, who could only give a 'general outline' of the main themes of a social history of psychiatric institutions in 1991.

Early research by history-conscious mental health administrators and professionals presented an unmistakable institutional perspective. As early as 1948, brief historical notes were compiled within the Division of Mental Hygiene of the Department of Health. These were probably the source of Hunter's brief narrative histories of different mental hospitals in 1957. Blake-Palmer ascribed progress to medical influence and progressive institutional psychiatry. Mirams authored an introductory historical section to a Department of Health policy statement of 1969. Some of my own early writings, as a departmental official, are said by Ernst to have been myopically endangered by rewriting history from the viewpoint of current policy.

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144 Ernst, Social History, p. 66. She may be referring to historical introduction to the Department of Health's unpublished first submission to the Royal Commission on Hospital and Related Services.
Officials’ or ‘insider’ accounts earned Ernst’s criticism for their presentism, contextual insularity, restricted focus and unsophisticated analysis.\textsuperscript{145} Despite these limitations, Wellington-based officials who operated within a national and bureaucratic system of psychiatric hospital management attempted to explain how mental health services grew as a result of national policy.

Mental health services do not feature in some general histories of New Zealand by Sinclair,\textsuperscript{146} Belich\textsuperscript{147} or Oliver.\textsuperscript{148} The subject has been included (perhaps because of some common elements of the national administration of lunatic asylums, public hospitals and charitable aid services between 1881-1907\textsuperscript{149}) but sidelined within other histories. Links between asylums and mainstream health care were ascribed to medical influence.\textsuperscript{150} Mental health services are incidental to or pass unnoticed in histories of mainstream health care\textsuperscript{151} or social security.\textsuperscript{152} Some studies of social policy, such as the work of Oliver, hint at links between state welfare and state control but not specifically in relation to asylums.\textsuperscript{153} Elsewhere, Oliver provided some background but admitted that the subject was so little explored that nothing could be

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1972. Volume 2, pp. 1-21. In keeping with Public Service practice of the day, this contribution was not authored.
\textsuperscript{145} Ernst, Social History, pp. 64-65.
\textsuperscript{147} J. Belich, Making Peoples, Auckland, 1996. A brief summary of the growth of health services and charitable aid is provided on p. 381, but this made no mention of asylums.
\textsuperscript{153} Oliver, p. 28; Oliver in AJHR, 1988, H-2, Volume I, pp. 12, 15, 23.
\end{flushleft}
confidently said about the work done in institutions. Nevertheless, Graham’s account of nineteenth century settler society lumps asylums with prisons and hints that different factors underlay government involvement in these fields than in others.

Olssen took up the point. He attributed the foundation of prisons, industrial schools and asylums to the exercise of the state’s police function and powers. More recent scholarship has continued to pursue the reasons for the growth in the role of the state in New Zealand life. Bassett’s wide-ranging account makes passing reference to mental health but does not explore the special reasons why state interventionism and administration in this field might differ from other policy domains. Thomson’s fresh look at the ‘rather smug, self-congratulatory tale’ questions the inevitability of state welfare. Thomson also aligns the establishment of asylums to government intervention in social welfare rather than health care.

Based on the role of psychiatry in European colonies in Africa and Asia, Ernst suggested that lunacy policy fulfilled an important ideological function in maintaining colonial order, but concluded that the matter had not been satisfactorily addressed for New Zealand.

The first history scholar to enter this field was Jermyn. His thesis of 1952 gave a general description of the public response to mental illness in New Zealand. Nearly 50 years later, Jermyn’s account remains a useful description of pragmatic administrative and legislative developments between 1840-1880. These are set against a background of English precedents. Historians did not follow Jermyn’s pioneering interest in this field for nearly two decades. Since then there has been a spate of institutional histories, biographies of some major figures, socio-clinical research, and studies of the professionalization of psychiatry.

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155 Jeanine Graham, ‘Settler Society’ in Oliver, Oxford History, p. 137.
156 Michael Bassett, The State in New Zealand 1840-1984: Socialism without Doctrines, Auckland, 1998, pp. 69, 71. Bassett is incorrect in saying that mental hospitals were run by the Department of Education.
158 Ibid., pp. 83, 93.
159 Ernst, p. 67.
The main thrust of historical research has been towards individual hospitals rather than systemic developments. In one category stand short narrative histories that are institutionally triumphalist or nostalgic. People associated with the hospital concerned have usually written these accounts, often as commemorative publications.\(^{161}\) Tod's local history stresses the role of the mental hospital in the life of Seaciff.\(^{162}\) Histories of general hospitals or hospital boards, some of them extensive, may also include mental health services.\(^{163}\) Some published histories of psychiatric hospitals are also substantial accounts.\(^{164}\)

Academic research is more robust and better documented, but it is also characterized by a focus on individual institutions,\(^{165}\) especially those in Otago. Academic requirements for, say, honours level long essays have encouraged students to make good use of local rather than national archives with the result that local developments are rarely scrutinised from the standpoint of centralized policy and administration. The forerunners were the complementary studies by Hubbard (1977) and Bloomfield (1979) of the characteristics of patients, types of care and treatment, staffing patterns and public attitudes for the periods 1882-1911 and 1863-


76 respectively. Fennell used a similar method for the period 1912-48.\textsuperscript{166} Her useful discussion of institutional hierarchy could have extended into the realm of patients and drawn upon Frame's writings.\textsuperscript{167} By studying the interest of relatives in patients as a gauge of public interest, these authors broke new ground. This could have been exploited by more extensive use of newspapers and Parliamentary debates, sources that were utilized in Grant's study of post-war public opinion.\textsuperscript{168}

The institutional focus of historical research has affected the study of other aspects of psychiatric care. Hospital histories have tended to treat the pre-asylum past as if it were a prelude to institutional solidification. Other policy options have received less attention. Research on specialized aspects of psychiatric care has sometimes presented mental hospital and non-institutional services as mutually exclusive alternatives. Haines and Abbott traversed some landmarks of psychiatric deinstitutionalization\textsuperscript{169} without observing the fact that in its broadest sense, such policy originated from institutional administrators themselves, as I have suggested elsewhere.\textsuperscript{170} Clarke's history of specialist provision for the treatment of war neuroses\textsuperscript{171} and Riseborough's work on intellectual disability\textsuperscript{172} say more about the institutional derivation or reaction that prompted breakaway services.

Historians have apparently accepted the notion of state predominance in the provision of psychiatric care and treatment in New Zealand. Yet the reasons why mental health became a public policy issue and why specialized services were provided predominantly by the state rather than by private or voluntary agencies are general policy considerations that have not been explored in depth. True, the origins of Ashburn Hall, New Zealand's only licensed private institution have been covered in

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\item[]\textsuperscript{166} S. Fennell, 'Psychiatry and Seaciff: A Study of Seaciff Mental Hospital and the Psychiatric Milieu in New Zealand 1912-1948', BA Hons Essay, University of Otago, 1981.
\item[]\textsuperscript{169} Hilary Haines and Max Abbott, 'Deinstitutionalisation and Social Policy in New Zealand: 1: Historical Trends', \textit{Community Mental Health in New Zealand}, 1, 2 (1985), pp. 44-56.
\item[]\textsuperscript{170} Warwick Brunton, 'Deinstitutionalisation: A Romance for All Seasons' in Hilary Haines and Max Abbott, eds, \textit{The Future of Mental Health Services in New Zealand: Deinstitutionalisation}, Auckland, 1986, pp 44-63.
\item[]\textsuperscript{171} R. Clarke, 'Not Mad, but Very Ill': The Treatment of New Zealand's Shellshocked Soldiers 1914 to 1939', MA Thesis, University of Auckland, 1991.
\end{itemize}
theses by Medlicott and Somerville, \(^{173}\) but not the reasons why Ashburn Hall remained the sole institution of this category after 1882. Little is revealed by histories of two voluntary organizations, the Dunedin Patients’ and Prisoners’ Aid Society (1877)\(^{174}\) and the Wellington After Care Association (1928).\(^{175}\) Riseborough’s discussion of the stormy relationship between departmental officials and the Intellectually Handicapped Children's Society is insightful and relevant, even though it concerns a later period and different population group.\(^{176}\) Several writers have associated mental health aspects of eugenics policies and the formation of the Plunket Society with social control through state intervention.\(^{177}\)

Biographies and autobiographies of prominent psychiatrists or mental health administrators have also been written. These range from obituaries or panegyrics for perceived heroes of psychiatry\(^{178}\) to more critical and contextual studies.\(^{179}\) Reference has already been made to Duncan MacGregor and Mrs Grace Neill. Sir Truby King’s contribution to psychiatric services as well as to infant welfare is a topic of growing consideration. Earlier biographies were less critical of his achievements.

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176 Riseborough, pp. 81-82, 89 ff.
and they incorporated an element of folklore.\textsuperscript{180} Olssen broke from such hagiography and suggested that it was probably 'no coincidence' that King's experience as a psychiatrist-administrator shaped the Plunket ideology.\textsuperscript{181} Others, notably Brookes\textsuperscript{182} and Caldwell,\textsuperscript{183} have made the connection more explicit by studying King's superintendence of Seaciff Asylum (1889-1921).

The rich fields of clinical and social information recorded in patients' files at psychiatric hospitals have become an attractive source of research. New Zealand studies have presented a social class and gender analysis.\textsuperscript{184} A feminist perspective is well represented.\textsuperscript{185} The patient perspective is also available in biographies of or works by patients of literary bent, among them Lionel Terry,\textsuperscript{186} Janet Frame,\textsuperscript{187} and Robin Hyde.\textsuperscript{188}

Primrose's analysis of the social and occupational origins of patients at the Auckland Mental Hospital\textsuperscript{189} was the precursor to more recent studies using patient records. Labrum also used the Auckland records and concluded that the social significance and explanations behind the resort to asylum care by people in the community remains obscure.\textsuperscript{190} Hubbard, Bloomfield and Somerville included an analysis of social and aetiological patterns among admissions to Otago institutions. Brookes

\textsuperscript{180} Mary King; R.M. Burdon, \textit{New Zealand Notables (Series 2)}, Christchurch, 1945, pp. 13-66.
\textsuperscript{181} Olssen, Truby King, p. 23.
\textsuperscript{183} C. Caldwell, 'Truby King and Seaciff Asylum 1889-1907', BA Hons Essay, University of Otago, 1984, pp. 31-32, 35, 62-63. See also Brunton, \textit{Second Public Health}.
\textsuperscript{186} Frame, Faces; Frame, Angel.
\textsuperscript{188} Primrose, pp. 188-319.
\textsuperscript{189} Labrum, Gender, pp. 7, 243-8.
showed that patterns at Seacliff confirmed national trends. Her research also found that in keeping with other colonial societies, men were over-represented in the asylum population. This is obviously a fertile ground for further study. Holloway’s methodical analysis of a sample of case histories from Seacliff between 1928-37 led her to the conclusion that madness embraced the more fundamental constructions of masculinity and femininity. Families, rather than doctors or agents of the state, were the most influential party to committal proceedings when mental illness at home became unmanageable. Thus demography and social views of insanity help explain why institutions expanded and new forms of insanity had to be dealt with.

There is a paucity of historical research on Maori experience of mental illness and mental health services. Dow avoided the area, although Lange provided a solid introduction to historic Maori understandings of health. Buck’s early bicultural perspective and more ethnographic studies have yet to be assessed. Utilization of what were essentially Pakeha psychiatric services by Maori in the years before biculturalism became a hot health-political issue is also unexplored. Blake-Palmer, Gluckman, and Durie represent the psychiatric viewpoint, but this work has not yet been synthesized with the early medical observations of Victorian psychiatrists such as Lindsay and Tuke.

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191 Brookes, Early Days, pp. 172-6.
192 Brookes, Men and Madness, pp. 208-9.
195 Lange’s 1972 MA thesis ‘The Revival of a Dying Race: A Study of Maori Health Reform 1900-1918 and its Nineteenth Century Background’ has since been revised and published under the title May the People Live, Auckland, 1999. Pages 7-15 describe Maori perceptions of health.
197 This policy issue arose from scandals at Oakley and Carrington Hospitals, Auckland, which led to a commission of inquiry (1987) and the take over of the Whare Paka Unit by Maori activists. The inquiry report placed a decidedly cultural slant on psychiatric hospital utilization by Maori for the first time.
Work on mental health professionals is confined almost exclusively to psychiatry. Belgrave has provided an overview of the process by which medical practitioners controlled major medical institutions and came to dominate other health professions.\textsuperscript{201} Belgrave thought that the roles ascribed to women doctors forced them into hospital and salaried positions in public health, child health, and psychiatry.\textsuperscript{202} Cody disputes that finding on the strength of interviews with women who worked in psychiatry from the 1930s.\textsuperscript{203} A history of medical specialization in Australasia and the formation of British-style medical colleges\textsuperscript{204} are a backdrop to the professionalization of psychiatry. The official history of the Royal Australian and New Zealand College of Psychiatrists is obviously more specific but it excludes initiatives prior to 1946.\textsuperscript{205} Philp studied the ‘psychiatric profession’ in New Zealand between 1877-1930 and set it against the general professionalization of medicine. Philp linked the identification of the specialty with the acquisition of a management monopoly by its practitioners. He claims that the somatic approach of asylum doctors refined the nature of their institutional authority and facilitated the expansion of their role as scientific pastors of society in general. At times Philp seems to credit professional ambition with various policies and practices that were, in fact, influenced by wider social forces.\textsuperscript{206} Thompson\textsuperscript{207} accepted Philp’s basic argument and extended the review to 1950. The coincidence of professionalization with apparent therapeutic breakthroughs and changing public attitudes to psychiatry was noted. Thompson linked growing professional aggrandizement, influence and status to legislative change, the academic teaching of psychiatry, and the diversification of services. What is less clear is why somatic approaches underpinned institutional and bureaucratically organized psychiatry but psychotherapeutic approaches became

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\item R.R. Winton, ‘Vocational Medical Colleges in Australia and New Zealand: A Latter-Day Phenomenon’ in Atwood, Gillespie and Lewis, pp. 281-6.
\end{itemize}
identified with community psychiatry, private practice and a new generation of post-World War II psychiatrists. Cody's gendered twist to theories of professional power in mental hospitals noted that medical recruitment campaigns were invariably directed towards males.

Further studies of the professionalization of psychiatry need to consider why some groups of mental health workers became professions but not others. Particular attention needs to be given to the mental hospitals' large workforce of male and female attendants and the professionalization of psychiatric nursing. General histories of nursing or psychology do not yet adequately explain differences in the organization of some professions over others. Nor do they show why attendants identified with the union movement, as Roth's history of public service unionism notes.

CONCLUSION

The historiography of mental health services, particularly in Britain and New Zealand, combined with some themes from public policy-making literature sets the scene for the rest of this work. Major strands in the general historiography offer incomplete explanations of the broadly comparable way mental health services evolved in industrialized countries. There are signs that views polarized between what might generally be called progressivism and revisionism may have been succeeded by a more balanced look at the reasons for common patterns of development and for national differences.

This debate is a backdrop for studying events in New Zealand. As a colony, New Zealand was bound to British culture, institutions and systems of government. It is

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209 Cody, p. 38.
important to look beyond the Anglocentric focus of the literature to consider the extent of policy convergence or divergence throughout the United Kingdom and the effects upon New Zealand as a British colony. That understanding could show how colonial policy has mirrored, adapted or rejected imperial precedent in the light of New Zealand’s own demographic, social, political and cultural change. The foundations of mental health as a matter of public policy have imperial roots, but the antipodean version differed because of a virtual state monopoly on specialized psychiatric care and treatment with very limited roles for profit-making private or voluntary services.

Some important themes have been introduced from the overview of the literature on policy and policy-making. The literature on the actual process of policy-making contains a range of views. Decision-making models raise questions about the extent to which policy is rational, idealistic, incremental, cyclical, or an unpredictable response to a particular constellation of circumstances. An historical review of New Zealand’s mental health policy can test whether, over time, policies are novel, cumulative or cyclical.

By accepting a definition of policy that embraces the effects as well as the formulation of policy, implementation theories are important for this thesis. A government department that both tendered mental health policy advice and then implemented that advice through its own services was the preferred agency for the greater part of the period 1840-1947. That model should be assessed for the way it may have smoothed the pathway of implementation through direct implementation rather than through the mediation of third parties. Gaps between policy aspirations and results can be assessed using administrative records of that department. The bottom-up perspective, represented by biographies and the published works of some psychiatric hospital patients and staff, will help to gauge the pressures faced by local administrators in implementing national policy. Those writings have been little used although they throw a spotlight on the uneasy effects of policy implementation.

Policy literature offers different insights about participation in the formulation of public policy. Powerful interest groups need to be identified and arranged in terms of their influence and role in policy-making. State power is particularly important but this too
needs to be analysed under changing constitutional conditions and by component parts such as state institutions and different branches of government. Policy literature remains divided about the privileged influence of government officialdom.

The third element of this literature review concerns the history of mental health in New Zealand. Historians in this country have participated in the international interest in the medical, social and administrative history of psychiatry, particularly since the 1970s. The literature reveals a pattern of medical, official and academic accounts. Most involve standard historical methods based upon official records. Later research has utilized quantitative methods and is tapping into the clinical archives of some older mental hospitals. Oral histories also feature in a limited way. Accounts of patients' experiences are starting to be utilized. Methodological variety and perspectives will help to give a rounded picture to the intentions and rhetoric of national policy pronouncements on the one hand, and the effectiveness and reality of their implementation at local level, on the other. This contextual dimension is needed to rectify some imbalances within the literature. For example, institutional histories reveal common strands and simultaneous developments that stemmed from national policy and the national organization of public mental hospitals under a single government department.

In the absence of a history of the national policy framework in this country, the corpus of knowledge remains a somewhat disparate collection of studies, with an emphasis on local institutions and the professionalization of psychiatry. The nineteenth and early twentieth centuries have fascinated scholars. Very few studies have crossed the threshold of the therapeutic revolution in psychiatry since World War II.

By studying the development of national mental health policy and policy-making, I will obviously adopt a top-down view. Official publications and the surviving administrative records of provincial and central government agencies and individual mental hospitals are the principal sources for such a study. These records have not been analysed in the aggregate for the entire period 1840-1947 by other historians, nor have they used various models of policy-making as tools in that task. As a contribution to the history of mental health in New Zealand, my top-down approach will hopefully construct the skeleton for which local, social, institutional and
professional studies are the flesh. I bring to that task many years in my previous career as a national health policy-maker. That experience has taught and often reminded me of the value of applied history in the realm of policy-making.
PART ONE

1840-1876
LUNACY IN A NEW LAND

'Insanity is at hand.'

Insanity was identified among colonial settlers in New Zealand a few years after the Treaty of Waitangi was signed in 1840 between Maori and representatives of the British Crown. Official record keeping was essential to the organized government that began in that year, so reports on some individual cases were brought to the attention of government authorities. There were almost certainly some cases prior to 1840, given the lifestyles of the more transient Europeans who came here as sailors, sealers or whalers. Throughout the years of Crown colony (1840-52) and provincial government (1852-76), however, incidents were recorded. Lunacy had arrived and was here to stay.

This chapter will look at the way Pakeha colonists understood lunacy. Pakeha settlers attributed insanity to the problems of migrants, the demographic features and stresses of settler society, and medical conditions. In this chapter, too, I will explain why mental health policy was accepted as a matter of state responsibility. Early governments responded to the problem by placing lunatics in gaols, hospitals or in paid private care. The limitations of these expedients drove officials to seek a durable system based upon English and Scottish models.

INSANITY AMONG PAKEHA COLONISTS

Each culture and era explains insanity in its own way. Cultural perceptions of insanity are shaped by the frequency, disruptiveness and danger of behaviour beyond what is ritually or socially defined. Insanity may be explained as a

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1 Dr M.S. Grace, M.L.C. [Member of the Legislative Council]. Appendices to the Journals of the House of Representatives (AJHR), H-10, p. 11.
2 New Zealanders of non-Maori origin, normally of British or European descent.
supernatural, natural, biological or sociopsychological phenomenon. According to Porter, in the western tradition, mad people have included 'all those who have been judged by themselves or by society to be intellectually, emotionally or behaviourally disturbed, from 'mere' depressives or neurotics to the full-blown 'lunatics' of old, or those who would nowadays be deemed schizophrenics orpsychotics.' Madness is a state bordered by 'the ecstatic visionary, the religious prophet, the melancholy churchyard sonneteer, the distraint eccentric'.

British settlers brought their views on insanity as part of their cultural baggage. In pre-industrial Britain, popular ideas on mental well-being and disorder were shaped by traditional beliefs about the supernatural. The slow pace of social change fostered continuity in the definition of mental abnormality. Popular thinking about insanity survived in colonial parlance. Insane persons were described occasionally as ‘sick men’ or suffering from a ‘frightful malady’ but more often as afflicted by misfortune or divine visitation. Insane persons were said to bear the impress of ‘the great Creator’. Supernatural influence was also conveyed in the official nomenclature of ‘lunacy’. By early Victorian times, however, sociocultural perceptions of insanity existed side by side with medical views - not that forms of insanity were systematically and scientifically classified until the late nineteenth century. In the 1840s, experts generically grouped different forms of insanity around ancient entities like mania, melancholia, dementia and idiocy.

The medical lens framed the notes on insanity among Maori recorded by early Pakeha explorers, missionaries, doctors and ethnographers. Maori held a supernatural view of mental aberration before the arrival of Pakeha. Allowing for

6 D. Monro to Provincial Superintendent, 20 November 1855; Nelson Province Archives, National Archives, Wellington, NP 71b: *New Zealander*, Auckland, 8 June 1865.
8 J.B. Clarke, letter to West Coast Times, 6 June 1870; *Auckland Weekly News*, 9 March 1867.
some variation among iwi (tribes), te reo (Maori language) distinguished between insanity (pourangi, porangitangi, porewarewa, haurangi, potete), demented or foolish persons (wairangi, karearea), intellectual disability (karakiraki, pororirori) and spirit-possessed (apa, mate kikokiko).\textsuperscript{11} Visitors generally observed very few cases of insanity among Maori.\textsuperscript{12} Intellectual disability was prominent among the occasional cases noted.\textsuperscript{13} Tuke, who was later an eminent Victorian psychiatrist, listed in order of frequency among Maori idiocy, senile mania and dementia, morbid impulse, and general paralysis of the insane. An unknown authority cited by Goldie confirmed the order of this list.\textsuperscript{14} Polack suggested that with the exception of a 'little comatose affection', Maori did not suffer greatly from senility.\textsuperscript{15} In 1910, the Maori doctor Te Rangi Hiroa / Peter Buck (later Sir Peter) portrayed ancient Maori forms of mental disorder in medical terminology. These forms corresponded to epilepsy or hystero-epilepsy, hysteria, and demon possession.\textsuperscript{16}

The Pakeha population of New Zealand grew rapidly through systematic colonization by commercial ventures, the gold rushes, and government-assisted immigration. Immigration was the major source of population increase until the 1870s. It had a major impact on the size, growth rate, age-sex structure and ethnic composition of the population. A large surplus of males, and particularly young, mobile males was attracted to New Zealand. European males outnumbered females by 3:2 in 1867 and


\textsuperscript{14} Goldie, p. 75.

\textsuperscript{15} Polack, p. 272.

\textsuperscript{16} Buck, \textit{Medicine}, pp. 50-52.
the ratio remained unbalanced until 1906. Overseas-born residents outnumbered the number of New Zealand born residents until 1881. The immigrant and colonist Pakeha population first exceeded the Maori population in 1858. Pakeha immigrants settled unevenly. From 1861-96 a majority of non-Maori lived in the South Island.\(^{17}\)

Nineteenth century immigration advertisements for New Zealand offered various attractions, most notably the opportunity to 'get on' in a land whose physical, social and cultural similarities and differences from Britain were manipulated as draw cards or 'pull factors'. Getting on meant opportunities for material or social advancement. Similarities and differences meant the opportunity to restore in the far-flung colony the romance of rustic England free from industrial and urban blights, with abundant natural resources, good prospects, steady jobs, good living conditions, and mutual respect between employer and employee.\(^{18}\) As Belich puts it, 'various prophets of colonization offered migrants different New Zealand lotteries, but a common quality was that everyone would win.'\(^{19}\)

Publicity was geared towards enterprising, versatile and independent Britons or Anglo-Saxons who had the tough physical and mental stamina and moral qualities of ideal pioneering stock. ‘The feeble-minded, the emasculate, the fastidious, the timid do not emigrate,’ declared Hursthouse. ‘It is the strong and the bold who go forth to subdue the wilderness and conquer new lands.'\(^{20}\) Women of the same ilk were needed. Hodder observed in 1862 that hard manual work by women was not a disgrace in the colonies. Wives and daughters did chores, gardening and handiwork instead of hiring servants.\(^{21}\) In the first instance, genteel, respectable and decent


\(^{19}\) Belich, p. 311.

\(^{20}\) C. Hursthouse, New Zealand, the "Britain of the South", 2\(^{nd}\) ed., London, 1861, p. 404.

\(^{21}\) E. Hodder (1862) cited in Fairburn, pp. 72-73.
English, Scots and Protestant Irish were wanted, moneyed or else young, healthy and rural. A gender balance was sought among settlers who were expected to attain respectability after a substantial apprenticeship as labourers and servants. 

Pioneering qualities lived on in the Pakeha mythology of the settler family and the conquest of the land. Frank Hay, Inspector-General of Mental Hospitals (1907-1924) suggested that

... one may safely venture the opinion that, on the whole, the issue of the [mental health of the] earlier settlers is the more stable. The romance of pioneering attracts the venturesome, the brave, and the vigorous - the best class of Briton. These empire-builders are also the builders of shelters for the less robust...

Who were these less robust settlers? Hay continued:

... as the country becomes more settled, [the less robust] find hardship where the others had found adventure. Thereafter “gold rushes” provided their quota; and, since those days, though we have had and still get many of the best that the older lands can give us, there have been many of the class we all know, “the man who never had a chance,” and, between the two, varying degrees of settlers and unsettlers, the average being, as our figures clearly indicate, below the average of the country of origin.

Hay’s opinions on the prevalence of insanity in colonial New Zealand were guided neither by early records nor pioneer opinion. Statistical information is scanty until the early 1870s, when the first national information was published about lunatics confined in some form of institution. The earliest national estimate of about 100 chronic lunatics in New Zealand gaols was made in 1858, but that was a political estimate. Subsequent returns showed about 50-60. An 1857 estimate of

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22 Belich, p. 313.
23 Phillips, pp. 38-42
24 AJHR, 1907, H-7, p. 4.
25 New Zealand Parliamentary Debates (NZPD), 20 April 1858, 2, p. 387.
26 Provincial Superintendent, Auckland to Colonial Secretary, 9 June 1859, Colonial Surgeon to Provincial Superintendent, New Plymouth, 28 May 1859, Provincial Superintendent Hawke’s Bay to
1:517.27 Pakeha inhabitants in Auckland Province considerably exceeded lunacy in England's agricultural districts (1:796). The differential was attributed to the gender imbalance in New Zealand. The male ratio of 1:431.05 in Auckland Province contrasted with 1:689.7 females and was quite the reverse of England. Contemporary information about the prevalence of insanity among Maori is much sparser. Staff-Surgeon R.K. Prendergast, speaking from personal experience in 1858, said that Maori were very backward in making known cases that occurred among themselves. Prendergast could not say whether this arose from ‘their putting them aside’ or from the infrequent occurrence of insanity among the native population. From the cases he had seen, Prendergast thought that insanity among Maori was seldom, if ever, curable.

National statistics provide a better picture of the extent of insanity throughout the colony, although they refer only to lunatics held in official custody. On 1 January 1873, 542 lunatics (363 males and 179 females) were confined in lunatic asylums, and 53 in gaols. An unknown but smallish number must have been in hospitals. In 1873, too, 23 persons died of suicide while suffering from “temporary insanity”. This represented 5 per cent of total coronial inquests. Using the simple ratio of persons in institutions to the general population as the basis for international comparison, however, was unreliable and ‘by no means brings out such a flattering account of the lesser prevalence of insanity in New Zealand.’ There was one lunatic per 1,180 persons in New Zealand in 1877, much higher than the stated prevalence in Australian colonies or England.

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Colonial Secretary, 4 June 1859, Superintendent Wellington to Colonial Secretary. 17 May 1859, Provincial Surgeon Otago to Provincial Superintendent to Colonial Secretary, 28 May 1859, Department of Health file, H 30/21, present whereabouts unknown. No returns were filed from Marlborough, Nelson or Canterbury. Canterbury, however, had about five lunatics on average in 1858, according to J. Hall in evidence to the Select Committee on the General Lunatic Asylum. Legislative Department Archives, National Archives, Wellington, File LE 1/1858/4.

Evidence to Select Committee on the General Lunatic Asylum. 26 May 1858, LE 1/1858/4.

Statistics of the Colony of New Zealand for 1873, Wellington, 1874, pp. 38, 42, 19. The hospital data is based on the fact that general hospitals received 29 patients who were diagnosed with “insanity” in 1873.

AJHR, 1877, H-8, p. 8.
Migration from one cultural context to another, with consequent disruption of traditional support systems, can be seriously stressful and it can contribute to psychopathology among migrants. Hursthouse warned that the first week of the voyage out was a 'black time' of dullness, desolation, misery, sea-sickness and general discomfort as the immigrant realized the finality of farewells with familiar faces and landmarks and was surrounded by strange shipmates and routines. Immigrants occasionally became insane on the voyage out. Lindsay was told of cases of mania among wealthy and educated men on immigrant ships. Violently insane passengers sometimes had to be hunted down with weapons, fastened in irons and / or confined in a caged section of the hold. Nevertheless, the number of persons whose insanity was attributed to emigration was only 2.4 per cent in 1878-80. Even then emigration was linked to congenital weakness.

Assisted immigration schemes opened up the country to a supposed influx of insanity. This was obvious upon or soon after arrival:

Formerly we reaped all the benefits of the fact that advancing communities attract all the more energetic and pushing members of retrograde communities and employments, while the weak and lunatic are left behind ... There is every reason to fear that our recent [immigration] policy has with lamentable rapidity reversed this state of things ... Even our types of lunacy will change. Instead of acquired, and therefore largely curable insanity, the result of a selected, active and enterprising people, we may expect numbers of idiots and imbeciles, the outcome of long-continued poverty, ignorance, and a low degree of development.

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32 Hursthouse, pp. 298-9.
35 Extrapolated from Table showing Causes of Insanity in the Admissions, AJHR, 1880. H-6, p. 9; 1881, H-13, p. 15; and 1882, H-9, p. 25.
37 Inspector to Provincial Superintendent, Otago, 7 July 1875, AJHR, 1875, H-2A, p. 4; cf. AJHR, 1879, H-4, p.2; 1882, H-9, p.2. The Medical Superintendent of Sunnyside Asylum blamed the scheme or the desire to increase the country's population at any cost for bringing to New Zealand 'waifs and
'Certificated scum' one newspaper emotively branded such new immigrants. Modern scholars dispute such an assertion. Arnold, for instance, says that of the 60,000 migrants admitted between 1870-4, only 47 were committed to asylums in that time and 20 of them were discharged. The evidence for mass shipments of lunatics to the antipodes is very scanty, but sometimes well-to-do families despatched members abroad. People categorized as insane and sent to New Zealand seem to have fallen into the categories of imbecility or moral insanity. Some may have been patients in a British asylum. The limit of how far people were removed from the metropolitan community depended upon what was individually and socially tolerable, politically expedient and financially affordable. However small the number of persons who were dumped abroad, the issue was politically significant, as seen in the moves to tighten criteria for government-assisted immigrants and the Imbecile Passengers [Restriction] Act 1873. Records hint that poor law authorities deliberately sent groups of lunatics from Guernsey or Ireland's Queenstown Reformatory. Poor law authorities may also have made arrangements for individuals. In 1852, B.G.'s brother-in-law alleged that the parish of Inveravon paid him £63 to accompany B.G. and his pauper mother to New Zealand to relieve the parish rates. B.G. landed at Wellington quite insane.

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38 Editorial, Otago Daily Times, 30 April 1874.
41 The Auckland Weekly News of 5 November 1864 complained about the number of remittance men who had ended up in the asylum-annexe at Auckland Hospital. In 1871, the brother of a British peer was admitted to the Whau Asylum, Auckland. He had been sent abroad and paid an annual remittance of £200. Carrington Hospital Archives, National Archives, Auckland, YCAA 1025/1, File 2235.
43 New Zealand authorities were alerted to this tendency, hence the Premier's instructions to the Immigration Commissioners, 20 December 1869, AJHR, 1870, D-4, No. 3.
44 Lindsay, p 222; Otago Daily Times, editorial, 30 April 1874.
Constitutional predisposition to insanity was sometimes racially construed. In 1875, Scandinavians were regarded as particularly predisposed to insanity - a warning to a government that wanted Scandinavian settlers. Chinese were also resented, especially the 'the leprous Mongolian' at Dunedin. Racist comments reflected a western European cockiness about their sense of global destiny, biological superiority and progress.

The pull factors of immigration - an anonymous place, a fresh start, social and material advancement, and good land - could disguise a negative side of life. Anonymity and superficial friendship could become loneliness. A fresh start could turn into an overwhelming challenge or restless transience. Prosperity could turn to penury. Social mobility might spiral downwards. Good land might only be a harsh landscape. Settlers' inability to cope with the new physical and social environment was a significant cause of insanity. This was aggravated by the nature of the frontier environment, the demographic make up of colonial society, the character of jobs, and the absence of familiar support networks.

In 1872, G.T. Chapman advised new settlers that:

all things appear to come strange, and to present themselves in the most awkward manner. A man is so left to his own resources, so bereft of kindly sympathy and assistance, that what might otherwise be trifling annoyances, become important embarrassments. Coming ... into a new country, where he must

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46 Inspector to Provincial Superintendent, Otago, 25 June 1872, AJHR. (1872), G-27, p. 20; Inspector, Hawke's Bay to Colonial Secretary, 26 April 1876, and Inspector, Canterbury to Colonial Secretary, n.d. [April?] 1876, AJHR, 1876, H-4, pp. 8, 11.

47 Inspector's Report, 25 June 1872, Otago Provincial Archives, National Archives, Wellington, OP 7777, L. 13063. In the previous year, the Provincial Government approved a recommendation to repatriate four Chinese lunatics provided that they subscribed towards the cost of fares. Medical Officer to Provincial Treasurer, 12 May 1871 (?), OP 7777, L. 11916/1. The Asylum's Inspector recommended that a separate ward be built for Chinese patients because of their habits and general conduct. Inspector to Provincial Superintendent, 26 July 1871, AJHR, 1871, G-26, p. 13. Cf. Provincial Surgeon, Otago to Provincial Treasurer, 23 May 1872 and Inspector, Otago to Provincial Superintendent, 25 June 1872, AJHR, 1872, G-27, pp. 15, 20.


rely on himself for everything is a hard lesson to learn; and New Zealand seems a harsh school in which to learn it.\(^{50}\)

All the characteristics of what Fairburn pictures as the minimal social organization and ample opportunities for personal autonomy of colonial Pakeha New Zealand which prevailed until about 1880\(^{51}\) were summarized as the 'flux and changefulness' of the new society.\(^{52}\) In 1857, the Auckland Provincial Surgeon considered that 'many of those who emigrate to this country are of a romantic and unsettled disposition, and this leads to excesses of various kinds, which, I have no doubt, very frequently result in mental disorder.' Intemperance was singled out as a direct\(^{53}\) and indirect cause of insanity. Married women were said to become over excited and anxious about their husbands' intemperance.\(^{54}\) In 1871, M.S. Grace, a medically qualified Legislative Councillor put the sequence together this way:

Insanity is much more common in this country than it is at home, chiefly on account of the limited range of sympathy which the isolation of individuals and families in the country gives rise to, and also on account of the oppressive loneliness which many new comers experience even in our crowded towns. Many immigrants too, form the most extravagant anticipations of their new home, and are proportionately depressed by the result of the actual experience. Again, the migratory population from our gold fields, excited, by the varying chances of their fortune and exhausted by hardship and exposure, swell the numbers of our lunatics out of all proportion to the population....

An ignorant man goes into the country, and from comparing himself with himself, and contemplating in solitude the grand sights of nature, he becomes depressed. His hard fare and constant exposure, and the newness of everything around add to his depression. He becomes careless of food, and occasionally goes without, then gets dyspepsia. He grows weak and miserable, craving for excitement, which grows upon him, and if he cannot get to the public houses and company, he commonly practises masturbation. The seminal discharge for a time does

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\(^{51}\) Fairburn, pp. 235, 250.

\(^{52}\) Edwin Cox, letter to editor, *New Zealand Herald*, 28 April 1886.


\(^{54}\) Dr C.F. Fischer in evidence to the Select Committee on the General Lunatic Asylum. 14 June 1858, LE 1/1858/4.
him good, but very soon he is quite exhausted; then comes the loss of the balance of reason, and insanity is at hand.\textsuperscript{55}

Lindsay thought that 'mere imbeciles' shipped to the colony most commonly became back country shepherds where the solitude, exposure to the weather and the panoramic but monotonous ranges played upon the mind.\textsuperscript{56} If back-country shepherding, was a typical example of a solitary occupation, then the loner was regarded as "more or less cranky," a "hatter," "bush ratty," "gone silly", or suffering from "bush fright", to use popular expressions of the day.\textsuperscript{57} Maud Moreland, travelling through south Westland about 1910, met some hatters who lived in virtual isolation. She described them as 'old derelicts, whose ties were too long broken to be upended'. They lived as diggers, she said, from sheer force of habit.\textsuperscript{58}

Contemporary medical opinion largely blamed moral causes for the prevalence of insanity in New Zealand. Intemperance was generally recognised as the leading cause of insanity.\textsuperscript{59} Phillips explains the problem this way: Frontier society was dominated by young, single males who had been lured by the opportunities of transient frontier jobs like gold mining, gum digging, bush clearing, transport, public works, and sheep farming occupations. As a result, a male culture characterized by versatility, mobility, making-do\textsuperscript{60} and physical endurance, compensated for the loss of family ties and home links with mateship, pubs and heavy, if not binge-drinking.

\textsuperscript{55} Dr M.S. Grace, M.L.C., evidence to Joint Parliamentary Committee on Lunatic Asylums, AJHR, 1871, H-10, p. 11.
\textsuperscript{56} Lindsay, Emigrants, pp. 216-9.
\textsuperscript{57} Fairburn, p. 205.
\textsuperscript{58} A. Maud Moreland, Through South Westland, A Journey to the Haast and Mount Aspiring, New Zealand, London, 1911, p. 20.
\textsuperscript{60} As an example of making do, Professor Duncan MacGregor, in his capacity as Inspector of Asylums in Otago, opined that miners had a less rational mode of life because of the monotony of their diet. AJHR, 1874, H-2, p. 9. W.P. Reeves (1887) cited in Fairburn, p. 249, described the usual fare of up-country stations as 'damper, mutton, and tea; tea, and damper, and mutton, mutton, and damper, and tea.'
Alcohol consumption was high by international standards.\textsuperscript{61} Drunkenness and associated crime was a major law and order problem for police.\textsuperscript{62} Not only the quantity but also the type of alcoholic liquor consumed contributed to insanity as is suggested by the Westland colloquialisms of 'thunder and lightning' or 'stone fence':

The spirit retailed under the name of brandy and at present in such general use among the residents in country districts is an abominable distillation or local mixture of substances not fully understood. The effect however is very stupufying [sic] on those persons who use even moderate quantities [sic] ... and is too expressive of some special cause exciting to produce so large a ration [of insanity] in so small a population.\textsuperscript{63}

According to Lindsay, "drinking customs" of pioneer colonists and of the "roughs" who largely constitute society in young countries', offered greater temptations to dissipation than habits would permit in the more refined home society.\textsuperscript{64} The high level of delirium tremens cases treated as lunacy in goldfields Hokitika betokened 'habits of a class in the community and account for the unusual number of lunacy cases' in the district.\textsuperscript{65}

Mateship, the Inspector-General of Lunatic Asylums in New South Wales argued, was no substitute for family support networks in rehabilitating lunatics:

\textsuperscript{64} Lindsay, Emigrants, p. 219.
\textsuperscript{65} Surgeon-Superintendent's Report, Hokitika Hospital, 1866-67, Canterbury Province Archives, National Archives, Christchurch, CH 287 CP 529a, No. 4/61.
... nothing so much tends to help their progress towards recovery as the presence and personal sympathy of relations or friends in whom they can have confidence and trust.65

But there was generally 'neither room nor sympathy' for those without such ties in the colony.67 The rapidly advancing settler frontier absorbed a large component of the population. By 1881, approximately 57 per cent of the non-Maori population was living in areas that were not settled by Pakeha in 1850.68 The imbecile immigrant who found his way to a back country sheep station would be tolerated within the communal element of station life where 'everybody's peculiarities are known, and the latter made allowance for'.69 Otherwise, colonists were generally too busy getting on.70 Lacking kinship support in an anonymous frontier settlement or larger town, the "morally insane" person drifted socially downwards into positions as shepherds, draymen, navvies, or common labourers, road makers or road metal breakers, coach drivers, hotel waiters or billiard makers. The "morally insane" person was considered too incompetent to manage a home and could not with propriety be placed in lodgings or boarding houses. The intemperate or vicious rapidly sank into a life of pauperism or crime or died from disease, accident or violence.71

Causes of insanity among colonial women were discussed less often and with less agreement. Dr T.F. McGauran, Provincial Surgeon at Auckland, thought that New Zealand did not have the class of unmarried 'governesses and sempstresses' who were driven mad by penury and want.72 Dr Grace regarded hysteria, which commonly took a religious turn, as the chief cause of insanity among unmarried women. This was easily treated within a few months but unfortunately the use of even the smallest coercion was thought apt to make them violent and condemned.

68 Fairburn, p. 183.
69 Lindsay, Emigrants, pp. 218, 220.
70 Graham, p. 113.
71 Lindsay, Emigrants, pp. 221-2.
Gold diggers seek solace in an all-male hotel, Kyeburn, Otago, 1862.


'Dancing girls' outside the 'Casino', Ahaura, Westland, 1866.

CAUSES OF INSANITY

A 'hatter' outside his shack, Westland.

such women to long-term if not life-long insanity. In Westland, "moral" causes seemed to prevail. In 1869, 'long-continued intemperance, prostitution, and the pregnant condition' were blamed.

However sparse the numerical information on the prevalence of lunacy, other factors ensured that the issue secured the attention of Crown colony and provincial governments. The issue arose in the form of personal trouble and became a social issue that required policy intervention. When the first lunatics came to official attention, responsibility for their care had to be clarified.

INITIAL POLICIES

The large number of single persons in colonial society placed pressure upon traditional family obligations to care for lunatics. Until the new colony could shape its own colonial code, the same legal rights and responsibilities of individuals and families to care for and maintain insane persons prevailed in New Zealand as in the United Kingdom. A Scottish Royal Commission of 1857 neatly summarized the situation:

... At a very early period, it was the policy of the law to entrust the person of lunatics to the care of their relatives. This policy has continued to the present day. As a general rule the law takes no special cognisance of lunatics, so long as no application is made either for the decision of their persons, or for the protection of their property. It leaves them to the care of themselves, or to be taken care of by their relatives, subject, of course, to the protection which the common law affords every individual against maltreatment or injustice.

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73 AJHR, 1871, H-10, p. 11.
A mix of familial responsibility and public welfare epitomized welfare provision in the 'colonial welfare experiment', as Thomson calls it. Yet Fairburn contends that an atomized society quickly led to state intervention. Fairburn argues that the first signs of state power arose from the shell created by the New Zealand Company and Crown colony government administration. These arrangements were set out in early legislation. The Supreme Court was given jurisdiction for idiots, lunatics and 'such as being of unsound mind are unable to look after themselves and their estates' in 1841. Near relatives became liable for the support of destitute persons in 1846. In the same year, the Lunatics Ordinance split the financial responsibility. Transit care in gaols or hospitals would be defrayed by the colony; but in all cases where a lunatic or idiot admitted to an asylum had sufficient means, the person's estate should be used to maintain him or her. So, according to Thomson's interpretation, the 1846 legislation did not establish a right to support by the community. Wider community assistance was left to voluntary or charitable auspices. When customary social and familial support networks were missing or could not cope, however, insanity was usually dealt with by the state. The state usually intervened when a person's behaviour deteriorated to the point that it threatened the maintenance of law and order.

Organized settlements or planned colonies of the New Zealand Company in Wellington, Canterbury and Otago apparently made no specific provision for insanity in their midst - hospitals and prisons, yes, but no lunatic asylum. The Crown

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77 Fairburn, s. 12.
78 Fairburn, pp. 12, 241.
79 Supreme Court Ordinance 1841, s. 5. This was consistent with English and Scottish law from the Middle Ages. See John Reeves, *History of the English Law from the Time of the Saxons to the End of the Reign of Philip and Mary*, London, Second Edition, 1787, Volume 2 [1969 reprint, New York I South Hackensac, N.J.], pp. 305-11; *Royal Commission ... Scotland*, pp. 4, 6-9.
80 Destitute Persons Ordinance 1846, s. 2.
81 Lunatics Ordinance 1846, ss. 10-11. cf. Lunatics Act 1868, ss. 105-6, 149-50, 152, 154-5.
82 Thomson, p. 24.
The earliest known insane persons came to official attention because they posed a threat to public safety or because they could not safely look after themselves. The first occurred in April 1842, when Auckland's chief constable apprehended J.H. for idly wandering about the town with no visible means of support. The man was taken into custody and declared a lunatic because he was apt to wander and pilfer. E.E. was committed at Nelson on 9 October 1843, 'nominally for an assault, but in reality with a view of his being better guarded in the Gaol as he is at all times exceedingly violent'. J.L., another vagrant who suffered from delirium tremens, was put in Auckland Gaol because it was 'decidedly unsafe' to set him free.

The management of lunacy that presented as destructive or threatening behaviour fitted the generally accepted purposes of colonial government and the civilising mission of British imperialism, as expressed in the foundation documents of the new colony. The Instructions to the Lieutenant-Governor (1839), the Treaty of Waitangi (1840) and the Royal Charter that constituted New Zealand as a separate colony (1840) all refer to law and order. Lofty principles notwithstanding, the first Governor was enjoined to conduct public administration with 'the utmost possible parsimony'.

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84 Lindsay, Emigrants, p. 218. The New Zealander, Auckland, of 11 December 1857 gives an example of doctors in Panmure who were unwilling to certify a man with delusions of grandeur.
85 Police Magistrate to Colonial Secretary, 13 April 1842, L. 42/611, Sheriff to Colonial Secretary, 18 April and 4 May 1842, L. 42/687, Colonial Surgeon, Auckland to Colonial Secretary, 19 April 1842, L. 42/623, and Colonial Secretary to Colonial Secretary, New South Wales, 18 May 1842, Department of Internal Affairs Archives. National Archives, Wellington, IA 1/11.
86 Blue Book for the Colony of New Zealand, 1843, Q. 20, IA 12/5.
87 Police Magistrate, Auckland to Colonial Secretary, 30 April 1842, IA 1/11, L. 42/693.
Priorities were needed, so 'public health and safety', crime prevention and punishment, would be more important than internal communications, 'and so of the rest' of the general rules for colonial development.89

By 1846, a court system, policing and basic custodial facilities had been established in the principal Pakeha settlements, though their organization did not necessarily meet with Governor Grey's approval. He presented several Ordinances on law and order matters to the Legislative Council that year. Sheriffs' duties (including their charge of gaols) were spelt out. Policing was reorganized into a quasi-military force like the Irish constabulary. Prison management was coordinated. Provision was made for the management of destitute persons and lunatics. Hill has interpreted Grey's legislative package as conveying a view of police as the crucial mechanism of social control, the inspectors of all society, and the agents of government pacification of the country beyond the frontiers of Pakeha settlement.90 Fairburn also shows the prominence of law and order issues in this period.91

The Lunatics Ordinance 1846, a measure of 14 sections, was the first coherent statement of lunacy policy in New Zealand. Lindsay, that observant Scottish alienist, thought the Ordinance 'short and simple' and a fair illustration of British colonial lunacy laws 'at an early stage in the history of the colonization of a new country'.92 Typical of Attorney General W. Swainson's drafting style, the Ordinance was couched in 'simple, concise, and intelligible language', which, he said, avoided 'prolixity and tautology by which our English enactments were usually distinguished'.93 The Ordinance provided guidance by legitimating (if that were necessary) what seemed to be existing practice. The Ordinance was hot off the

91 Fairburn, pp. 243, 245.
92 W. Lauder Lindsay, 'Lunacy Legislation in New Zealand', Journal of Mental Science, 18, 84 (1873), pp. 504, 511.
press - just the answer for a Resident Magistrate who asked what to do with a deranged woman found wandering naked around the streets of Auckland.\textsuperscript{94}

The emphasis and tone of the Lunatics Ordinance 1846 made lunacy fairly and squarely a law and order issue. Its very purpose was 'to make provision for the safe custody of and prevention of offences by persons dangerously insane, and for the care and maintenance of persons of unsound mind.'\textsuperscript{95} Lunatics identified through the public processing stream were handled accordingly. Practice at Hokitika was evidently typical:

At present, if anyone is arrested as being insane, he is locked up with criminals; he is marched through the streets to the Court House with criminals; he is informed against as a criminal; and lastly, he is placed in the dock, and seriously charged with lunacy, as though it were an offence ... exactly as any other prisoner. He is certainly not called upon to plead guilty or not guilty, but in that respect alone he differs from the others with which he is associated. After this he is again marched back, to be gazed at as he goes, and once more consigned to gaol.\textsuperscript{96}

When someone was apprehended under circumstances denoting mental derangement and with a purpose of committing suicide or some indictable crime, two Justices of the Peace could call for evidence from two medical practitioners before deciding what to do. The disposition options were limited to a 'gaol, house of correction, or public hospital' where the person was to stay until discharged or a Governor's order transferred the lunatic to a 'public colonial lunatic asylum'.\textsuperscript{97} The law and order theme continued elsewhere in the Ordinance. The Governor could order criminal lunatics or any person detained in a prison or place of confinement

\textsuperscript{94} Resident Magistrate, Auckland to Colonial Secretary, 23 December 1846, IA 1/45, L. 46/1944.
\textsuperscript{95} Lunatics Ordinance 1846, Long Title.
\textsuperscript{96} Editorial, \textit{West Coast Times}, 1 May 1869. Cf. \textit{New Zealand Herald}, Auckland, 17 October 1864, citing the \textit{Southland Times}; \textit{New Zealander}, 8 June 1865. The \textit{West Coast Times} of 4 June 1869 noted that the practice was discontinued, but court appearances continued elsewhere. Wellington's \textit{New Zealand Times} of 7 January 1882 complained of the practice but noted that a case had been heard in the privacy of chambers.
\textsuperscript{97} Lunatics Ordinance 1846, s.1.
except for debt or civil process to be transferred to an asylum. Lunatics could be discharged to the care of friends or relatives provided that recognisances were entered into for peaceable behaviour and safe custody.

Such principles may have been fine in the towns, but in country or remote areas they were not so easy to apply until 1868 when the law was changed to allow a lunatic to be detained for up to seven days on the basis of one medical certificate in special circumstances. An emergency procedure was needed because of the paucity of doctors outside the main settlements and the readiness of doctors to certify only the most obvious cases of insanity. Only one doctor at Panmure was prepared to certify a digger returned from Victoria who was known to be quite mad. The family could not afford the expense of a commission de lunatico inquiendo. So the unfortunate man kept being gaoled for offences that, according to his delusions, were not offences.

Similar difficulties were encountered taking people into care. The Resident Magistrate at Raglan was the only person within 100 miles able to commit J.E. There was only one local doctor who could sign a medical certificate. This 'out of the way place', the magistrate complained, was 120 miles from a lock-up and 19 days away from police assistance. Such journeys were very trying, slow and expensive. It could take seven days to bring a 'sturdy [lunatic] prisoner' from Roxburgh to Dunedin on horseback or three days coach travel from Queenstown. These were exceptions. ‘Feeble and exhausted men, acutely excited, violent and dangerous or suicidal, and delicate women labouring under puerperal mania and hardly fit to be kept out of bed’ were more typical. They were frequently transported under police escort in handcuffs, or ‘bound like criminals’.

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98 Lunatics Ordinance 1846, ss. 3-6.
99 Lunatics Ordinance 1846, s. 3.
100 Lunatics Act 1868, s. 15.
101 New Zealander, 11 December 1857.
103 AJHR, 1877, H-8, p. 7.
The law and order purposes of early lunacy policy remained prominent in later legislation. An amendment to the Lunatics Ordinance in 1858 authorised a resident magistrate or two justices to order the apprehension, medical examination and detention of someone who was suspected of being mentally deranged, dangerous or likely to be so, or 'in any way disposed to violence'. The stated primary purpose of the Lunatics Act 1868, which was modelled on contemporary English law, was to consolidate measures regarding dangerous or criminal lunatics. Moreover, the Act made it possible to apprehend and inquire into the situation of supposed lunatics who were not properly taken care of, cruelly treated or neglected, to recapture escaped patients and to commit drunkards who neglected to support their families or who habitually threatened or resorted to domestic violence. Lunatics who were dangerous or unfit to be removed could not be discharged.

Only when insane persons who threatened public safety were provided for did the law provide for other insane persons. The 1846 Ordinance permitted private applications from a friend or relative to the Governor to admit to an asylum someone 'insane but not dangerously so'. Until 1868, the application had to be supported by two medical certificates and be sanctioned by a court, in keeping with Scottish practice. Between 1868-82 judicial endorsement was by-passed in favour of English practice, so that a private application and two medical certificates were sufficient authority for admission. These cases were received only if there was room for them in an asylum. Nevertheless, the section generated a public expectation and a steady demand for private admissions, although it is not clear whether these were motivated by family strain or financial burden.

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104 Lunatics Ordinance Amendment Act 1858, ss. 1-2.
105 Lunatics Act 1868, Preamble and Part I.
106 Lunatics Act 1868, s. 10.
107 Lunatics Act 1868, s. 20.
108 Lunatics Act 1868, s. 21. The same section also mandated voluntary admission of habitual inebriates.
109 Lunatics Act 1868, ss. 70, 73.
110 The Supreme Court was involved under Lunatics Ordinance 1846, s.9, and a resident magistrate or two justices of the peace under the Lunatics Ordinance Amendment Act 1858, s. 3.
111 Lunatics Act 1868, s. 15.
112 W. Nichol to Colonial Secretary, 13 February 1852, IA 1/92, L. 52/347.
113 E.g., William N. to Colonial Secretary, 24 December 1846, IA 1/45, L. 45/1976; Rev. A.G. Purchas to Colonial Secretary, 24 April 1849, IA 1/67, L. 49/886; Harriet C. to Lieutenant Governor, 5
New Zealand first managed the problem of dangerous lunatics in much the same way as other early British settler colonies or, indeed, as developing countries were advised to do on the brink of post-Second World War decolonization. Gaols or lock-ups provided the most secure facilities, but they had to look after convicts and felons, waifs and strays, drunkards, military prisoners, deserting sailors, convicts awaiting transportation, debtors, vagabonds and wayward women as well as lunatics. A sympathetic correspondent told the Wellington Independent what he saw at the local gaol in 1852:

I think it my bounden duty to lay before the public what I there saw, and heard. The goal [sic] is a small wooden building ... [which] is divided into still smaller apartments: the cells being only 5'6" x 7", and four human beings are crowded into this small hole and fastened in. There are no bedsteads; five blankets between four prisoners is the amount of covering allowed. There is neither light nor ventilation, and when the turnkey opens the goal [sic] in the morning, he is first compelled to light his pipe, the stench being so offensive from the foul air.

December 1850, NM 8/23, L. 50/1086; Resident Magistrate, Wellington to Colonial Secretary, 19 September 1851, NM 8/25, L. 51/1274.


116 The terms gaol and lock up were used interchangeably. R.I.M. Burnett, 'Hard Labour, Hard Fare and a Hard Bed': New Zealand's Search for its Own Penal Philosophy, National Archives Occasional Monograph Series, No. 1, Wellington, 1995, pp. 11-12.

Twenty human beings are crowded into this pest house, of whom three are lunatics, one a female, one a debtor, a runaway from Hobart Town, and prisoners of all kinds. The lunatics are locked up in a cell by themselves every night, without any covering, and the strongest has a custom of endeavouring to knock the door of the cell down, by battering the weaker one against it. There is no convenience for cleanliness, and therefore the poor maniacs are in a dreadful state every morning. One of the unfortunate creatures has his legs covered with putrid sores and must be suffering dreadfully therefrom. There are other painful details regarding this establishment which I will not relate, as they will not be credited by the community. I trust sufficient has been said to awaken public sympathy on the subject for the poor unfortunates who are now incarcerated in that miserable hole.118

Gaolers tried to impose some sense of order based on practice in England and New South Wales but they were constantly thwarted by environmental and financial constraints.119 Overcrowding threatened inmates with fever.120 Makeshift premises were often insecure.121 Living conditions simply stopped early gaols functioning as penitentiaries.122 Nelson Gaol was declared to be 'neither fit for punishment or confinement or reformation' in 1849 and was much the same five years later.123 A debtor at Wellington Gaol was outraged at being incarcerated

in a place where Felons and Mad-men are confined in the same Hovel - hence compelled to be a hearer of language such as I suppose was never used outside the gates of a Bedlam. I refer more particularly to a madman or rogue ... whose general language is of the most horrid description, swearing, profanation of the Sacred Name, etc. Also in addition to this painful

119 Burnett, p. 42, 91.
120 Blue Book for the Colony of New Zealand, 1843, p. 215; IA 12/5: Police Magistrate, Auckland to Colonial Secretary, 4 May 1841; IA 1/6, L. 41/504: Sheriff and Gaoler in evidence to Select Committee on Nelson Gaol. Nelson Votes and Proceedings, 2, 1854, p. 202: Gaoler, Lyttelton to Provincial Secretary, 19 November 1858, CH 287 CP L. 568/58; editorial, Lyttelton Times, 6 September 1862.
122 Burnett, p. 19 ff.
annoyance through the day, I neither can sleep nor few else of
the unhappy inmates from his roaring, shouting, singing, and
swearing through the night.\textsuperscript{124}

The debtor’s complaint was valid. Lunatics could be dirty or destructive.\textsuperscript{125} One
lunatic at Nelson Gaol constantly destroyed his bedding and clothing and had to be
kept naked in a cell with nothing but straw to lie on.\textsuperscript{126} Rowdy lunatics had to be
quietened for the sake of general order and discipline.\textsuperscript{127} Getting a bath or shower
installed, as a device to shock and quieten disturbed lunatics was most difficult;\textsuperscript{128} so
seclusion in a dark cell was more common.\textsuperscript{129} Straitjackets were used if available; if
not, handcuffs and cords restrained disturbed lunatics.\textsuperscript{130} Sometimes the din of the
lunatics stopped hard labour convicts from sleeping and they refused to work.\textsuperscript{131}

Police and gaolers were said to have lacked skill to treat lunatics\textsuperscript{132} but the kindliness
of some of them has been favourably commented upon.\textsuperscript{133} Monson, Dunedin’s
Gaoler (1851-61) believed in ‘treating everyone as a human being, as a man, and as
a christian [sic]; whatever may have been his offence against Society’.\textsuperscript{134} He once

\textsuperscript{124} Enclosure n Sheri St, Wellington, to Colonial Secretary, 16 May 1843, IA 1/19, L. 43/1386. The
protesters were bought off with the expectation that the completion of a new gaol in three months
would remove ‘all these evils’. Sheri St to Colonial Secretary, 31 May 1843, IA 1/19, L. 43/1386.
\textsuperscript{125} E.g. Gaoler, Lyttelton to Visiting Justice, 19 November 1858, CH 287 CP L. 588/58; Wellington
Gaol Journal, 10 January 1851, formerly located in the basement of Wellington District Court House
prior to demolition but current whereabouts unknown; H. Monson Journal, 22 July 1852, Hocken
Library, Dunedin, MS-0088; Nelson Votes and Proceedings, 2, 1855, p. 205.
\textsuperscript{126} Report on Nelson Provincial Council debate, Nelson Examiner, 12 April 1856.
\textsuperscript{127} Gaoler, Lyttelton, enclosure to Provincial Surgeon to Provincial Secretary, 24 August 1855,
CH 287 CP L. 957/55.
\textsuperscript{128} Sheri St, Auckland to Colonial Secretary, 30 December 1846, IA 1/45, L. 46/1988; Colonial
Surgeon, Auckland in requisitions, 29 October 1849 and 8 January 1850, IA 1/74, L. 49/2174 and L.
50/45; Auckland Colonial Surgeon’s annual report, 1 January 1850, IA 1/74, L. 50/265. Gaoler,
Dunedin to Provincial Superintendent, 30 August 1860, OP 6/7, L. 60/398.
\textsuperscript{129} Coroner to Resident Magistrate, Lyttelton, 3 August 1852, NM 8/34. L. 52/1075; Wellington
Gaol Journal, 25 January 1849 and 19 November 1850; Nelson Gaol Journal, 26 March 1856,
formerly held Trentham Police College but current whereabouts unknown.
\textsuperscript{130} Sheri St, Auckland to Colonial Secretary, 28 April and 4 May 1842, IA 1/11, L. 42/687 and L.
42/711; Colonial Surgeon, Wellington to Colonial Secretary, 8 December 1852, NM 8/35. L. 52/1569a;
C. Elliott, M.P.C. reported in Nelson Examiner, 12 April 1856; Monson Journal, 20 July 1852 and 20
November 1856; Nelson Gaol Journal, 3 April 1856.
\textsuperscript{132} Provincial Superintendent’s opening address, 28 October 1853, Wellington Acts and
\textsuperscript{133} J. Broadhead, ‘An Enquiry into the New Zealand Prison System, 1840-1880’, MA Thesis,
Victoria University College, 1947, p. 18; Daily Southern Cross, Auckland, 13 January 1844.
\textsuperscript{134} Monson Journal, 1 January 1855.
proved the point by allowing a lunatic to remain in his apartment to get him away from the depressing atmosphere of the gaol.\textsuperscript{135}

Gaolers encountered a number of problems in institutions that lacked the contemporary moral purpose and a choice of coercive institutions available in the parent country.\textsuperscript{136} They lacked adequate guidance and resources. Mills, the Gaoler at Wellington in 1854, had no written instructions about caring for lunatics. He was left to send for the doctor when necessary.\textsuperscript{137} At Wellington and Nelson, medical attendance was limited to physical needs.\textsuperscript{138} Convicts might be assigned to look after lunatics, sometimes to the point of exhaustion, and nurse tenders ("attendants") had to be engaged temporarily.\textsuperscript{139} Lunatics qualified for No. 2 or special rations, which contained more meat,\textsuperscript{140} but in the early years, when only one shilling was allocated for a prisoner's daily rations, the quantity and quality of food sometimes became a problem.\textsuperscript{141}

Little could be done until lunatics appeared more constantly and numerously than isolated cases, and their behaviour became sufficiently troublesome as to necessitate special attention, in 1844. Separate accommodation was provided when lunatic numbers became too great, their behaviour became too disruptive, or when public criticism became too strong. Special officers were sometimes appointed or detailed to look after lunatics in gaols. Either response was consistent with the general

\textsuperscript{135} Monson Journal, 5 August 1860; Gaoler to Provincial Superintendent, 30 August 1860, OP 6/7, L. 60/398.
\textsuperscript{136} Burnett, p. 31.
\textsuperscript{138} Gaoler R. Mills in evidence to Select Committee on the Colonial Hospital, 29 January 1854, Wellington Acts and Proceedings, I, 1854, p. 14; Provincial Superintendent to Dr D. Mono, 29 November 1855, NP 11/1, L. 55/439; Nelson Gaol Journal, 19 March 1856.
\textsuperscript{139} Sheriff, Auckland to Colonial Secretary, 12 April 1852, IA 1/93, L. 52/685 and L. 52/695; Sheriff, Lyttelton to Colonial Surgeon, 6 January 1854, CH 287 CP L. 54/339; Medical Attendant in evidence to Select Committee on Nelson Gaol, Nelson Votes and Proceedings, 1, 1854, p. 207.
\textsuperscript{140} The daily allowance under special rations was 1\frac{1}{2}lbs bread, \frac{1}{2}lb. potatoes, \frac{1}{2}lb. meat and \frac{1}{2}oz. salt. Blue Book for the Colony of New Zealand, 1844, IA 12/6, p. 201. The special scale was set in 1840. See Burnett, p. 55.
\textsuperscript{141} C. Townsend to Lieutenant Governor, 5 January 1851, NM 8/30, L. 52/11; Wellington Gaol Journal, 12 March 1849; Grand jury visit to Wellington Gaol reported in New Zealand Spectator and Cook's Strait Guardian, 13 June 1849; Burnett, pp. 55-59.
EARLY PROVISIONS FOR INSANE PERSONS

Auckland Courthouse and Gaol, c. 1850, a drawing by Edward Bartley.

(Auckland Public Library Photograph Collection, Negative 2587.)

Asylum annexe (front) in the grounds of the Auckland Colonial Hospital, c. 1853, a drawing by Charles Heaphy.

(Auckland Public Library Photograph Collection, Negative 673.)
EARLY PROVISIONS FOR INSANE PERSONS

Drawing of proposed lunatic asylum annexe, South Spit Hospital, Hokitika, by James Rochefort, Westland County Engineer, 15 October 1866.

(National Archives, Christchurch, Reference Public Works Department, Hokitika, CH 86, item GR 790.)
impression that gaolers tried to do their best for lunatics under very trying circumstances.

Physical separation was necessary, gaol officials believed, for the mental health and well being of the lunatics and for the discipline of other inmates. A ‘gaol for insane persons’ or ‘pauper lunatic asylum’ was opened at Wellington Gaol. In 1844 also, the debtors' day room at Auckland Gaol was converted into a ‘gaol hospital’ for lunatics. Neither place was suitable. The ‘poor creatures’ had to be convinced that that they were held there primarily to facilitate medical assistance. Continued ‘intercourse with the prisoners’ was regarded as prejudicial to the lunatics. Early arrangements were primitive by comparison with the male lunatic wing at Hokitika Gaol (1869-72). Lunatics there had their own exercise yard with a sea view. Some lunatics helped to clear the nearby bush and one, a carpenter, was allowed to work at his trade. Lunatics had access to chess, cards, slates and books. If they did not have their own clothes to wear, then they could wear unbranded prison garb. Lunatics were allowed to smoke although the gaoler considered the practice inimical to gaol discipline.

The use of hospitals rather than gaols to care for lunatics can be traced to consultation with doctors. Special wards housed lunatics in the general hospitals at Auckland (1853-67), Nelson (1854-64), Dunedin (1862-3) and South Spit, Hokitika

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142 E.g. Sheriff, Wellington to Colonial Secretary, 27 January 1849, NM 8/14, L. 49/71; Sheriff, Lyttelton to Provincial Secretary, 22 August 1855, CH 287 CP L. 939/55; Sheriff and Gaoler in evidence, Nelson Votes and Proceedings, 2, 1855, pp. 204, 206; Gaoler to Provincial Superintendent, Otago, 30 August 1860, Otago Provincial Archives, National Archives, Wellington, OP 6/7, L. 60/398; Gaoler to Provincial Secretary. 15 February 1864, OP 7/17, L. 3134/64; Gaol report. Otago Votes and Proceedings, 16, 1862, p. 46; Chairman's opening address, Westland County Council Proceedings 12 January 1870, 6, p 3.

143 Superintendent to Colonial Secretary, New Munster, 18 April 1844, NM 10/4, L. 44/2; Blue Book for New Munster, 1849, NM 11/2, pp. 182-93. This building was separate from the main gaol, which was supposed to form part of a 26-cell block in two radial wings with a central hall and officers' quarters. The plan for the main building is reproduced in Burnett, p. 99.

144 Sheriff, Wellington to Superintendent, New Munster, 31 March 1846. NM 8/4, L. 46/202. Sometimes there was trouble getting enough bedding for the inmates. See Surgeon, Gaol Hospital, Auckland to Colonial Secretary, 7 October 1846, IA 1/43, L. 46/1493.

145 Blue Book for the Colony of New Zealand, 1844, p. 195, IA 12/6. Colonial Surgeon's annual report on Auckland Gaol Hospital and Colonial Hospital for 1849. IA 1/74, L. 50/265

(1865-72). At Nelson, arrangements were also made to accommodate lunatics in premises originally used for refugees from the Taranaki Wars (1864-76).

State involvement in medical care commenced with the appointment of medical officers to the civil service at the principal North Island settlements in 1841. The practice was then extended to other important settlements. The cumbersome title of 'Health Officer, Coroner and Medical Attendant at the Goal [sic] and for the Aborigines' at Nelson conveys something of the duties of these officials, but J.P. Fitzgerald, Colonial Surgeon at Wellington, expanded on his duties in 1846. His duties involved, firstly, attending to prisoners in gaol and supplying them with medicine. Next, he attended lunatics confined in the asylum and supplied them with medicine. Then he attended and supplied medicine to the local native population, the majority of whom, he said, went to him. Fourthly, Fitzgerald provided advice and medicine to any and every native coming from up country. Finally, Fitzgerald offered help to Pakeha who suffered accidents but were unable to pay for medical advice and whom the Superintendent of New Munster Province referred.

In 1846-7, Governor Grey set up state-run colonial hospitals in major North Island settlements as the kinder face of Grey's policy of native pacification. Colonial hospitals were set up primarily to show Maori the effectiveness of western medicine and to provide a base for the general treatment of poor Pakeha. The local colonial surgeon was accountable to the Governor for running the place as part of a government department. In spite of the coincidental timing of the Lunatics Ordinance and the setting up of colonial hospitals, there is no evidence to suggest that they were regarded as more than transit points for appropriate mental care in an asylum, as section 1 of the Ordinance implies. Grey, however, was not averse to the

147 New Zealand Gazette, 7 and 14 July 1841, 15 March 1843. For the sake of convenience, these officials will be referred to as colonial surgeons or provincial surgeons as the case may be.

148 Colonial Surgeon, letter to Wellington Independent, 29 April 1846. The Colonial Surgeon at Auckland was directed to attend professionally any person in the gaol as medical attendant. Colonial Secretary to Colonial Surgeon, Auckland, 23 January 1844, IA 4/281. New Munster was one of the provinces established by the Constitution of 1846.

principle of admitting lunatics to his hospitals. After an earthquake destroyed Wellington Gaol in 1848, Grey overrode the views of his Lieutenant-Governor and the Wellington Colonial Surgeon who thought that it would be ‘highly injudicious and improper’ to admit lunatics to the hospital. In Auckland, however, the Colonial Hospital opened its doors to ‘free’ lunatics from the outset. In 1851, Grey facilitated provision of a lunatic ward within the hospital grounds. He considered it ‘most feasible’ to subsidize public subscriptions. Dunedin’s original hospital (1850) was instituted on Grey’s authority and its first patient was a lunatic. The hospital apparently met local needs until 1860 when committals to the gaol became more frequent. Lunatics were occasionally admitted to Nelson Hospital before 1854 when local doctors agreed that the hospital should be furnished with proper accommodation for the insane. A detached ward was incorporated into Hokitika’s South Spit Hospital from 1866-72.

Hospital care was not ideal. Other patients were upset if lunatics became disturbed. Staff had variable experience. The Cooks, a husband and wife team who ran the South Spit annexe, were attendants with experience in Scotland and Dunedin. The first two keepers at Nelson were dismissed. The physical environment of the Auckland establishment was depressing and basic. There was no way of classifying patients. There was no recreation hall. Exercise yards provided neither shelter nor a view. The Hokitika ward deteriorated so badly that

150 Colonial Secretary to Colonial Surgeon, 5 July 1849, NM 10/9, p. 715.
151 Sheriff, Auckland to Colonial Secretary, 28 September 1847, IA 1/50, L. 47/1796.
152 New Zealander, 19 and 23 April 1851.
154 Nelson Provincial Government Gazette, 3 March 1855, p. 16.
156 New Zealander, 21 January 1852; Resident Magistrate, Whanganui to Colonial Secretary, 25 September 1852, NM 8/34, L. 52/1291.
157 Inspector’s report, Westland County Council Proceedings, 6, 1869, p. xxvii; Angus, p. 48.
158 C. Evans to Provincial Superintendent, 20 February 1863, NP 7/8b, L. 63/136; J. Mead to Provincial Superintendent, 7 January 1863, NP 7/8b, L. 63/12; Provincial Secretary to R. Crawford, 21 November 1866, NP 7/16a, L. 66/828; Nelson Examiner, 20 July 1867.
159 Evidence of Provincial Surgeon, former Provincial Surgeon, Keeper and Rev. J.F. Lloyd to Select Committee on Gaol, Stockade, Hospital and Lunatic Asylum, Auckland Acts and Proceedings,
by 1871, the local inspector called it ‘a miserable den’ for its lack of amenities and therapeutic programmes. Nelson’s establishment soon became unsatisfactory because it was built with green timber. Overcrowding and non-classification were general problems. Asylum annexes generally had little land. The exercise yard at Nelson’s Taranaki Buildings was called a ‘moderate sized poultry yard’. A provincial select committee criticised the Auckland Asylum-Annexe because the ‘physical powers or mechanical genius’ of patients could not be exercised outside a small enclosed garden.

The limited therapeutic environment of most lunatic wards generally constrained the introduction of progressive practices along the lines advocated by John Conolly and other leading English alienists. The original requisitions for the Auckland asylum annexe included four strait waistcoats made of No.3 canvas, two handcuffs, and canvas trousers but as early as 1854, a maniacal patient at Auckland Asylum was ordered to be carefully watched instead of being restrained. By 1859, even the appearance of mechanical restraint had been abolished, but three years later (and after a change of medical management) patients were described as ‘merely prisoners, vacant, idle, “raging waves of the sea, foaming out of their own shame”’.

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14, 1862, A-11, pp. 3, 14-15, 19, 23, 28; Deputy Surveyor-General and Auditor-General to Colonial Secretary, 25 February 1853, IA 1/105, L. 53/487, Rev. F. Thatcher to Colonial Secretary, 26 February 1853, IA 1/105, L. 53/498; editorial, New Zealander, 26 February 1853; Deputy Surveyor-General to Colonial Secretary, 23 May 1853, IA 1/105, L. 53/1202; Colonial Surgeon, Auckland to Colonial Secretary, 2 June 1853, IA 1/105, L. 53/1422.

150 E.g., Inspector’s report, Westland, 14 January 1871, AJHR, 1871, G-26, p. 8.

151 W.B. Sealey to Provincial Superintendent, 8 December 1859, NP 7/4a, L. 59/1011; “Nelson”, letter to Nelson Examiner, 20 February 1864.

152 E.g., Select Committee report on Lunatic Asylum, Nelson Votes and Proceedings, 8, 1861, p. 183; Provincial Surgeon to Provincial Secretary, 25 November 1862, OP 7/7, L. 1168/62 and 18 July 1863, OP 7/13, L. 2268; Select Committee report on Gaol, Stockade, Hospital and Lunatic Asylum, Auckland Acts and Proceedings, 14, 1862, A-11, pp. 3, 19; A. Hibble to Provincial Superintendent, 25 February 1864, NP 7/11, L. 64/158; County Surgeon-Superintendent, letter to West Coast Times, 18 May 1869.


154 Select Committee report on Gaol, Stockade, Hospital and Lunatic Asylum, Auckland Acts and Proceedings, 14, 1862, A-11, p. 3.


156 Colonial Surgeon to Colonial Secretary, 2 June 1853, IA 1/105, L. 53/1422 and 22 July 1853, IA 1/105, L. 53/1786.

Overcrowding forced a return to the use of strait waistcoats and tied wrists.\textsuperscript{168} Irons were used to secure lunatics at Dunedin Hospital and possibly at the Nelson Depot.\textsuperscript{169}

Payment from public funds for private care or repatriation of individual lunatics provided an alternative to maintenance in a gaol or hospital.\textsuperscript{170} These solutions were considered on a case-by-case basis. Decisions depended on social and behavioural considerations, the calibre of the possible carer, and the state of gaol accommodation.\textsuperscript{171} A genteel doctor and a harbour master were boarded out.\textsuperscript{172} Two women were boarded out to avoid being incarcerated with male prisoners.\textsuperscript{173}

The incessant care of an epileptic man wore out the prisoners ordered to nurse him in Auckland Gaol. The hospital would not admit him; so two private attendants were engaged.\textsuperscript{174} Approval was sought to pay a native three shillings per week when a policeman could no longer be spared to look after J.W. at Wanganui.\textsuperscript{175} Certifiable lunatics may also have been boarded out in an area where two doctors could not be found. J.E., of Raglan, who was mentioned earlier, was possibly such a case.

Maori were boarded out, in the sense of being returned to their tribe, almost automatically. T. remained quite insane and still needed to be looked after when his sentence for vagrancy expired. Relatives were unobliging but a Wanganui chief

\textsuperscript{168} Carrington Hospital Case Book, YCAA 1048/1, Folios 19, 49, 56, 67.
\textsuperscript{169} Dunedin Asylum Medical Journal, 14 December 1863, Healthcare Otago Ltd Archives, National Archives, Dunedin, DAHI / D 284/2; Nelson Asylum Journal, 1 November 1864, Nelson-Marlborough Adult Mental Health Services Records, Ngawhatu Hospital.
\textsuperscript{170} Mrs S. Stoddart to Governor, 11 November 1846, IA 1/48, L. 47/807; Otago Votes and Proceedings, 17 March 1856, 4, p. 23; Chief Constable to Provincial Superintendent, 26 January 1861, OP 6/7, L. 61/44.
\textsuperscript{171} Colonial Surgeon to Provincial Superintendent, Canterbury, 6 January 1854, CH 287 CP L. 54/330.
\textsuperscript{172} Louisa C. to Governor, 10 October 1849, IA 1/72, L. 49/2214; Colonial Surgeon, Auckland to Colonial Secretary, 12 October 1849, IA 1/72, L. 49/2092; Sheriff, Lyttelton to Provincial Secretary, 11 January 1858, CH 287 CP L. 19/58.
\textsuperscript{173} Sheriff, Wellington to Superintendent, Wellington, 9 September 1846, NM 8/5, L. 46/478 and Colonial Secretary to Police Magistrate, Wellington, 10 September 1846, NM 10/6; Sheriff, Auckland to Colonial Secretary, 23 December 1846, IA 1/45, L. 46/1990.
\textsuperscript{174} Carrington Hospital Admission Papers, YCAA 1025/1, No. 1: Sheriff, Auckland to Colonial Secretary, 21 January 1852, IA 1/91, L. 52/175.
\textsuperscript{175} Resident Magistrate, Whanganui to Colonial Secretary, 30 August 1852, NM 8/34, L. 52/116. A. Domett, the Colonial Secretary of New Munster Province minuted that ten shillings was the smallest expense for private care of a lunatic under any circumstances. He thought it time to consider building a central lunatic asylum.
eventually agreed to call for him.\textsuperscript{178} K. was described as being simply of weak intellect. He did not benefit from confinement among drunkards at Auckland Gaol. Sending him back to his Rotorua relatives was the answer.\textsuperscript{177} Authorities were reluctant to confine an insane Maori who harassed and threatened a New Plymouth clergyman. The Resident Magistrate advised the minister to use his influence with chiefs to ‘secure the maniac’ and prevent mischief.\textsuperscript{178}

The cultural differential in boarding out has two probable explanations. First of all, Pakeha sovereignty was geographically limited. Colonial law and institutions could not be easily enforced beyond the parameters of close Pakeha settlement until those areas were brought within the zone of influence through land acquisition, assimilation or conquest. Avoiding antagonism made sense when enforcement systems were stretched. Cultural considerations must also have been important. Colonial governors were enjoined to leave native custom alone except where it was blatantly uncivilized.\textsuperscript{179}

Far fewer insane persons were boarded out or repatriated than passed through gaols or hospitals. If something went wrong, like the suicide of a lad whose boarding out cost 28s. weekly, the idea was criticised.\textsuperscript{180} Finding a suitable keeper could be problematic, especially in isolated settlements.\textsuperscript{181} No one was found to look after Private J. McD. after his discharge from the Army at New Plymouth. McD. was idiotic, and of offensive and mischievous habits.\textsuperscript{182} The inaugural session of the Wellington Provincial Council was informed by the Provincial Superintendent that humane care was no substitute for professional skill or suitable accommodation for

\textsuperscript{176} Sheriff, Auckland to Colonial Secretary, 31 December 1846, IA 1/45, L. 46/1990.
\textsuperscript{177} Inspector, Armed Constabulary, Auckland to Colonial Secretary, 12 July 1847, IA 1/50, L. 47/1280 and L. 47/1376.
\textsuperscript{178} Resident Magistrate, New Plymouth to Colonial Secretary, 16 July 1850, IA 1/78, L. 50/1328.
\textsuperscript{179} E.g., Instructions and Supplementary Instructions from the Secretary of State for War and Colonies to H.M. Consul, New Zealand, 14 August 1839, cit., McIntyre and Gardner, pp. 14-15 17-18.
\textsuperscript{180} Resident Magistrate, Lyttelton to Colonial Secretary, 20 June 1852, NM 8/33, L. 52/876; Coroner to Resident Magistrate, Lyttelton, 3 August 1852, NM 8/34, L. 52/1075.
\textsuperscript{181} Resident Magistrate, Akaroa to Colonial Secretary, 13 May 1848, NM 8/12, L. 48/566.
\textsuperscript{182} Resident Magistrate, New Plymouth to Colonial Secretary, 30 April 1852, IA 1/95, L. 52/959.
the care of lunatics. Boarding out, like the care of the insane in gaols, was publicly
condemned. 183

CONCLUSION

The state became involved in lunacy policy in New Zealand within a few years of
setting up organized government for several reasons. The Supreme Court exercised
the ancient parens patriae jurisdiction over the estates of insane persons and idiots
which had been part of English and Scottish legal tradition for centuries. State
intervention was also consistent with the police function of government when
individuals posed a threat to public safety. No specific preparation was made to
manage insanity in the plans for organized Pakeha settlements. Some improvisation
was therefore inevitable in a frontier society.

Conventional social and legal obligations upon families to care for lunatics were
retained as part of the British culture, with two key exceptions. Violent or dangerous
lunatics could not be managed easily at home, nor could families be prevailed upon if
an insane person had no kin in the colony. The mental health consequences of the
peculiar demographic composition of colonial New Zealand society with its large
numbers of transient single males who worked in development frontier jobs, gave
added impetus to the role of the state in regulating and providing mental health
services.

Lunacy entered the public policy agenda within the first decade of organized
government. It surfaced as a law and order problem and was tackled within the court
system and multi-purpose gaols and lock-ups. The initial lunacy law had a strong law
and order flavour. Gaolers had enough difficulties to cope with in managing assorted
social misfits in ill-equipped facilities. As the number of lunatics held in custody grew.

183 Provincial Superintendent's Opening Address, Wellington Acts and Proceedings. 28 October
1853, I, p. 15.
so special arrangements were made for them within gaol confines. They received medical oversight from colonial surgeons, who were government officials. In some settlements, lunatics were looked after in the colonial hospitals until, once more, special facilities and attendance became necessary.

Officials and opinion-makers opposed the improvised care of lunatics in gaols, lock-ups or hospitals. Gaol and medical officials tried hard to ameliorate conditions in these facilities in the interests of both lunatics and other inmates but the juggling act could not obviate basic humanitarian and professional objections to inadequate forms of care in an inappropriate environment. The best that could be achieved with limited resources and guidance was some form of segregation and special staffing arrangements. A 'community care' option, of boarding out or repatriation was used in some cases but there was no general policy on this option, except perhaps for the care of Maori.
Apart from practical difficulties, improvised arrangements for the care of lunatics in gaols or hospitals did not accord with contemporary public expectations. Popular terms like lunacy betokened a state distinct from criminality or sickness and this warranted a distinctive regime. In essence, the choice lay between the English model of lunatic asylums or the Scottish mixed model of institutions and boarding out. I will examine the factors that underlay the choice of the English model at the expense of the Scottish.

When the central and provincial governments of New Zealand opted for the asylum model of care, several subsidiary policy issues had to be resolved. Which level of government (or rather governments when there was a central government and provincial administrations) should run them? Should philanthropic or business interests be allowed to run private asylums? How many asylums should the colony have? Were consistent and uniform standards of management and care needed for all asylums? If so, how should they be achieved? Politicians and officials tackled these questions in the 1870s first, by considering the desirability of setting up a national or central asylum for the whole colony and, secondly, by moves to set up a national inspectorate within central government. Such initiatives became feasible as telegraph, railway and road links broke down provincial isolation and engendered a national consciousness. As provincial finances strained to meet the demands for economic and social development, so the locus of policy-making shifted from the provincial periphery to the national political stage.

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SCOTTISH AND ENGLISH MODELS OF CARE

When New Zealand became a British colony, the Scottish system of boarding out harmless patients was some years away from being formalized. A comparable system at Gheel, in Belgium, attracted the attention of British alienists in their professional journals from the 1850s. Some New Zealand politicians and newspapers were also familiar with the scheme, perhaps as a result of an article in the intellectual Quarterly Review in 1857.

Community based care for insane persons was not developed in a substantive way in New Zealand or other Australasian colonies. Boarding out lunatics with relatives or friends may have been anticipated in 1858. The Lunatics Ordinance Amendment Act of that year enabled a lunatic to be discharged provided that sureties were given that the person would receive proper treatment and keep the peace. On top of the cost of maintaining a non-productive family member at home, the £50 bond required under a similar section in the Lunatics Act 1868 would have been beyond the reach of many families. Given the province's Scottish roots, some local adaptation of the boarding out model might have been expected in Otago but there, as elsewhere, boarding out ventured little beyond the realm of intellectual curiosity. Suggestions that poor families be paid up to the cost of institutional maintenance got nowhere. Visiting justices in Nelson thought that long-term harmless patients might be boarded out with relatives, 'cottagers' and farmers to relieve accommodation pressures at the asylum annexe, but nothing came of the idea. Maybe wages were too high and

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4 F.N. Manning, 'Address in Psychological Medicine'. Journal of Mental Science, 35. 150 (1889), p. 156.

5 Lunatics Ordinance Amendment Act 1858, s. 4.

6 Lunatics Act 1868, s. 66.

7 Asylum report, Otago Votes and Proceedings, 1871, 29, No. 11, p. 51; editorial, Star, Christchurch, 30 June 1874. The newspaper editorial suggested that Victoria had such a scheme.

time too valuable, a private carer cost £2.3s.0d. at Dunedin in 1852. The cost of boarding someone out was thought to be higher in Auckland than in Britain. Proper supervision would also have been problematic in a geographically scattered population. Social characteristics such as kinlessness, heavy internal migration and transience also needed to be considered. In January 1872, Westland's medical officer noted in his case notes on one lunatic:

If this district presented the facilities for employment and quietude that are to be found in other places where farming pursuits are carried on, there would be no reason to fear in discharging; with the dangerous travelling and the scant population of the West Coast even sane men who are poor can hardly make a livelihood, and this difficulty I feel needs to be considered in certifying the discharge of patients from this Asylum.

Humanitarian concern as well as administrative convenience pointed officials towards the notion of the lunatic asylum as the proper solution. The colony's earliest known case of insanity, J.H., needed 'care and management in a proper asylum' rather than detention at Auckland Gaol. Sydney had the nearest proper asylum but it could not accommodate the person or other New Zealand lunatics. A. Domett, Colonial Secretary of New Munster Province, was concerned about the cost and thought that a lunatic asylum would be more efficient than boarding out. Dr I.E. Featherston, Wellington Province's first Superintendent, preferred an asylum 'with proper means of attention and treatment'. Featherston's identification of proper care with a lunatic

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9 Editorial, Nelson Colonist, 6 May 1864.
10 Resident Magistrate, Dunedin to Colonial Secretary, New Munster, 26 July 1852, Resident Magistrate's Court, Dunedin, Letter Book (1852-60), Hocken Library, Dunedin, MS 89.
11 Inspector's report, Auckland, 8 February 1870, Appendices to the Journals of the House of Representatives (AJHR), 1870, D-29, p. 6.
13 Seaview Hospital Case Book, Westland Hospital Board Archives, National Archives, Christchurch, CAHW 87 CH 22, Patient Folio No. 54.
14 Colonial Secretary to Colonial Secretary, New South Wales, 18 May 1842, Department of Internal Affairs Archives, National Archives, Wellington, IA 1/11; D. Rough to Colonial Secretary, 8 December 1846, cit. R.L. Jermy, 'The Treatment of the Mentally Ill in New Zealand 1840-1880', MA Thesis, Victoria University College, 1952, p. 28.
15 Minute on Resident Magistrate, Whanganui to Colonial Secretary, New Munster, 30 August 1852, New Munster Provincial Archives, National Archives, Wellington, NM 8/34, L. 52/1156.
asylum was echoed often. Despatch to Australian asylums was scarcely feasible as a policy except for families who could afford it. Shipboard conditions en route were hard. The Scottish alienist, W. Lauder Lindsay, was appalled that a lunatic sent to Tarban Creek Asylum, Sydney, was manacled and chained in a specially built stall where he sat in his own excrement. Another lunatic was chained like a monkey to the mizzenmast and treated as if he were a wild bear in a menagerie.

TOWARDS THE LUNATIC ASYLUM

Colonial settlers supported an institutional model of care because it was progressive, humane and fashionable in Britain. British ideas were part of the colonists' frame of reference. Thus an Auckland provincial select committee thought that the lunatic asylum accorded with 'humane ideas as expressed abroad.' The architect of Auckland's Whau Asylum defended his design because the superintendents at Colney Hatch Asylum, near London, had approved it. Plans of Yarra Bend Asylum, Victoria, were obtained before the Nelson Asylum could be designed. English alienists, especially John Conolly, were widely regarded as authoritative. Conolly's famous works, *The Construction and Government of Lunatic Asylums and Hospitals for the Insane* (1847) and *The Treatment of the Insane without Mechanical Restraints* (1856) were available in New Zealand. Local therapeutic results were compared

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17 E.g., Grand jury presentment and Mr Justice Gresson reported in *Otago Witness*, 19 January 1861; J. A. Bonar, M.L.C. (Westland), M.C.C. reported in *West Coast Times*, 7 February 1870; E.W. Stafford (City of Nelson), NZPD, 17 September 1867, I, pp. 941-2.
18 W. Lauder Lindsay, letter to *Otago Colonist*, 26 September 1862.
Silver testimonial presented to Conolly upon his retirement from Hanwell Asylum, and gifted by his descendants and loaned permanently to Auckland Hospital by the Auckland Art Gallery in 1955-6. The statuette is two feet high and represents lunatics with and without restraints. The statuette is surmounted by the god of healing. The *Lancet* of 3 April 1852, p. 339, reported that the statuette was worth £500. The gilt frame of a portrait of Conolly is shown in the background. The photograph was taken at Oakley Hospital, Auckland.

*(Author's collection)*
with Britain. Staff with superior overseas experience would have to be recruited to provide care in New Zealand asylums. A ‘competent governor’ conversant with ‘the modern more humane, and more successful treatment’ could only be found in British asylums.

With due Scottish jaundice, Lindsay regretted the narrowness of New Zealand’s growing dependence on the English asylum model:

Unfortunately, colonial legislators, with an overwhelming confidence in everything that is of home growth, and with an inordinate penchant for home precedents and home models, because they are of and from home, usually frame their lunacy laws and construct their asylums after the fashions of the faulty ones of England. They act upon the adage, “There’s no place like home,” in a mischievous and absurd way - ignorant or oblivious of the fact that the lunacy system of England is admittedly corrupt, and that it cannot easily be reformed in an old country abounding in prejudice, vested interests, time-honoured customs, and hereditary creeds, however ridiculous or noxious these may be shown to be ... For laws have been enacted and amended, and asylums built, after the orthodox English fashion; and after money has been sunk and laws have taken hold, it is not easy to undo and substitute, however desirable progress or reform may be.

Lindsay’s exhortations for New Zealand to adopt alternatives from countries ‘which are most advanced in civilisation’ (especially the Belgian and Scottish systems of family care) went unheeded. Legislation was tilted towards the asylum model. The

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24 Dr W. Lauder Lindsay to Provincial Secretary, Nelson, 21 October 1864, NP 7/12. L. 64/915.


25 T. Ball (Mongonui), Auckland Provincial Council Journal, 8 February 1865, 18, p. 40.


27 Ibid., p. 813.
'public colonial lunatic asylum' was a core concept of the 1846 Ordinance. In 1858, the Legislative Council successfully blocked an amendment that would have allowed certain lunatics to be committed to a hospital, thereby preserving the role of the hospital or gaol as a place for temporary safekeeping pending treatment in an asylum.

According to Kirkbride, the leading American alienist who was cited when Auckland considered building an independent asylum, the ethos of the special purpose lunatic asylum began with

the very choice of a site, it continues in the construction of the buildings, in the arrangement of the wards, in their furniture and fixtures, in the kind and position of the enclosures, and in the conveniences, comforts and luxuries of the establishment.

So it was in New Zealand, whether the ideal was a central or provincial asylum. Proper lunatic asylums were geographically and functionally independent of gaols and hospitals. These asylums were usually built on an elevated site on the outskirts of settlements - close enough to facilitate interaction with local communities, provide a measure of freedom and to anticipate future growth. The relationship of the site to the town belt, which girdled some New Zealand Company settlements and Hokitika, and which separated town from country, meant that for the most part, asylums were to be of the town but not in it. Karori, Sunnyside and Seaview all lay beyond the town belt, Dunedin and Mount View, Wellington (1873-1910), just inside it. So it was with the lunatics. Humanitarian concern identified the insane as members of society, but the segregation imposed by asylums left them out of society.

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28 Lunatics Ordinance 1846, ss. 1, 3, 5-6, 9.
29 Journal of the House of Representatives, 17 August 1858, p. 177; Lunatics Act 1868, s. 22. No regulations under this section were promulgated.
31 E.g., visits by respectable citizens and groups. See New Zealand Herald, 6 March 1868 and 22 January 1870, Resident Medical Officer to Provincial Superintendent, 8 June 1876, Auckland Provincial Archives, National Archives, Wellington, AP 2/49, Asylum report (1863-67), Canterbury Journal of Proceedings, 1867, 27, No. 52; Dunedin Asylum Keeper’s Journal, 21 February 1867, Healthcare Otago Ltd Archives, National Archives, Dunedin, DAHi D 264/1.
Ample and suitable land was vital to the asylum’s moral purpose of providing work therapy. Karori Asylum’s miserable five acres allowed a half-acre for a kitchen garden and flower garden where two or three patients worked. The rest of the Karori site was bush clad, which enabled some male patients to split firewood. Wellington’s second-generation asylum at Mount View, Newtown, had 70 acres that allowed, after some levelling, for more extensive cultivation of fruit and vegetables to deter laziness. The adequacy of land reserved at Mount View was typical of most provincial asylums and a proposed central asylum. Only Nelson Asylum was cramped upon eight acres. Although this allowed some cultivation, the site was considered too small even before the asylum was opened. Male patients broke in the land of most asylums. The Whau site had a good prospect, good soil, and an adequate water supply but consisted of ‘a flat mass of marly rubbish, tipped with scraggy furze’. There were about 22 acres, 16 of them in paddocks, two in potatoes and two in a vegetable garden. Full development of the Seaview site at Hokitika had to be hacked from the bush. Saw pits were set up and 20 of the 170 acres of bush behind the asylum were cleared within a few years. This was one way that Gribben, the asylum’s first superintendent, could ‘employ them as much as possible’. The Dunedin Asylum site’s 19 acres of ‘wild and rough waste’ were slowly levelled and turned into productive land. Vegetable gardens, piggeries and poultry farms were typical agricultural activities that offered outdoor employment to male patients. Other patients worked at industrial activities, such as shoe making.

34 Sunnyside Asylum had 50 acres. Press, Christchurch, 22 February 1863.
35 Sites considered for a central asylum near Nelson in 1858-59 ranged from 36-200 acres. An area of flat land of 50-75 acres was eventually chosen. Provincial Secretary to Dr R.K. Prendergast, 24 September 1858, Nelson Provincial Archives, National Archives, Wellington, NP 11/1, L. 58/312; Colonial Secretary to Provincial Superintendent, Nelson, 11 December 1858 and reply, 24 March 1859, Nelson Votes and Proceedings, 1859, 6, pp. 93-94.
38 Inspector’s report, 8 February 1870, AJHR, 1870, D-29, pp. 3-4; Daily Southern Cross, 8 January 1874.
39 Keeper, Hokitika to County Chairman, 12 July 1873, CAHW 87 CH 22, pp. 443-51.
tin ware, and rope making or, in the case of female patients, sewing or other domestic tasks.  

Dunedin Asylum's Inspector (1873-6), Professor Duncan MacGregor, moralized about the value of employment:

One of the marked characteristics of chronic lunatics is a strong aversion to regular industry. .... Nothing is more mischievous, next to actual restraint, than that lunatics, strong and in the prime of life, should be allowed to stroll all day in pleasuregrounds, indulging in aimless brooding and morbid fancies. Mere walking exercise, be it ever so regularly taken, has comparatively little effect in checking this evil. In the case of women the matter is still worse; and this I take to be the greatest defect in our mode of treating them. All except the few who can be regularly employed in washing, scrubbing, and cooking, are usually employed in sewing, one of the most automatic of all employments, and which therefore leaves the mind free to roam. May not much that is characteristic of women generally be traced to the fact that sewing and other kindred avocations are so admirably calculated to leave the wandering fancy free?

When he wrote that, in 1875, MacGregor was already contemplating a less restricted site of 300-500 acres near to town where there would be plenty of scope for agricultural pursuits and 'curative efficiency'.

Asylum design was distinctive. Judges of the architectural competition for Sunnyside Asylum in 1853 acknowledged that 'it is on the system of treatment by the latter [physician] that the design for the building in which that treatment must be carried out...'

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41 Steward Sunnyside to Provincial Secretary, 5 October 1863, CH 287 CP L. 567a/63; Asylum Report, Otago Votes and Proceedings, 1865, Departmental Reports, No. 6, pp. 36-37; Keeper. Sunnyside to Provincial Superintendent, 17 November 1874, CH 287 CP L. 2912/74.
42 Inspector's report, Otago, 7 July 1875, AJHR, 1875, H-2A, p. 4.
43 Inspector's reports, 14 [?] July 1875, Otago Provincial Archives. National Archives. Wellington, OP 7/77, L. 13063/3, and 15 May 1876, AJHR, 1876, H-4, p. 12. MacGregor did not seem to have any particular location in mind, but sites near the railway line at Tokomairiro, Green Island, Lawrence, Clinton and Mataura were considered before 894 acres at Seacliff was chosen for a new asylum and industrial school, apparently on the advice of the Provincial Surgeon. Provincial Superintendent's Message No. 6, Otago Votes and Proceedings, 13 May 1874, 33, p. 28; Superintendent, Dunedin to Provincial Superintendent, n.d. [May 1875?], OP 7/94, L. 15263/5; Otago Votes and Proceedings, 12 May 1875, 34, p. 30; editorial, Otago Daily Times, 7 October 1875.
must be based'. The plans show that first generation asylums were small enough to be homely. They were also designed to impose institutional order through classification of male and female, and various groups of disturbed and docile, dirty and clean, ambulant and bedridden patients. Sleeping accommodation, day rooms and exercise courts were designed accordingly. Security features such as padded rooms, single rooms, shower baths, solid locked doors and iron-framed windows with small panes were essential features. Auckland newspapers declared that only with a properly designed new building could the public expect proper classification and treatment. When the new asylum at Whau was eventually built, it was praised for the total absence of a 'gaol-like appearance so deterring to the insane' and a 'hospital smell'. The specially designed Mount View Asylum, too, would promote 'curative measures' and recovery such as was impossible at Karori, with its defective buildings and site. The new premises had the comforts of a 'well-conducted home'. The Sunnyside environment was conducive to 'improved health, cheerfulness, and tractability'.

All of the original asylums, save Auckland, were wooden buildings. This was appropriate when some original asylums were supposed to be temporary. The buildings were practical if not architecturally elegant, in line with a former provincial surgeon's hopes for a cottage style and not a 'palatial' design. Take Sunnyside, for example. Its original block was not said to be handsome, but 'strong, solid and useful' as befitted fiscal circumstances. Systematic planning and redevelopment in permanent materials were more than a decade away.

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44 Messrs Mountfort and Luck to Provincial Secretary, 28 January 1863, CH 287 CP L. 229/63.
48 Wellington Independent, 4 January 1872.
49 Lyttelton Times, 3 December 1863.
50 Canterbury Provincial Executive Council minutes, 20 December 1862, CH 287 CP 372, p. 20;
51 Provincial Surgeon to Provincial Secretary, 13 August 1863, OP 7/7, L. 1168/41.
53 Lyttelton Times, 29 August 1863.
54 Inspector's Report, Canterbury, 30 May 1871, AJHR, 1871, G-26, p. 11.
Lunatic asylum management was also distinctive. At their inception, all asylums except the Whau, shared authority between a visiting medical officer and a lay keeper, superintendent, or keeper-clerk. This system was acknowledged in the Lunatics Act 1868. In practice, the keeper or superintendent was responsible for safekeeping and the visiting medical officer for treatment. Lay superintendents considered themselves subject to medical direction, but they rather than the visiting medical officers, set the tone of their establishments. In words reminiscent of the authoritative Conolly, J. Hume set out his philosophy soon after the Dunedin Asylum opened:

Patience, gentle treatment, nourishing diet, cleanliness with light employment or exercise goes far to recover the lunatic, and in chronic cases, serves to make them comfortable and even happy. Amusements for the insane are indispensable .... Good example in the attendants is the greatest guide, and gives confidence to the patients.

Seager's proposed rules for Sunnyside advised 'attendants' to act with 'firmness, temper, and humanity' and to 'govern by wisdom rather than subdue by terror', setting a 'new world' before the patients. Gribben made it clear that he was determined not to use restraint at the new Seaview Asylum.

Asylums aspired to be communities that functioned best at the domestic level. Comments concerning worship and social occasions illustrate the point. Great was Hume's satisfaction with the celebration of the Queen's Birthday at the Dunedin Asylum in 1864. At the conclusion of the evening, patients joined hands to sing 'one

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54 Lunatics Act 1868, ss. 23-27. The medical officer was to keep the casebook with details of the history and treatment of patients. The superintendent was to maintain the registers of admissions and forward notices of admissions, discharges and deaths to the Colonial Secretary.
55 Proposed rules for Sunnyside Asylum, c. December 1864, CH 287 CP L. 2666/64; Keeper, Sunnyside to Provincial Superintendent, 17 November 1874, CH 287 CP L. 2912/74; Dunedin Asylum Medical Journal, 20 June 1864, DAHI D 264/2; Dunedin Asylum Keeper's Journal, 20 June 1864, DAHI D 254/1; Nelson Asylum Keeper's Journal, 19 August 1867 and 24 June 1868, Nelson-Marlborough Adult Mental Health Service records [NMAMHS], Ngawhatu Hospital, Nelson.
56 Dunedin Asylum Keeper's Journal, 20 April 1864, DAHI D 264/1.
57 Proposed Rules for Sunnyside Asylum, c. December 1864, CH 287 CP L. 2666/64.
58 Keeper to County Chairman, n.d. [July 1872] CAHW 6 CH 22. cf. Keeper to County Chairman, 14 January 1873, CAHW 6 CH 22.
59 E.g., Sunnyside Asylum Inspector's Book, 27 December 1876, p. 119, Sunnyside Hospital Archives, National Archives Christchurch, CH 388/39; Dunedin Asylum Keeper's Journal, 5 June 1864, DAHI D 264/1.
of Scotland's sweetest songs', Auld Lang Syne. Female patients at Nelson used to kiss and embrace each other before retiring. The social sense of community complemented a desire to maximize institutional self-sufficiency as shown in the nature and scope of work programmes.

In time, limited social tolerance for boarding out reinforced the idea of the asylum as community. Westland was too poorly populated and lacked the 'facilities for employment and quietude' of farming districts. J.O'L., who had no friends and was lonely, thus remained a patient, making roads and tracks, and driving the horse and dray. Without suitable work outside the asylum, men would only 'knock about the diggings'. Rehabilitated patients risked exploitation by their bosses.

A former Whau inmate who quarrelled with his brother had nowhere else to go. He was found on premises warming his hands by a fire he had lit in a can of wood-shavings. Charged with vagrancy, the man was recommitted. If such anecdotal information is indicative of a changing level of public tolerance, it is understandable that asylums retained employable patients who could contribute to the life of the asylum community. A few "graduated" to the staff.

Social intolerance of even eccentric behaviour reinforced the role of asylums as communities with an expanded role. Within a short few years, kinlessness and the lack of alternatives for other social problem groups manipulated the primary purpose of lunatic asylums. This is borne out by comments of officials and concerned members of the public alike.

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60 Dunedin Asylum Keeper's Journal, 24 May 1864, DAHI D 264/1.
62 Cases of T.L. and J.O. O'L., January and October 1872, CAHW 87 CH 22.
63 Superintendent, Hokitika to Ferries Bros, West Oxford, 2 June 1884, CAHW 10 CH 22. Cf: Inspector, Auckland, letter to Auckland Evening Star, 18 April 1872 re C., who had been a patient at the Whau for two years. Repeated efforts to discharge him when he improved failed because no one would take him. When someone eventually did, the man quickly reverted to a life of 'irresponsibility of his own volition'. Drink was to blame. "W", letter to Auckland Evening Star, 23 April 1872.
64 Star, Christchurch, 18 July 1868.
65 Daily Southern Cross, Auckland, 27 July 1874.
66 Inspector's report, Auckland, 26 January 1876, AJHR. 1876, H-4, p. 2; Evening Post, Wellington, 11 June 1872; Patient Folio No. 33, October 1872, Seaview Hospital Case Book 1, CAHW 87 CH 22.
Throughout the colonies, lunatic asylums are becoming the refuge for all who are at all feeble-minded, and idiots; this must arise from the want of a benevolent asylum.\(^67\)

In practice, lunacy is made to signify anything or everything according to the views of the parties concerned. This is quite evident when a man is sent to the lunatic asylum for *sleeping in the open air*.\(^68\)

A few of those sent in have been persons naturally of weak intellect or with some marked peculiarity of disposition having been arrested and taken before a Magistrate. An asylum is of no service in such cases – they are generally quite able to take care of themselves, and in a large place, would escape notice. In a small community, however, their peculiarities attract attention. They would not in the United Kingdom be considered as suitable inmates for an Asylum.\(^69\)

Published statistics do not fully reveal how often lunatic asylums were used for persons who, in Lindsay’s professional judgement, were ‘non-productive’ persons and ‘certain pests’ in a young colony.\(^70\) These were cases that involved eccentricity, impropriety or public nuisance rather than actual or threatened violence\(^71\) and who were sent to asylums merely because there was nowhere else to put them.\(^72\)

When the central and provincial governments of New Zealand opted for the asylum model of care, several subsidiary policy issues had to be resolved. These involved issues of responsibility within government administration, access, regulation of privately run asylums, the distribution of asylums throughout the country, and finding ways to ensure that asylums provided a satisfactory standard of care and treatment.

\(^{67}\) Steward, Sunnyside, MS of December 1871, CH 287 CP L. 71 / [?].
\(^{68}\) "The Ghost of Samuel (1 Sam. XXVIII: 15)"*, letter to *Nelson Examiner*, 3 March 1864.
\(^{70}\) W. Lauder Lindsay, ‘Lunacy Legislation in New Zealand’, *Journal of Mental Science*, 18, 84 (1873), p. 511.
\(^{71}\) *E.g.* the lunatic who stripped himself naked and performed ‘antics and capers’ at German Bay (Lytton Times, 17 May 1864); the lady who raved about religion in the streets of a Wairarapa town and was about to bathe naked when apprehended (Evening Post, 26 February 1876); the Maori whose arms ‘sailed like a windmill’ (Daily Southern Cross, 23 July 1870); “S.G.” and “One who has Seen the Man whilst in Confinement”, J.G. Cox, and T.A. Bowden, letters to *Wellington Independent*, 8, 10, 15, 19 July 1871; the deluded G.S. who imagined himself to be Prince Leopold and about the marry Queen Victoria (Echo, Auckland, 20 August 1875).
\(^{72}\) Editorial, *New Zealand Herald*, 16 September 1873.
Lunacy policy was caught amid the administrative tension, ambiguous powers and shifting roles of the central and provincial levels of government that bedevilled public administration between 1852-76. Provincial government responded to the political pressures brought about by the geographical isolation and relative self-sufficiency of the main Pakeha settlements. In 1846, Governor Grey accurately described New Zealand as 'divided into several settlements, separated by long intervals, having in some respects interests totally different from each other, and none of them exceeding the other so much in wealth and importance as to possess a preponderating influence and recognized superiority.'

Grey's delay in implementing parts of the colony's new constitution (1852) gave provinces a head start over central government. In August 1853, Grey outlined transitional financial arrangements that let provinces set up their administrative machinery. In October 1853, the Governor instructed departmental heads to receive their instructions from and make all their reports to the relevant provincial superintendent. Care of lunatics was included by virtue of the transfer of Sheriffs, Gaols, Police, Medical and Public Works Departments to the provinces. Provincial councils then quickly conferred upon their superintendents statutory powers vested in the Governor or Lieutenant-Governor. These arrangements, Canterbury's first Superintendent said, meant that 'almost every office and department of Government in which the practical and daily work of Government is carried on for the benefit of the community, is under the control of the Provincial Government, and is paid for out of the provincial Revenue.'

The Lunatics Ordinance 1846 mentioned a 'public colonial lunatic asylum' but did not define the term. Grey's actions show that government revenue was intended to fund the place, like the colonial hospitals, and in keeping with Irish and English precedents. The proposed public colonial lunatic asylum was to be available to any

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74 Ibid., pp 72-75.
75 *New Zealand Gazette*, 29 July, 16 and 30 August, 1 September and 3 October 1853, pp. 120, 138-9, 162.
insane person irrespective of financial status or ethnicity. 'Public' meant that the committal pathway ended there for dangerous and harmless lunatics alike. This safeguard was closer to Scottish law than English lunacy law of the time, which maintained separate procedures for public and private patients. Moreover, the Lunatics Ordinance 1846 made no reference to pauper or private patients, as had its New South Wales (1843) and South Australian (1844) antecedents.78

The principle of equal access was spelt out clearly in 1870 in a running battle between the Auckland provincial government and the central government over payment for Maori:

So long as the provincial Gov[ernmen]t is responsible for the peace and good order of the inhabitants it is clearly its duty to provide for the safe custody of lunatics without any distinction of race or nationality; and although exceptional circumstances interfere with the operation of the law in remote Native districts, yet within all the settled limits the Natives are subject to the same laws as other members of the community. The Hospital endowments were originally granted for the benefit of all classes of Her majesty's [sic] subjects without any distinction of race or colour ... and the former [Maori] are equally entitled to admission to the Hospital as any other of the inhabitants and should receive the same care and treatment.79

Early lunatic asylums felt the effects of a powerful, vague colonial ideology of egalitarianism. The egalitarian myth, which Belich believes might be better defined as populism,80 emphasized equality before the law and a resentment of oppressive class distinctions. Lunatics from all social classes were admitted.

Lunacy legislation of 1846 and 1858 anticipated that institutional care would be provided publicly. So did the abortive Lunatics Bill 1862.81 Profit-making institutions

79 Minute by Native Minister, 3 November 1870 on Provincial Superintendent, Auckland to Colonial Secretary, 9 August 1870. IA 1/288, L. 70/2141.
were not considered until the Lunatics Bill 1867-8 anticipated that private houses might receive one or more lunatics provided that the houses were licensed and inspected by the state. This idea might have been included simply because the Bill borrowed from recent English and Australian measures. The idea received little attention in the Legislative Council, but in the House of Representatives, passage was stormy. Sensing trouble, E.W. Stafford (the Premier and Colonial Secretary) stressed the safeguards set out in the Bill that would prevent horrors associated with notorious 'private madhouses' in the past that made 'the blood run cold'. He reassured Members that a private establishment in Britain he had visited provided a higher standard of care than the madhouses of the past. Stafford also argued that private asylums would remove much distress to lunatics and their relatives.

Stafford’s fundamental attitude towards private asylums shifted in the course of the debate. He was prepared to drop the licensing provision to secure the passage of the Bill in 1867. Next Session, however, his government got tough. The licensing clause brought about the only division on the Bill in the House, which the Government won, 24-12.

Licensing was debated on the grounds of civil liberty and efficiency. The Government countered by claiming that sensational or popular novels swayed opponents of the move. Private asylums could also meet local needs and provide for paying patients who could enjoy the company of people from the same social position. Private patients there would appreciate comforts and ‘remedial

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82 J.H. Harris (Otago) in NZPD, 20 August 1867, I, p. 499.
83 E.g., licensing, minimum staffing requirements, information about dismissals, the power to revoke a licence, statutory documentation, medical visitation, independent authority for discharge, regulation of commissions de lunatico inquirendo, and powers of intervention given to the Colonial Secretary to order an independent examination of a patient or a special inspection of a licensed house. Lunatics Act 1868, Parts III-IV.
84 NZPD, 17 September 1867, I, pp. 941-2 and 18 August 1868, 2, p. 507.
85 NZPD, 20 September 1867, I, p. 1010.
86 NZPD, 28 August 1868, 3, p. 6.
87 J. O’Neill (Northern Division), G. Graham (Newton), and H. Bunny (District of Wairarapa), NZPD, 20 September 1867, I, pp. 1005-6.
88 T. Macfarlane (Northern Division), NZPD, 20 September 1867, I, p. 1006.
89 J. Hall (Heathcote District), NZPD, 20 September 1867, I, pp. 1006-7.
appliances’ that could not be afforded in public asylums. Continuing to mix up patients in public asylums would reduce the prospects of recovery."  

Despite the Government’s victory, the licensing provisions of the Lunatics Act 1868 lay dormant until 1882 when Ashburn Hall was opened. Reasons for the delay are hard to find. The Stafford Ministry remained in office until June 1869, which gave several months for the proprietor of any private house to apply for a licence under a sympathetic government. The likelihood of applications would surely have been mentioned in Parliamentary debates. The silence suggests that the private market was too small and public sector provision already well entrenched. The dormancy of the licensing provisions was partially offset within the public system. Park House at Dunedin Asylum was set up to receive a ‘better class of patients’, but there were only two in 1869. They paid between £100-300 annually for the privilege.  

A similar ‘cottage’ was mooted in Auckland, but it did not materialize. In this respect, New Zealand experience resembled that of the Australian colonies. New South Wales was the only state that had private asylums.

Provincialism, not private asylums, was the really contentious political issue in New Zealand. Two mental health policy issues were sucked into this wider debate. From the late 1850s until the issue was finally settled in 1876, debate surrounded the relative merits of a central lunatic asylum to serve the whole colony or a series of provincial lunatic asylums. E.W. Stafford mooted the idea of a ‘systematically...

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92 Provincial Secretary to Provincial Treasurer, 19 June 1869, OP 11/15, L. 9035/1; A. Peyman to G. Dunedin, 20 July 1868, OP 7/44, L. 9035/6; Asylum annual report, Otago Votes and Proceedings, 1869, 25, Departmental Reports, p. 62.
94 F.N. Manning, ‘Address in Psychological Medicine, delivered at the Inter-colonial Medical Congress in Melbourne on January 11, 1888’, Journal of Mental Science, 34, 150 [New Series 114] (1889), pp. 156-7. Manning was wrong. Following up comments by Dr G. Graham of Cremorne Private Lunatic Asylum, Melbourne, in the Sunnyside Hospital Visitors Book in March 1874 (Sunnyside Hospital Archives, National Archives, Christchurch, CH 396/49), I found that Cremorne was opened about 1858 and that the proprietor had run a similar place in Ascot Vale in 1854. Manning might have been more accurate had he mentioned that prior to 1867, lunacy law in Victoria made no provision for licensed houses. See C.R.D. Brothers, Early Victorian Psychiatry 1835-1905, Melbourne, 1962, p. 79.
conducted' central asylum in 1855, when he was Provincial Superintendent of Nelson. For two years, he claimed, he failed to persuade the general government to build and maintain such an institution. The Governor apparently backed the idea and favoured Nelson because the site was central. Stafford’s attempts to secure provincial cooperation were unsuccessful.⁹⁵ Pending resolution of the question by the general government, Nelson was only prepared to make temporary provision from its own resources.⁹⁶

Stafford’s political career transferred this debate to the Parliamentary stage. Midway through his first term as Premier and Colonial Secretary (1856-61), the House of Representatives, on the motion of J. Ollivier (Christchurch Country District) and T. Beckham (City of Auckland), resolved that a central lunatic asylum be erected. A central asylum was said to be humane, economical and expected to significantly increase the chance of recovery because it would offer the ‘sound curative measures’ associated with the non-restraint system and the leading English alienist, Conolly. From his own experience as a provincial councillor,⁹⁷ Ollivier thought that each province had too few lunatics to allow for a proper system of care and treatment. T. Beckham argued that a central asylum would care for cases other than those where a crime was actually involved.⁹⁸ Stafford used the debate to refer the issue to a Select Committee that duly supported the idea. The report was adopted and the Governor requested to give effect to its recommendations.⁹⁹ A Commissioner was then appointed to choose the central site. Land was purchased at a ‘retired but romantic and easily accessible site’ at Stoke, near Nelson, on which a 100-bed institution was envisaged. Plans for a building in the old English style were drawn up.

⁹⁵ Provincial Superintendent, Nelson to Dr D. Monro, 29 November 1855. NP 11/1, L 55/439; Provincial Solicitor reported in Nelson Examiner, 27 February 1856; S.G. Muller, M.P.C. reported in Nelson Examiner, 12 April 1856.
⁹⁸ NZPD, 20 April 1858, 2, pp. 387-8.
⁹⁹ NZPD, 20-1 April, 8 and 16 June and 9 July 1858, 2, pp. 387-8, 401, 497, 531; Select Committee report, 9 July 1858, Department of Health file H 30/21, current whereabouts unknown. The Committee comprised E.W. Stafford (Nelson), J. Hall (Canterbury), F.W. Merriman (Auckland), H. Carleton (Bay of Islands), Beckham, A.W. East (Taranaki) and Ollivier. Taranaki’s representation was changed from East to C. Brown. Later on, Dr D. Monro (Nelson) was added to the Committee.
Stafford personally sought help in drafting the rules from Dr (later Sir) Charles Hood, Medical Superintendent of Bethlem Hospital.\(^{100}\)

Planning was wasted. With their own pork barrel interests, provinces squabbled over the choice of site.\(^{101}\) Parliament would not vote the funds, so the project was put on hold indefinitely.\(^{102}\) A central asylum did not feature among the priorities of the next government headed by Fox. This avowed provincialist even contemplated legislation requiring provinces to build their own asylums.\(^{103}\) Besides, the outbreak of war in the North Island and resulting financial pressures took priority and urgency.\(^{104}\)

While this drama was acted out, provinces had to make their own provision. With the most to gain from a central asylum, Nelson continued with various temporary arrangements.\(^{105}\) Other, more realistic provinces, soon tired of looking for relief from elsewhere,\(^{106}\) and reluctantly provided their own asylums.\(^{107}\) When Stafford resumed

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\(^{100}\) Provincial Secretary to Dr Prendergast, 24 September 1858, NP 11/1, L. 58/312; Dr Prendergast's report, 24 November 1858, H 30/21; Colonial Secretary to Provincial Superintendent, Nelson, 11 December 1858, NP 5/2, L. 58/77; Nelson Examiner, 15 December 1858 and 6 June 1860; Premier to C. Shoppee, 17 September 1859, H 30/21; E.W. Stafford to C.W. Richmond, 19 June 1859 in G.H. Scholefield, ed, The Richmond-Atkinson Papers, Vol. I, Wellington, 1960, p. 467; Dr C. Hood to Colonial Secretary, 30 November 1859, Legislative Department Archives, National Archives, Wellington, LE 1/1860/222; Provincial Superintendent to T. Marsden, 2 August 1860, NP 11/3, L. 60/314.

\(^{101}\) Provincial Secretary reported in Nelson Examiner, 31 May 1862.

\(^{102}\) Colonial Secretary to Provincial Superintendent, 16 November 1860, NP 5/3, L. 60/63; Mr Justice Gresson in charge to Grand Jury, Lyttelton Times, 5 December 1860.

\(^{103}\) Nelson Provincial Secretary reported in Nelson Examiner, 24 May 1862.

\(^{104}\) A. Buchanan (Otago), NZPD, 7 September 1871, p. 295.

\(^{105}\) Nelson Provincial Government Gazette, 14 June 1859, p. 45; Nelson Votes and Proceedings, 28 May 1861, 8, p. 17, 6 June 1862, 9, p. 40, and 26 April 1870, 20, p. 7; Colonial Secretary to Provincial Superintendent, 29 April 1859, NP 5/2, L. 59/23; Provincial Superintendent, Nelson to Colonial Secretary, 20 January 1860, H 30/21; Provincial Secretary reported in Nelson Examiner, 31 May 1862; Keeper to Provincial Secretary, 28 December 1871, NP 7/31a, Unregistered Letter.

\(^{106}\) Provincial Superintendent, Nelson to Provincial Superintendent, Wellington, 14 December 1853, IA 1/107, L. 53/2437; Provincial Secretary, Wellington to Provincial Superintendent, Canterbury, 8 November 1853, CH 287, L. 209/63; Provincial Superintendent, Wellington to Provincial Superintendent, Nelson, 6 January 1854, NP 7/1a, L. 1854/16; Provincial Superintendent, Nelson to Provincial Superintendent, Wellington, 14 December 1854, NP 11/1, L. 54/297; Provincial Superintendent, Wellington to Provincial Superintendent, 1 November 1854, CH 287, L. 54/305; Colonial Surgeon to Provincial Superintendent, 15 November 1854, CH 287, L. 54/290; Provincial Superintendent, Auckland to Provincial Superintendent, 23 January 1855, CH 287, L. 55/524; Westland County Votes and Proceedings, 12 January 1870, 7, p. 3; Canterbury Executive Council minutes, 13 December 1860, CH 287 CP 371, p. 101; Colonial Secretary to Resident Magistrate, Otago, 25 November 1852, NM 10/12, L. 52/177.

\(^{107}\) Resolution of Otago Provincial Council, 1 October 1863 enclosed in Provincial Superintendent to Colonial Secretary, 29 February 1864, H 30/21; Select Committee report of Westland County Council reported in West Coast Times, 4 March 1871; Canterbury Executive Council Minutes, 16
the premiership in 1865, the scene had changed. Sunnyside (Christchurch) and Dunedin Lunatic Asylums had opened. Auckland was committed to plans for an asylum at the Whau Creek. Wellington already had its own provincial lunatic asylum at Karori.

Some Parliamentarians may have still hankered after a central institution, but not Stafford. His government had no plans to establish a public colonial lunatic asylum in 1866 and the idea did not feature in the Lunacy Bills of 1867-8. Nevertheless a central institution had some support, mainly because resources and expertise could be concentrated. Opponents made some telling points. Sending patients by sea to Nelson would be detrimental to their health. Friends and relatives would not be able to visit so patients would suffer from not having familiar associations and objects around them. Transport costs would be considerable. The standard of some provincial asylums, particularly Sunnyside, was very good and this reduced the need for a central institution. What was needed then was some administrative arrangement to lift the standard of all asylums.

By the end of the provincial era, the notion of a central lunatic asylum was largely spent. As the debate ran its course, the purpose of a central asylum changed from acute care to the care of chronic cases. "It" also became "they" with the idea that...
each island should have its own central asylum\textsuperscript{117} as well as the existing provincial asylums\textsuperscript{118} to relieve pressure there.\textsuperscript{119} As Figure 1 shows, by 1876, only the smallest and struggling provinces had no asylum of their own. Marlborough made arrangements with Nelson and other provinces to care for its lunatics.\textsuperscript{120} Hawke’s Bay ran a small ‘temporary’ annex next to Napier Gaol from 1870-86 but this place served largely as a transit point to Wellington.\textsuperscript{121} Some ‘cells’ in the New Plymouth Hospital which were gazetted in 1871 were closed in 1879.\textsuperscript{122} Invercargill Hospital was no longer used as an asylum when Southland was reunited with Otago in 1869. Patients were transferred to the Dunedin Asylum.\textsuperscript{123}

\begin{flushright}
A NATIONAL INSPECTORATE
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Leaving asylums to be run by the provinces was a recipe for variable quality. The central government’s reluctance to provide guidance or coordination compelled each province to independently replicate the policy walk from gaol to asylum. Even the transfer of lunatics between provinces was regarded as a matter for local negotiation.\textsuperscript{124} Section 67 of the Lunatics Act 1868 empowered the Colonial Secretary to order the transfer of a lunatic, but the effect was negated by the delegation of powers. Provincial administrators, especially in smaller provinces, acted unilaterally. Nelson Asylum deliberately shipped a dangerous lunatic to Dunedin.

\textsuperscript{117} E.W. Stafford (Timaru), NZPD, 13 September 1871, 10, p. 394.
\textsuperscript{118} J. Hall (Healthcote District), NZPD, 13 September 1871, 10, p. 395.
\textsuperscript{119} Dr M.S. Grace (Wellington), NZPD, 7 September 1871, 10, p. 297.
\textsuperscript{120} Provincial Superintendent, Marlborough to Provincial Superintendent, 29 November 1862. NP 7/8a, L. 62/629; Provincial Secretary, Marlborough to Under-Secretary, Colonial Secretary’s Department (telegram), 11 September 1871, AJHR, 1871, G-26, p. 6. Land was reserved for a gaol, hospital and lunatic asylum at Picton in 1857 on a site subsequently occupied by the hospital only.
\textsuperscript{121} Controller-General of Prisons to Director-General, 17 March 1931, Mental Hospitals Department File MH 8/1245, formerly held in Department of Health records storage but current whereabouts unknown.
\textsuperscript{122} Provincial Superintendent, Hawke’s Bay to Colonial Secretary, 22 August 1870, AJHR, 1870, D-29, p. 20; Inspector’s report, Hawke’s Bay, 29 April 1876, AJHR, 1876, H-4, p. 7, and 1887, H-9, p. 3.
\textsuperscript{123} Inspector and Colonial Surgeon, Taranaki to Colonial Secretary, 27 June 1872. AJHR, 1872, G-27, p. 5; AJHR, 1880, H-6, p. 11.
\textsuperscript{124} Provincial Superintendent, Southland to Provincial Superintendent, Otago. 16 March 1869. OP 7/52, L. 9866/1 and 5 July 1869, OP 7/52, L. 9866/4.
\textsuperscript{125} Colonial Secretary to Resident Magistrate, Lyttelton, 5 September 1853, CH 287, L. 1853/61; Provincial Superintendent, New Plymouth to Colonial Secretary, 24 October 1853. IA 1/107, L. 32437.
without a transfer order, escort, or due notice. C.B. was ‘chained like a savage animal sent to a menagerie’ on the voyage.\footnote{I}{Inspector’s report, Otago, 25 June 1872, AJHR, 1872, G-27, p. 21. C.B. was a determined escapee. To prevent him from rushing the door of his room, he was hobbled by the leg. The Visiting Justices strongly criticized this practice, and the Government then instructed the Keeper to have him removed to Dunedin. Keeper, Nelson to Provincial Secretary, 28 December 1871, NP 7/3/a, Unregistered Letter. For another instance, see Inspector’s report, Hawke’s Bay, 7 June 1874, AJHR, 1874, H-2, p. 4.}

In 1871, Captain T. Fraser, M.L.C. (Otago) claimed, with some justification, that the central government knew nothing whatever about the internal management or discipline in public institutions, and the provincial governments knew just as little!\footnote{II}{Capt. T. Fraser (Otago) was also Inspector of Asylums, NZPD, 7 September 1871, 10, p. 296.} With very little national coordination or direction, considerable discrepancies emerged in the staff ratios, institutional size, the average cost of care and levels of pay in provincial asylums. Truly comparative data is unavailable before the central government appointed commissioners to obtain financial planning information before the provinces were abolished.\footnote{III}{The exceptions are general summaries of expenditure by provincial governments (1862-) and limited patient throughput figures (1873-) that were published without comment in the annual Statistics of the Colony New Zealand from those years. These figures have been used as appropriate in Table 1.} The information then assembled, some of which is given in Table 1, showed that more populous South Island was better served. At 7s.1d. per capita expenditure on these services was far higher in the South Island than North Island provinces (4s.10d.) Wealthy South Island provinces spent on average 18.4 per cent of their budget on health and welfare services (including asylums). Canterbury and Otago were South Island provincial asylums more generously bedded relative to the general population (2.9:1000) than their North Island counterparts (2.35). Two-thirds of the colony’s asylum beds were in the South Island, which had about 60 per cent of the population in the 1870s. The information available on asylum staffing ratios must be interpreted very cautiously. For example, no information is available about the number of hours spent in clinical contact by visiting medical officers. Auckland’s resident medical officer probably provided greater patient contact than visiting medical staff in other provinces.
SUNNYSIDE LUNATIC ASYLUM, CHRISTCHURCH (1863)

Sunnyside Asylum and the Superintendent's residence, c. 1870.
A game of cricket is being played in the field.
(Canterbury Museum, Negative 5130.)

Edward and Esther Seager, first Superintendent and Matron.
(Madeleine Seager, 'Edward William Seager: Pioneer of Mental Health', Waikanae, p. 59.)
The original Dunedin Asylum, c. 1863, before it was greatly enlarged to meet requirements of Otago's population explosion during the gold rushes.


James Hume, Superintendent of the Dunedin Lunatic Asylum (1863-82)

This photograph was taken after fire swept through the building on 20 September 1877. The west wing of the asylum was not yet completed, which meant that 163 patients were crowded into accommodation intended for 75.

(Auckland Public Library, Negative 306)
HOKITIKA LUNATIC ASYLUM (1872)

Female wing during demolition (1923).
(Seaview Hospital collection)

Hugh and Winifred Gribben, first Superintendent and Matron, 1872-1904.
(Warwick Brunton, 'Sitivation 125: A History of Seaview Hospital, Hokitika, and West Coast Mental Health Services 1872-1997', Hokitika, 1997, p. 16.)
NELSON LUNATIC ASYLUM (1876)

Nelson Lunatic Asylum shortly after opening.  
(Author’s collection)

Main entrance and female wing, c. 1900.  
(Alexander Tumbull Library, Tyree Collection, Reference 160)
### TABLE 1
COMPARATIVE INFORMATION ON NEW ZEALAND LUNATIC ASYLUMS (1876)

<table>
<thead>
<tr>
<th>Province</th>
<th>Auckland</th>
<th>Taranaki</th>
<th>Hawke's Bay</th>
<th>Wellington</th>
<th>Nelson Marlborough</th>
<th>Canterbury</th>
<th>Westland</th>
<th>Otago</th>
<th>N.Z.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expenditure</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1874 Non-Maori Population</td>
<td>67,451</td>
<td>5,465</td>
<td>9,228</td>
<td>29,790</td>
<td>22,558</td>
<td>6,145</td>
<td>58,775</td>
<td>14,860</td>
<td>85,113</td>
</tr>
<tr>
<td>Province % N.Z. Population</td>
<td>22.5</td>
<td>1.8</td>
<td>3.1</td>
<td>9.9</td>
<td>7.5</td>
<td>2.1</td>
<td>19.6</td>
<td>5.0</td>
<td>26.4</td>
</tr>
<tr>
<td>Medical/Charitable Expenditure</td>
<td>13,959</td>
<td>1,279.0</td>
<td>2,891.3</td>
<td>6,064.4</td>
<td>8,181.9</td>
<td>1,278.8</td>
<td>26,789.3</td>
<td>7,347.5</td>
<td>18,821.21</td>
</tr>
<tr>
<td>Total Provincial Expenditure</td>
<td>156,038</td>
<td>22,031.2</td>
<td>59,514.2</td>
<td>130,715.3</td>
<td>62,375.5</td>
<td>15,125.2</td>
<td>771,350.5</td>
<td>53,883.7</td>
<td>722,220.49</td>
</tr>
<tr>
<td>% Provincial Expenditure</td>
<td>9.7</td>
<td>17.2</td>
<td>20.6</td>
<td>18.7</td>
<td>7.6</td>
<td>11.8</td>
<td>26.8</td>
<td>7.3</td>
<td>.38.4</td>
</tr>
<tr>
<td>Med./Char. £ per capita</td>
<td>0.21</td>
<td>0.23</td>
<td>0.31</td>
<td>0.23</td>
<td>0.36</td>
<td>0.21</td>
<td>0.49</td>
<td>0.49</td>
<td>0.22</td>
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### Asylum Beds

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<tr>
<th></th>
<th>Auckland</th>
<th>Taranaki</th>
<th>Hawke's Bay</th>
<th>Wellington</th>
<th>Nelson Marlborough</th>
<th>Canterbury</th>
<th>Westland</th>
<th>Otago</th>
<th>N.Z.</th>
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</thead>
<tbody>
<tr>
<td>Asylum Beds</td>
<td>162</td>
<td>12</td>
<td>23</td>
<td>69</td>
<td>54</td>
<td>-</td>
<td>197</td>
<td>48</td>
<td>220</td>
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<tr>
<td>Beds : 1000</td>
<td>2.4</td>
<td>2.2</td>
<td>2.5</td>
<td>2.3</td>
<td>2.4</td>
<td>-</td>
<td>3.4</td>
<td>3.2</td>
<td>2.6</td>
</tr>
<tr>
<td>% Asylum Beds in N.Z.</td>
<td>20.6</td>
<td>1.5</td>
<td>2.9</td>
<td>8.8</td>
<td>6.9</td>
<td>-</td>
<td>25.1</td>
<td>6.1</td>
<td>28.0</td>
</tr>
<tr>
<td>Average No. Resident</td>
<td>163</td>
<td>1</td>
<td>17</td>
<td>72</td>
<td>46</td>
<td>-</td>
<td>177</td>
<td>50</td>
<td>222</td>
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### Staff Nos:

<table>
<thead>
<tr>
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<th>Auckland</th>
<th>Taranaki</th>
<th>Hawke's Bay</th>
<th>Wellington</th>
<th>Nelson Marlborough</th>
<th>Canterbury</th>
<th>Westland</th>
<th>Otago</th>
<th>N.Z.</th>
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</thead>
<tbody>
<tr>
<td>Visiting Medical Officer</td>
<td>-</td>
<td>0.5</td>
<td>20.5</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>70.5</td>
<td>1</td>
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<tr>
<td>Resident M.O.</td>
<td>1</td>
<td>-</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>-</td>
<td>1</td>
<td>-</td>
<td>?</td>
</tr>
<tr>
<td>Superintendent</td>
<td>1</td>
<td>-</td>
<td>21.0</td>
<td>1</td>
<td>1</td>
<td>-</td>
<td>1</td>
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<tr>
<td>Matron</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>1</td>
<td>-</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Head Attendant</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>-</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Male Attendants (Day)</td>
<td>11</td>
<td>?</td>
<td>1</td>
<td>8</td>
<td>4</td>
<td>-</td>
<td>12</td>
<td>4</td>
<td>11</td>
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### Female Attendants

<table>
<thead>
<tr>
<th>Location</th>
<th>Day</th>
<th>Night</th>
<th>Total</th>
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<tbody>
<tr>
<td>Auckland</td>
<td>8</td>
<td>?</td>
<td>8</td>
</tr>
<tr>
<td>Taranaki</td>
<td>1</td>
<td>?</td>
<td>1</td>
</tr>
<tr>
<td>Hawke's Bay</td>
<td>4</td>
<td>?</td>
<td>4</td>
</tr>
<tr>
<td>Wellington</td>
<td>1</td>
<td>?</td>
<td>1</td>
</tr>
<tr>
<td>Nelson</td>
<td>8</td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td>Marlborough</td>
<td></td>
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<tr>
<td>Canterbury</td>
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<td>Otago</td>
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<td></td>
</tr>
<tr>
<td>N.Z.</td>
<td></td>
<td></td>
<td>N.A.</td>
</tr>
</tbody>
</table>

#### Notes:

1. N.A. means information not available.
2. Medical/Charitable includes hospitals, asylums, medical and charitable relief.
3. Total provincial expenditure includes public works.
4. Expenditure is expressed in £.
5. Asylum beds may include shakedowns.
6. Time allocation for visiting medical officers is an estimate.
7. Excludes one night nurse at Auckland, a night watchman at Wellington, and a night attendant at Christchurch.
8. The Hawke's Bay asylum superintendent was also the gaoler.

### Sources:

AJHR, 1876, A-4, pp. 48, 69, 75, 80, 83, 88, and 1876, H-8, p. 11; Statistics of the Colony of New Zealand, Wellington, 1876, p. 57; Auckland Votes and Proceedings, 1875, 30, B-7, p. 3; Otago Votes and Proceedings, 1876, 34, p. 16.
Variable standards were sometimes attributed to lay management, which, Dr M.S. Grace told the Legislative Council, deprived lunatics of the 'fruits of medical science'. Keepers or superintendents lacked the 'special capacity for the work' to achieve a high rate of cures. Grace's claim was somewhat unfair, as witness, for example, the tribute of visitors who favourably compared Sunnyside Asylum with overseas institutions. From his own observation of lunacy management in New Zealand, Lindsay concluded that 'humane, modern and enlightened views' pervaded 'all classes of their officials; and every disposition existed to imitate, if not to rival, in their arrangements, the asylums of the home country.' Those officers were generally overworked and underpaid, he claimed, whereas an efficient asylum saw to it that all classes of officer were maintained in the 'utmost vigour both of mind and body, which can only be effected by liberal expenditure, and a proper recognition of their social rights and status.

Although Lindsay's visit preceded the appointment of the long-serving Hume, Seager and Gribben, each fitted Lindsay's description of capable, conscientious officers. In 1870, Hume was working from 6 a.m. to 10 p.m. each day and he often slept in his office. He had to get up three or four nights a week to attend to patients. The Seagers were driven to the 'indulgence' of mixing with general society for relief from the incessant pressures of the job. The vision, management capability and an effective working partnership between lay and medical officers enhanced the reputation of Sunnyside, Dunedin and Hokitika Asylums.

Exemplary leadership qualities were not so evident elsewhere. Difficulties arose if authority was not defined or leadership asserted, as at Auckland in 1871. Nelson's medical officers, S.A. Cusack (1863-1868) and T.S. Vickerman (1865-68)
admitted that little was attempted in the way of treatment. Cusack confided that ‘medical men who have had much to do with lunatics, know that little can be done by medicine for their cure’ because ‘common sense and good temper’ were the chief qualifications needed for asylum management. Nevertheless, Crawford, the Keeper at Nelson (1863-66), attributed therapeutic success to ‘God’s divine Blessing attending the means used and the very superior skill and attention of the Medical officers who carefully watch over the asylum’. To compensate for the weekly medical attendance, Crawford had to keep an institutional diary. Eight months after the diary began, Crawford was asked to resign for his harsh and improper treatment of patients. His successor, T. Butler, quickly asserted his own authority and suggested improvements. Amid a deteriorating physical environment, he was enjoined to avoid the appearance of restraint as much as possible while ensuring safe custody. He was also instructed to always grant any favour or indulgences recommended by the medical officer. Using his discretion, Butler resorted to handcuffs instead of straitjackets, claiming full authority over everything relating to custodial responsibility and discipline. The ‘zealous’ medical officer, however, held himself responsible for everything directly or indirectly affecting the health and cure of the lunatics. There were no clear instructions to interpret these roles. The Keeper’s standpoint was substantiated by the practice of channelling official correspondence to the Keeper and not the Medical Officer. The provincial authorities

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135 Drs S.A. Cusack and T.S. Vickerman to Provincial Secretary, 15 March 1865, NP 7/13, L. 65/156.
137 Keeper to Provincial Secretary [annual report?], 9 March 1866, NP 7/14b, L. 66/144.
138 Emphasis in original.
139 See W.A. Brunton, ‘Hospital or Prison? Some Attitudes at the Nelson Lunatic Asylum’, Comment, 31 (1967), pp. 19-23 for a record of institutional life based upon the Keeper’s Journals. A similar diary was kept at Dunedin Asylum (1863-4) and Sunnyside Asylum. See Steward to Provincal Secretary, 4 March 1864, CH 287, L. 743/64 and Proposed Rules of Sunnyside Asylum, December [?1864, CH 287, L. 2666/64. The Sunnyside diary has not survived.
139 Provincial Superintendent to Keeper, 21 November 1866, NP 7/16a, L. 65/828; Report on Crawford’s petition in Nelson Evening Mail, 20 July 1867.
139 Annual report, Nelson Votes and Proceedings, 1867-8, 18, p. 7; Keeper to Provincial Secretary, 5 and 21 September 1867, NP 7/17, L. 67/796 and L. 67/836; Visiting Justices to Provincial Secretary, 26 September 1867, NP 7/17, L. 67/849. Attendant E. Weadson then offered her resignation to the Provincial Secretary, 15 October 1867, NP 7/17, L. 67/900a.
140 Provincial Secretary to Master [Keeper], 5 October 1869, Miscellaneous official correspondence stored with patient files, NMAMHS records.
141 Annual report, Nelson Votes and Proceedings, 1868, 19, p. 32.
142 Visiting Justices to Provincial Superintendent, 27 July 1870, NP 7/24, L. 70/675.
declined to sanction the Medical Officer’s liberty in styling himself ‘Medical Superintendent’ which would ‘materially strengthen the position of the Medical officer [sic] until such time as regulations for all Asylums in the Colony are issued.’

Management difficulties affected the quality of care, but the watchful eye of provincial governments on public expenditure and priorities also made for variable standards in the country’s asylums. Otago’s inspector decried the extent to which asylums were resourced as ‘a reflex of the varying fortunes of the Provincial treasury.’ To this, he might correctly have added goldfields, population size, land revenues, and economy of scale. All of these helped make asylums of the lower South Island the best in the country.

If governments would not provide adequate or appropriate facilities, it became difficult for asylum staff to fully adopt the non-restraint system. Nelson and Auckland illustrate the difficulties. Advice that a purpose-built asylum was needed at Nelson went unheeded until there was absolutely no chance of a central asylum proceeding. By 1869 the roof leaked and it was difficult to classify male and female patients. The Taranaki Buildings were not repaired from 1871-4. In desperation the Keeper invited the Provincial Secretary to see conditions for himself. Many of the timbers were nothing but dust and the whole place swarmed with bugs. Butler disclaimed responsibility for safe custody of the patients. Periodic directions to tighten security and prevent escapes understandably confused Butler.

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1 Medical Officer to Provincial Secretary, 15 November 1876, NP 7/46, L. 76/1659.
2 Inspector, Otago to Provincial Superintendent, 14 (?) July 1875, OP 7/77, L. 13603/6.
3 Medical Officer to Provincial Secretary, 11 February 1869, NP 7/20b, L. 69/134.
5 Annual report, Nelson Votes and Proceedings, 1869, 19, p. 32.
6 Keeper to Provincial Secretary, 10 December 1874, NP 7/37, L. 74/1684 and 11 January 1875, NP 7/38, L 75/51; Keeper to Provincial Superintendent, 27 May 1875, NP 7/40, L. 75/905.
7 Provincial Secretary to Keeper, 17 September 1869, and reply, 4 October 1869, Provincial Secretary to Keeper, 26 January 1872, Patient’s File No. 52, NMAMHS records. In consultation with the Provincial Engineer, some agreement was reached on the security measures to be made. Provincial Engineer to Provincial Secretary, 22 October 1869, NP 7/22, Unregistered letter.
The partially completed Whau Asylum was gloomy. Patients dressed in garb similar to that worn by convicts, which added to a sense of degradation for many patients. Conditions of service were hard. The Government would not take on a fourth female attendant from the want of funds, although temporary relief allowed the eldest nurse to take her first holiday in five years. Overworked staff could not give the same amount of care as they would wish. They just kept going, it seemed, because if one dropped from over-fatigue, the other two could not cope. One female attendant to an average of 15 patients was simply not sustainable. Above all else, overcrowding limited the quality of care. The Medical Superintendent could handle overcrowding equal to the number of beds (50), but with 142 patients, ‘the day-rooms, corridors, and every available space were called into requisition for sleeping accommodation’. The lack of single rooms for dangerous patients was very serious. He was surprised that no serious accident had occurred. The obvious answer was to complete the building according to the original plan, but the provincial government would not do so. It would not even sanction a lean-to block for male patients so the chapel was converted into a 25-bed dormitory.

More than any other provincial lunatic asylum, Karori epitomized management and political difficulties. Despite its reasonable proximity to Wellington city, the road was virtually impassable in winter. Physical conditions were modest at best. At worst, they were primitive and Spartan. An official inquiry in 1867 showed that the provincial government had not implemented recommendations from another inquiry a decade earlier, nor had it spent votes for capital improvements. In 1867, the ‘decayed and worm eaten’ premises still had to last for another five years. There

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8 Asylum annual report, Auckland Provincial Government Gazette, 18 April 1874, p. 50; AJHR, 1874, H-1, p. 4.
12 Resident Medical Officer to Provincial Superintendent, 20 May and 7 October 1875, AP 2/37, L. 1600/75 and L. 3081/75; H. Lloyd to Provincial Superintendent, 16 June 1874, AP 2/37, L. 2023/74; Inspector’s report to Provincial Superintendent, 21 May 1875, AP 2/37, L. 1624a/75; Resident Medical Officer to Inspector, 19 June 1875, AP 2/37, L. 1984/75.
13 Prendergast’s report, 24 November 1858, H 30/21; Medical Officer in evidence, 20 September 1871, AJHR, 1871, H-10, p. 8.
were too few staff and the grounds were not properly secure which meant that a number of patients had to be confined to their rooms.\textsuperscript{15}

Significant therapeutic limitations were hinted at when an 1857 inquiry recommended funding for a competent medical man who could live nearby.\textsuperscript{16} By the early 1860s, conditions were reported to have improved, with good superintendence and minimal use of restraint.\textsuperscript{17} The Master and Matron, Mr and Mrs Sutherland, had a long partnership (1858-72) with the new Visiting Medical Officer, Charles France (1861-81) but France basically wrote off the patients as incurable.\textsuperscript{18} In 1868, the Visiting Justices pointedly 'impressed on everyone who has any charge of the Asylum, that it is the cure and not the mere custody of the patients that demands their first and most constant care.' They could not fault the bodily care of patients but there was nothing like 'a systematic and persevering effort for the recovery of their reason.'\textsuperscript{19} No notice seems to have been paid to this criticism. Lack of professional or management: leadership was cloaked behind the unsuitability of the site and the incurability of the patients\textsuperscript{20} and France's unheeded recommendation that a new site be chosen.\textsuperscript{21} France was said to have held the resident staff responsible for curative treatment even though they were 'uneducated, and not at all capable to administer curative treatment.' The patients were largely left alone 'and sometimes nature has reasserted itself.'\textsuperscript{22} France regarded his twice-weekly routine visits as 'inspectorial, because hardly anyone else goes.'\textsuperscript{23}

\textsuperscript{17} Reports relating to the Lunatic Asylum at Karori, 23 October 1861, Wellington Acts and Proceedings, 1861, 9.
\textsuperscript{21} Medical officer's evidence to Joint Parliamentary Committee, 20 September 1871, AJHR, 1871, H-10, p. 8.
\textsuperscript{22} A. Johnston (former medical officer) Evidence to Joint Committee, 19 September 1871, AJHR, 1871, H-10, pp. 1-2.
\textsuperscript{23} He also visited whenever patients were physically sick. Evidence to Joint Committee, 20 September 1871, AJHR, 1871, H-10, p. 8.
The central government stepped warily into the minefield of provincialism from the mid-1860s. Immediately after receiving a report of a joint conference of both Houses on the Lunatics Bill 1866, the Legislative Council resolved that the Government should introduce a consolidation and amendment of existing lunacy law the following year. The resulting enactment was comprehensive and contained 193 sections. The Lunatics Act 1868 prescribed uniform standards of documentation and reporting that closely followed the English legislation of 1845. The management of patients' estates was carefully regulated. Medical and management requirements for public asylums and licensed houses were specified. Requirements for official visitation and inspection of asylums were spelt out. Offences and penalties were imposed for wrongful detention, making a false certificate, making an untrue statement in a licence application, ill-treating a lunatic or allowing a lunatic to escape.

The level of detail in the Lunatics Act 1868 amplified the principles of previous colonial legislation but these were invariably sourced not to antecedent New Zealand law but to relevant English statutes. No doubt to Lindsay's chagrin, the timetable imposed upon the government by the Legislative Council resolution gave little choice but to borrow extensively from English precedent. The Bill was one of a mammoth 120 Bills introduced during 1867. That was a particularly busy year for borrowing from English technical law according to a history of New Zealand law. Statutory imitation had some significant advantages for a colonial government. The resulting statutes could be assumed to be effective and could be produced at a low cost when legal resources were scarce. Less experience and ability were needed to adapt some other statute than to draft original legislation. Less time might be needed to

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24 Motion of J.B.A. Acland (Canterbury), NZPD, 3 October 1866, p. 1029.
25 E.g., committal orders, medical certificates, licence (for a licensed house), summons, statutory registers and notices of admissions, discharge or death, medical journal and visitation book.
26 Lunatics Act 1868, Part VI.
27 Lunatics Act 1868, ss. 23, 29.
28 Lunatics Act 1868, ss. 52-63.
29 Lunatics Act 1868, ss. 33, 47, 189, 191-192.
30 Lindsay, Suggestions, p. 488. In 'Lunacy Legislation', pp. 517-8, Lindsay emphatically argued that 'over-legislation will be the inevitable result of taking, as a model for a colony, the Lunacy Statutes of either England, Scotland, or Ireland.' Lindsay favoured the simplicity of legislation in some American states or Norway.
scrutinize the end product. Borrowing could provide convenient arguments in colonial political disputes and in correspondence with British authorities.\textsuperscript{32}

Exposés of the conditions at Karori Asylum accelerated the trend towards national administration. Dr A. Buchanan instigated a Parliamentary Committee upon Lunatic Asylums (1871) from his place in the upper house.\textsuperscript{33} He intended to make out such a case as to convince the General Government of the necessity of assisting to put Lunatic Asylums in a much better condition than they now are. We want evidence for that.\textsuperscript{34}

Information about the poor conditions at Karori were just what Buchanan and his reforming colleagues needed to recommend that 'whilst steps should be taken to improve all the Asylums of the Colony, the state of that at Karori, near Wellington, urgently requires immediate attention and reform.'\textsuperscript{35} Publicly, Buchanan said that no slur for the sorry state of affairs should be cast on the provincial authorities nor on those immediately in charge, but it would be 'a blot on humanity' if the colonial government failed to remedy things.\textsuperscript{36} Privately, however, Buchanan admitted that the 'miserable, small, wooden hovel' of an asylum had been the skeleton in Wellington's closet for many years.\textsuperscript{37} Nothing might have happened to change this state of affairs had the provincial government not been obliged to formally inquire into allegations of unnecessary violence. The husband and wife keeper and matron were criticized for their lack of training. The public inquiry placed responsibility upon the 'Medical Officer in-charge'. 'More searching' management supervision was required.\textsuperscript{38}

\textsuperscript{32} Peter Spiller, Jeremy Finn and Richard Boast, \textit{A New Zealand Legal History}, Wellington, 1995, pp. 79, 85, 110.
\textsuperscript{33} This was originally a Select Committee of the Legislative Council but became a Joint Committee when the House of Representatives agreed to participate.
\textsuperscript{34} AJHR, 1871, H-10, p. 9.
\textsuperscript{35} AJHR, 1871, H-10, p. 1.
\textsuperscript{36} AJHR, 1871, H-10, p. 10.
\textsuperscript{37} Lindsay, Lunacy Legislation, p. 499.
To understand why the demand for national uniformity among asylums arose when it did, lunacy policy must be placed in the context of overall relationships between provincial and central governments. Grey's constitutional manoeuvrings of 1852-3 created an ambiguity that bedevilled public administration throughout the entire provincial period. Administrative confusion reigned generally, Polaschek says, because the provinces wanted control without cost, an attitude whose essential selfishness was suicidal. The practice of delegating to provinces the administration of statutes that they could not amend also caused endless friction, perpetuated the confusion, and delayed the emergence of a unified departmental structure.39

The Joint Committee showed that statutory specification of standards alone could not guarantee compliance and consistency, largely because administration of the Act was delegated to the provinces. The Governor was largely written out of the 1868 Act, in part because responsible government had been introduced in 1856. His roles were transferred to the Colonial Secretary, as befitted the seniority of the portfolio at that time. According to the Royal Commission on the Civil Service (1866), the Colonial Secretary's Department was responsible for 'the general business of the Government, and especially of such as is transacted with Provincial Governments in New Zealand, and with Colonial Governments.' The Office was the general go-between Ministers, between the Executive, Legislature and other departments.40

Central government interference in provincial administration of lunacy matters was moderated by three factors. Firstly, the powers of the Governor or Colonial Secretary were delegated to provincial superintendents immediately the Lunatics Act 1868 was passed.41 Not to have done so would have bought a fight between the two levels of government.42 Canterbury's Superintendent thought that confusion was created between colonial officers, provincial authorities and the Governor's delegate (provincial superintendent) under the Act.43

40 AJHR, 1866, D-7a, p.5.
41 Lunatics Act 1868, s. 4; New Zealand Gazette, 2 December 1868, pp. 589-91.
42 T. Macfarlane (Northern Division) and E.W. Stafford (City of Nelson), NZPD, 18 August 1866, 2, pp. 508-9.
43 Provincial Superintendent, Canterbury to Joint Committee on Lunatic Asylums, 28 September 1871, AJHR, 1871, H-10, p. 12.
Secondly, no Regulations were made under the Act on matters that could be considered standards of care.\textsuperscript{44} For example, the cost of care was not regulated centrally beyond establishing the principle that families or estates were liable for maintenance costs in an asylum. The state bore the cost of care in hospital (until 1868) or gaol care.\textsuperscript{45} The Lunatics Act 1868 authorized the Governor-in-Council to promulgate a scale of fees, but this was not done. Provinces therefore set their own.\textsuperscript{46} The Colonial Secretary's Office occasionally published guidelines but these were not enforceable. One such exhorted the sending of suspected lunatics directly to a lunatic asylum rather than a gaol wherever possible.\textsuperscript{47} In 1875, the Colonial Secretary's Office published for general information the rules of Sunnyside Asylum, at the request of the Superintendent of Canterbury.\textsuperscript{48}

Thirdly, after 1870 the Colonial Secretary's Office coordinated and published the reports of provincial inspectors of lunatic asylums. These reports clearly showed how the fluctuating finances, diverse fortunes and uneven development of public works in the provinces impacted on the standard of care. In spite of the mounting evidence of variable standards, however, D. Pollen, Colonial Secretary (1873-6), took the view that Parliamentarians could collect information and advise where it would not cause offence, presumably to the provinces. Public opinion alone should force the hands of provincial governments.\textsuperscript{49} Direct intervention by the Colonial Secretary, therefore, was very rare. More than a year after the delegation of statutory powers, Nelson still had no Inspector, the Provincial Superintendent having interpreted the law as contemplating the appointment of a national salaried inspectorate.\textsuperscript{50} No inspection report from Nelson was tabled until 1875\textsuperscript{51} but the dereliction went unheeded. Patient safety was the only area where central government rarely intervened, as with the cost of a telegraph link between Sunnyside Asylum and fire

\textsuperscript{44} Lunatics Act 1868, s. 188.
\textsuperscript{45} Lunatics Ordinance, ss. 10-1; Lunatics Act 1868, s. 14.
\textsuperscript{46} E.g., \textit{Westland County Council Proceedings}, 24 June 1870, 7, p. 40 and 2 February 1871, 8, p. 25; \textit{Journal of the Auckland Provincial Council}, 1862, 22, A-2, p. 4, 10 February 1870, 25, p. 38 and 3 November 1870, 26, p. 11
\textsuperscript{47} \textit{New Zealand Gazette}, 21 August 1871, p. 477.
\textsuperscript{48} \textit{New Zealand Gazette}, 10 February 1875, pp. 123-8.
\textsuperscript{49} NZPD, 7 August 1874, 16, p. 477.
\textsuperscript{50} Provincial Superintendent, Nelson to Colonial Secretary, 9 March 1870, AJHR, 1870, D-29, p. 8.
\textsuperscript{51} AJHR, 1875, H-2A, pp. 1-3.
and police stations,\textsuperscript{52} or with pressing the Wellington provincial government to prosecute former staff for ill-treating patients.\textsuperscript{53}

The laissez-faire attitudes of Ministries directed attention towards medical management and a national inspectorate as the principal means for improving national standards. The Parliamentary Joint Committee urged that a duly qualified medical officer from the United Kingdom, with ‘special knowledge and experience in the treatment of the insane’ be forthwith appointed to ‘have supervision and control of all lunatic asylums’.\textsuperscript{54}

A national inspectorate avoided ruffling provincial feathers by the threat of transferring asylums to central government control.\textsuperscript{55} The concept increased the chances of achieving greater uniformity,\textsuperscript{56} and it could conceivably save the central government the cost of capital upgrading.\textsuperscript{57} The position was only established, however, after a hard fight. W. Fox, Premier (1869-72 and 1873), said he supported an inspection system, but his government would not fund the position,\textsuperscript{58} which Opposition Members called an example of ‘bland remarks and vague promises’ from the Ministry.\textsuperscript{59} Buchanan and Fraser in particular kept up the pressure for a national inspectorate. They pointed to Australian precedents and reminded the Legislative Council of the unsatisfactory conditions in North Island asylums in particular.\textsuperscript{60}

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\item Evening Post, 16 and 23 May 1872.

\item AJHR, 1371, H-10, p. 1.

\item H. Sewell (Wellington), NZPD, 7 September 1871, 11, p. 298.

\item G.M. O’Rorke (Onehunga), NZPD, 13 September 1871, 11, p. 392.

\item This was the implication of remarks made about the penurious state of some of the provinces. G.M. Waterhouse (Wellington), Capt. W.H. Kenny (Auckland), and J.A. Bonar (Westland), NZPD, 12 August 1873, 14, pp. 365-6.

\item NZPD, 13 September 1871, 10, p. 395, G.M. Waterhouse (Wellington), G.S. Whitmore (Hawke’s Bay) and H. Sewell (Wellington), NZPD, 31 October 1871, 11, pp. 661-2; Lindsay, Lunacy Legislation, pp. 499-501.

\item Capt. W.H. Kenny (Auckland), NZPD, 12 August 1873, 14, p. 365.

\item NZPD, 31 October 1871, 11, p. 660, 23 July 1872, 12, p. 51, 12 August 1873, 14, p. 362, and 7 August 1874, 16, p. 473.
\end{itemize}
The recommendation was referred to the government\textsuperscript{61} but the shaky Waterhouse and Fox Governments procrastinated. Dr E. Paley, Inspector of Lunatic Asylums in Victoria, was brought in as an overseas expert\textsuperscript{62} to revisit the Joint Parliamentary Committee’s recommendations. The report was not published until 1874.\textsuperscript{63} This report quashed further progress on a central asylum, with reasons that had already been advanced.\textsuperscript{64} The main recommendations, however, only strengthened the case of the reformers. Paley urged the government to appoint a duly qualified medical practitioner with knowledge and experience of the treatment of the insane and of asylum management as inspector of all the asylums, with support from salaried local inspectors. He recommended that a medical superintendent should run an asylum with more than 100 patients. Paley also recommended attendant-patient staffing ratios. His suggestion of salary and superannuation entitlements for staff hinted at a future national career service.\textsuperscript{65}

Only at that stage did the government, now headed by Vogel, include provision for an inspector’s salary in the 1874 Estimates.\textsuperscript{66} Financial provision would have been a contingency for likely future government administration given Vogel’s determination to be rid of the provinces altogether. Pollen, the Colonial Secretary, was a medical practitioner and sympathetic to a national inspectorate.\textsuperscript{67} The government set about recruiting a suitable alienist from the United Kingdom as the Inspector-General, with

\textsuperscript{61} Speaker, Legislative Council to Colonial Secretary, 17 October 1871, IA 1/299, L. 1871/3248.
\textsuperscript{62} Paley had extensive experience in English county asylums and licensed houses before being appointed Superintendent of Yarra Bend Asylum in 1863 on the recommendation of the English Lunacy Commissioners and Conolly. From 1867-83, he was Inspector of Asylums. Paley held progressive views on classification, voluntary admission, boarding out, after-care, and asylum size and construction that were ahead of their time. See Brothers, pp. 66, 85, 129-30.
\textsuperscript{63} NZPD, 23 July 1872, 12, p. 51, 18 October 1872, 13, p. 773, 30 July 1873, 14, p. 147, and 10 September 1873, 15, p. 983.
\textsuperscript{64} AJHR, 1874, H-1, p. 1. Cf. AJHR, 1877, H-8, p. 7.
\textsuperscript{65} AJHR, 1874, H-1, p. 9. Paley’s message was consistent with that of the Royal Commission of Inquiry into the Civil Service in 1866. That body found that the lack of systematic organisation of government administration resulted in confusion and irregularity. ‘Appointments, pay and promotion depend more upon fortuitous events than on settled principles’, the Royal Commission reported. AJHR, 1866, D-7, p. 2.
\textsuperscript{66} NZPD, 28 July 1874, 16, p. 270. Vogel may have been reminded of his unsuccessful attempt to persuade the Otago Provincial Council to appoint a medical superintendent to the Dunedin Asylum. Otago Votes and Proceedings, 24 and 29 September 1863, 17, pp. 119, 130.
\textsuperscript{67} NZPD, 12 August 1873, 14, p. 383.
some help from the English Commissioners in Lunacy. Dr Frederick W.A. Skae was appointed in July 1876. A new and post-provincial era was about to begin.

CONCLUSION

This chapter has shown that as improvised care in gaols and hospitals was condemned, settlers looked to the lunatic asylum as the progressive and humane model of care. The asylum ideal came with the colonists from the United Kingdom. Opinion-makers and policy-makers looked to imported ideas and models for inspiration. The lunacy reform movement in Britain had identified the lunatic asylum with progressive practice. The asylum was synonymous with proper care for a distinct class of human suffering that was neither criminal nor sick.

New Zealand preferred the English model to the Scottish mixed model of boarding out and institutional care. Although both options were available at a formative stage of development, by the end of the Crown colony era, the Scottish model was being sidelined. By 1846, the concept of the lunatic asylum was embedded in the first colonial lunacy legislation. The concept reappeared in 1858 and in the early 1870s as a proposal for a central lunatic asylum. The concept was realized, however, in the network of lunatic asylums that was established in the principal settlement of most of the main provinces between 1853-76.

With the fundamental direction of care settled, other policies filled in the detail. The state took on the responsibility to provide asylums because of the nature of the task, the background of the clientele, and the lack of alternative institutions to sustain viable alternatives. Even when a place for private asylums was legitimated in 1868, there were no immediate bids. From the outset, asylums were influenced by the powerful but vague colonial ideology of egalitarianism. Private sector development stirred memories and myths of the madhouse tradition. Asylums remained a state monopoly but arrangements under the 1852 constitution provided ample scope for central and provincial governments to haggle over their respective responsibilities.

AJHR, 1875, H-2b and 1876, H-4c.
This was reflected in the protracted debate about a central lunatic asylum. As the debate waxed and waned, all but the smallest provinces built their own special purpose lunatic asylum.

Lunatic asylums were distinctive institutions in their location, architecture and management. They also offered buildings and programmes of variable quality. The principles of non-restraint were widely espoused, but not all asylums reached the high standards of asylums in Christchurch, Dunedin and Hokitika. In due course, the variability was blamed upon lay management but the variability also reflected badly upon the impoverishment, priorities and size of some provinces.

Lunacy policy was sucked into the shifting relationships of provincial and central governments in the face of national consciousness, improved transport and communications, growing provincial insolvency, and questions of national development. From the late 1860s, some politicians sought intervention at a national level to obtain greater uniformity and consistent standards. The Lunatics Act 1868 went some way towards creating a detailed national framework. It defined a number of standards and established some procedural and administrative uniformity. Because implementation of the Act was largely left to the provinces, however, the measure did not lead to the degree of national coordination sought by lunacy reformers to improve standards of care generally. Official reports of asylum inspectors were published after 1870. These revealed the variability of standards. A similar picture was painted by the Joint Parliamentary Committee inquiry of 1871, which had been set up to galvanize the central government into action. Statutory specification of standards was not of itself sufficient to guarantee compliance and consistency when administration of the Act was delegated to the provinces. If a central asylum was viewed increasingly as a dubious proposition, then a national inspectorate was a practical alternative.

The debate over a national inspectorate matured over several years until the laissez-faire attitudes of governments of the early 1870s were swept aside by the persistence of lunacy reformers in the Legislative Council, consistent advice from an overseas expert, and Vogel's bold decision to abolish provincial administration altogether. The
appointment of an Inspector-General thus became part of a new post-provincial system of government.
Mental health policy was formulated amid significant changes in constitutional arrangements and public administration during the Crown colony (1840-52) and provincial periods (1852-76). Some functions and powers of government administration, as well as their officials, were transferred to provinces. There were two provinces under the constitution of 1846, then six in 1852, and finally eight. Representative government was partially adopted during the first provincial period (1846-52) and fully implemented during the second provincial era (1852-76). During the latter period, the colony’s House of Representatives and unicameral provincial councils were elected legislative assemblies. Responsible government was introduced at national level in 1856 with subsequent attempts to apply the principle in some provinces. Under responsible government, officials advised ministers of the Crown or members of provincial executive governments and took instructions from them. Provincial and national politicians made the rules and set the budgets within which officials operated. This transition occurred within a wider shift of initiative and power from the legislature to the executive branch of government. In this chapter, I want to show who helped to shape mental health policy and what part they played in the process.

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1 New Ulster and New Munster.
2 Auckland, New Plymouth (later Taranaki), Wellington, Nelson, Canterbury and Otago were the original provinces. Hawke’s Bay and Marlborough were created in 1858-9. Southland had a short-lived separation from Otago (1861-70). Westland became an autonomous county council in 1868 and a full province in 1874.
INTEREST GROUPS

A group of officials of the Crown colony government was accountable for carrying out general directions formulated by their superiors or for using their initiative to devise pragmatic solutions to administrative problems in dealing with recorded cases of insanity. The original policy-makers comprised firstly, a core of government officials who encountered lunatics in the course of their work as local policemen, court officials, gaolers or medical officers. These local officials were essentially street level bureaucrats, to use Lipsky's term. The second group of policy-makers consisted of senior officials of the government to whom the first group reported. Under the Crown colony system, these were appointed officials but under representative government, these officials were elected politicians.

An array of concerned individuals and interests shared periodic concern about mental health policy beyond this circle. Other parties were non-official in the sense that they expressed views on policy, but they were not charged with the administrative responsibilities of the core group for official advice, decision-making and policy implementation. Public opinion was most clearly expressed through grand jury presentments, newspapers, local and medical interests. Newspapers and medical interests were the most influential. Philanthropy and public meetings played a more limited role. The boundary between an outer circle of interested parties and an inner circle of official decision-makers was not always clear-cut. Public watchdogs, notably grand juries, visiting justices and inspectors of asylums, were technically part of the machinery of government administration but they acted in an independent fashion and could be outspoken in their criticisms. Inner and outer circles interlocked periodically to make lunacy a hot national or provincial political issue.

Newspaper ownership, journalism and subscription were initially the preserve of politically prominent wealthier and high status citizens. From Crown colony times,

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3 Michael Lipsky, Street-Level Bureaucracy: Dilemmas of the Individual in Public Services, pp. xii-xiii, 84, 161-2.
the press provided a forum for airing settlers' political views and for conveying those views to the authorities and to other settlements.4 Lunatics were recipients of genuine concern but sometimes they were pawns in a political game for local self-government.5 A Wellington newspaper made the point clearly:

Fellow colonists, if you had the administration of your own affairs by means of your elected representatives, do you think these things would happen? Would there be no better provision made by you for those whom the security of society compelled you to deprive of liberty, but to whose suffering in this respect, humanity claims that you should add no unnecessary torture?6

Graphic and emotive reports about suffering individuals could be used to arouse public sympathy or to publicize a political agenda. In 1855, for instance, Nelson politician Dr David Monro wrote about S., a lunatic whom he found confined in Nelson Gaol in a cell bereft of anything except straw. Monro alleged that the man had sometimes been stripped of his clothes, even in winter. Being of Herculean proportions, the lunatic could shred even reinforced straitjackets.7 Stereotypical associations between violence and lunacy were certainly made in some newspapers before asylums were founded8 but these instances were far outweighed by a general impression of sympathy.

Doctors were a powerful influence on policy-making though a national medical lobby did not exist in New Zealand. Nevertheless, the collective contribution of doctors was considerable if the combined impact of medical officials, medico-politicians and

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5 E.g., *Nelson Examiner*, 15 February 1845; editorial, *Colonist*, Nelson, 2 February 1858; *West Coast Times*, 17 April 1866.


7 Dr D. Monro to Provincial Superintendent, 20 November and 8 December 1855, Nelson Provincial Archives, National Archives, Wellington, NP 7/1/b, L. 55/327 and L. 55/332; Provincial Superintendent to Dr D. Monro, 29 November 1855, NP 11/1, L. 55/327; *Nelson Examiner*, 27 February 1856. Monro's actions offended the Provincial Surgeon whose permission had not been sought to see the lunatic. Provincial Surgeon to Provincial Superintendent, 23 November 1855 and 3 January 1856, NP 7/1/b, L. 55/330 and L. 55/333.

medical practitioners who were officially consulted because of their supposed expertise in the field, is taken into account. Members with a medical qualification were invariably included on select committees and inquiries. Governments sought advice from specialist medical experts overseas. Individual doctors influenced policy by the number and type of person they certified as lunatics.

Some select committees canvassed medical opinion. For example, the 1858 Select Committee of the House of Representatives questioned Auckland doctors about their views on insanity and its management. Nelson's Select Committee on the Hospital consulted doctors about the desirability of attaching an asylum to a hospital. Only three of the eight doctors consulted agreed with that idea. The majority favoured a stand-alone asylum. The recommendations of the subsequent Select Committee on the Lunatic Asylum (1861) were given prominence by the endorsement of local medical practitioners and they were reinforced by the advice of one of the province's medical officers, S.A. Cusack, on asylum construction. Medical officials and witnesses invariably joined ranks in supporting medical management for asylums. Maybe, too, it was medical opinion that helped to swing the tide against the idea of a central asylum. Drs T.M. Philson and T.F. McGauran were certainly opposed to the idea. Relationships between medical officials and medical colleagues were sometimes strained. As early as 1840, Dr J.G. FitzGerald foresaw that a colonial medical officer would have to 'parry off the shafts of calumny' aimed by
'meddling acquaintances' or 'jealous rivals'. Incumbents in Wellington, Nelson and Otago were all dogged by professional politics.

Public meetings had some influence upon policy-makers. The small but 'most respectably attended' public meeting held at Auckland in January 1851 successfully called for a lunatic asylum to be established in the grounds of the hospital. A public meeting held at Hokitika in 1870 made a similar local appeal, but the meeting failed to persuade the government. One local newspaper commented that public meetings had limited political leverage. Meetings were only 'a momentary excitement' with little more than speeches and resolutions.

Philanthropy played a very small part in the establishment of asylums. New Zealand lacked a wealthy philanthropic class. 'Public' hospitals and lunatic asylums were accessible to Maori and Pakeha alike. To the extent that they were instruments of native policy, these institutions were regarded as a state responsibility. The state also discharged police functions, so that perceived links between lunacy and law and order reinforced the notion of state responsibility. In Nelson, Cusack regarded the issue as political rather than medical, but in the 'existing state of social and public feeling in this Colony' charity could hardly be enlisted for a hospital.

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17 Letter to Wellington *New Zealand Gazette and Britannia Spectator*, 16 May 1840.

19 For details of the meeting and its follow-up, see *New Zealander*, Auckland, 7 December 1850, 7, 15, 18 January, 19 and 23 April 1851.

20 In a distant echo of the way Auckland Gaol had been declared a house of correction to remove any doubt about the legality of confining lunatics and vagrants, so the Upper Gaol at Hokitika was gazetted as a lunatic asylum. See *West Coast Times*, 7 February 1870; *Westland County Gazette*, 7 February 1870, 5, p. 25.

21 Editorial, *West Coast Times*, 4 April 1870.

22 S.A. Cusack to Provincial Secretary, 13 September 1864, NP 7/12, L. 64/694. He may have been unaware of the form of voluntarism that emerged in the gold fields where subscription hospitals provided a form of accident insurance. Benevolent societies also developed charitable institutions in some settlements. Both of these types of institution were granted some management autonomy.
Auckland provided the only instance of significant charitable contribution. In 1851, £299.18s.3d. was raised by public subscription towards the cost of building the asylum-annexe. Analysis of the 107 subscribers shows that people in the professions or civil and military officials contributed nearly one-third, nearly half by businessmen and manufacturers, and a further 10 per cent from settlers or persons in agricultural pursuits. ‘Room for a benevolent investment’ was otherwise limited to recreational needs and spiritual solace. Contributions towards recreational items were sometimes canvassed through special concerts or balls. Fund-raising projects had to be tangible or have a human side, like the £30 raised to bring a Rangitikei woman to Karori Asylum. Less specific projects, like a chaplain’s salary, had limited appeal. Newspapers periodically appealed for public assistance with asylum recreation, which suggests that ‘the eccentricities of insanity’ rendered benevolence ‘more impulsive than patient’, as an Auckland newspaper termed it.

Grand juries were a community voice that straddled the outer and inner circles of policy-making. These bodies were primarily required to consider bills of indictment before the Supreme Court. They could also comment on the machinery of justice in

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23 New Zealand Gazette (New Ulster), 1852, pp. 22-38; Auckland Almanac, 1853; Auckland Almanac and Directory, 1856; Auckland Provincial Government Gazette, 1853, pp. 79-123; and information kindly supplied by the Auckland Public Library.  
25 E.g., New Zealand Herald, Auckland, 22 January 1870; Resident Medical Officer to Provincial Superintendent, 8 July 1876, AP 2/49; Canterbury Journal of Proceedings, 1867, 27, No. 52; Evening Post, Wellington, 7 March 1877; Daily Southern Cross, Auckland, 25 April 1868; Dunedin Asylum Keeper’s Journal, 21 February 1867, Health Care Otago Ltd Archives, National Archives, Dunedin, DAHI D 284/1; “A Constant Visitor”, letter to Wellington Independent, 19 and 28 May and 30 September 1873; Warwick Brunton, Salvation 125: A History of Seaview Hospital, Hokitika and West Coast Mental Health Services, 1872-1997, Hokitika, 1997, p. 19.  
26 E.g., Press, Christchurch, 1 August 1864; New Zealand Herald, 6 March 1868, 3 August 1869, 23 March 1870 and 19 February 1872; Daily Southern Cross, 25 April 1868; Evening Post, 29 October 1872; Colonist, 10 December 1874; West Coast Times, 9 April 1874; Medical Officer to Provincial Secretary, 28 February 1876, NP 7/43, L. 76/323; Star, Christchurch, 22 April 1876.  
27 Wellington Independent, 18 December 1862.  
28 Otago Daily Times, 5 November 1867, reporting on a meeting of Protestant clergy with the Provincial Superintendent. They asked for £200 to be added to the Estimates. Public subscription had only raised £37 towards the cost. In Canterbury, similar moves to establish a chaplaincy were undertaken when the Provincial Council refused to meet the cost (Star, 9 March 1869, Canterbury Times, 17 April 1869). Prior to this, Rev. H. Torlesse had conducted services. Torlesse to Provincial Secretary, 15 November 1866, CH 287 CP L. 1706/65. At Auckland, Anglican services were discontinued after the Provincial Government refused to meet the cost of carriage hire for the clergyman. Daily Southern Cross, 16 October 1872.  
that area either upon their own motion or at the prompting of the circuit judge. That
was why grand juries sometimes criticized the care of lunatics in gaols.\textsuperscript{30} In Crown
colony times, grand juries were an avenue for political statements by leading settlers.
Bad-mouthing existing conditions for lunatics may have upset the authorities but such
advocacy showed that this ancient institution of the judicial system was neither
‘obsolete nor useless’.\textsuperscript{31} Justices Johnston and H.B. Gresson made particular use of
grand juries to stimulate improved care for lunatics. Gresson’s advocacy of separate
treatment for lunatics was also contained in his forceful memo to the Governor on the
justice system (1860),\textsuperscript{32} his membership of the Royal Commission on the Prisons
(1868),\textsuperscript{33} and his visits to Sunnyside Asylum.\textsuperscript{34} The Canterbury Provincial
Superintendent also sought Gresson’s advice on the desirable features of a
provincial asylum. His views were obviously respected.\textsuperscript{35}

Adverse publicity about innocent lunatics suffering in gaols was effective. Members of
a deputation to the Governor who visited Wellington Gaol in 1852 were shocked to
find a young man, who resembled a ‘wild bear in a cage’, sharing a cell with another
lunatic, who seemed to be dying. The screams of the latter sounded dreadful as the
stronger man tumbled upon him in his bid to make a bed of him. The weaker lunatic,
with swollen face and hands, and ulcerated limbs, was powerless to resist. The
authorities responded by transferring the sick man to the hospital, but he was
returned to the gaol where he died in 1853. The Coroner’s Jury attributed death to

\textsuperscript{30} E.g., Nelson Examiner, 11 October 1845; New Zealand Spectator, Wellington, 13 June 1849;
Wellington Independent, 8 June 1850; Colonist, 18 January 1859; Lyttelton Times, 16 July 1856, 23
April 1857, 3 December 1859, 2 and 6 June and 5 December 1860, 1 March and 6 December 1862,
11 March 1863; Otago Witness, 19 January 1861 and 24 May 1862; Otago Daily Times, 18 January
and 14 October 1862; Daily Southern Cross, Auckland, 2 December 1862 and 24 March 1863; New
Zealand Herald, Auckland, 2 September 1864. For the contribution of Justices Johnston and Gresson,
see R.I.M. Burnett, “Hard Labour, Hard Fare and a Hard Bed”: New Zealand’s Search for its own
Penal Philosophy, National Archives Occasional Monograph Series No. 1, Wellington, 1995, pp. 83-
85, 94-95.

\textsuperscript{31} Editorial, Lyttelton Times, 2 February 1862. For the role of grand juries more generally, see

\textsuperscript{32} AJHR, 1851, D-2a, p. 1.

\textsuperscript{33} AJHR, 1858, A-12, p. 1.

\textsuperscript{34} E.g. Sunnyside Asylum Visitors Book, 28 January 1864, Sunnyside Hospital Archives,
National Archives, Christchurch, CH 388/49.

\textsuperscript{35} Justice Gresson to Provincial Superintendent, 21 October 1861, CH 287 CP L. 1822/61;
Provincial Superintendent’s message to Provincial Council, Canterbury Journal of Proceedings, 10
December 1861, 17, p. 107.
the Visitation of God but added that the gaol, 'from want of proper attendance' has been an unfit place to care for him. This case caught the public's attention. A deputation waited upon the Governor. Coronal verdicts or inquests were also effective in bringing about improvements at Nelson and Hokitika.

Once asylums were established, public opinion began to change, as judged by the newspaper press. The tradition of political activism was tempered by the advent of the commercial press in New Zealand in 1861. The penny daily thrived on the new technologies of the steam press and electric telegraph, and the beginnings of professional journalism. It offered a form of cheap communication and mass readership very different from the limited circulation and appeal to educated elites of the earlier press. Established newspapers changed with the times and faced stiff competition from new and sometimes short-lived rivals.

Editors also differed in their approach to national solutions. The Christchurch Globe urged the government to implement medical management for larger asylums. On the other hand, the provincialist Otago Guardian resented Paley's intrusion into matters that would have been better investigated by New Zealand doctors. The same newspaper was suspicious about a national inspectorate. The West Coast Times, however, looked for greater intervention by central government:

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36 Wellington Independent, 31 July and 7 and 11 August 1852; New Zealand Spectator, 29 June 1853. The promise made to the deputation to build a lean-to at the gaol for the lunatics was never kept.

37 Wellington Independent, 11 August 1852. The deputation comprised a clergyman, doctor and Justice of the Peace. The doctor, G.D. Monteith, kept the Freemasons Tavern until 1847 when he re-entered medical practice. He was Provincial Surgeon from 1856-51 when he resigned on the grounds of ill health. A very rarely held commission de lunatico inquirendo found him insane from a time that predated his resignation by several months. He died in 1862. New Zealand Advertiser, Wellington, 12 March 1862; Wellington Independent, 1 July 1862.

38 Nelson Examiner, 23 May 1855; Nelson Provincial Government Gazette, 26 May 1855, 3, p. 52; Provincial Secretary to W. Fox, 6 July 1855, NP 11/1, L. 55/261. cf. the verdict of a coroner's jury in the death of S. Colonial Secretary to Provincial Superintendent, 10 April 1863, NP 5/4, L. 26/63; West Coast Times, 21 May 1869.

39 Day, pp. 52-56, 91-92, 126, 137, 165, 175, 181.


41 Editorials, Otago Guardian, 28 August and 1 September 1874 and 11 February 1875.

42 Editorial, Otago Guardian, 29 November 1876; editorial, Southern Mercury, 2 December 1876.
A country without a capital is like a body without a heart, a temple without an altar ... Little Peddingtons.\textsuperscript{43}

Views differed, too, about the value of a central asylum. The Christchurch \textit{Star} considered that asylums should remain a provincial responsibility but be funed centrally.\textsuperscript{44} Nelson's \textit{Colonist} supported a central asylum in each island and the local ones.\textsuperscript{45} Wellington's \textit{New Zealand Advertiser} thought that two central asylums would be a good idea.\textsuperscript{46} Attitudes towards national policy no doubt reflected the local or provincial interests of newspapers of the day. The dailies paid more attention to local and provincial institutions. This tendency is shown in the way the press handled the reports to Parliament on asylum inspections.\textsuperscript{47} Comparisons or contrasts with other institutions were used to expose or congratulate the local asylum.\textsuperscript{48}

The penny daily extended the press's role in relation to lunacy policy. The reporting of some events for their newsworthiness or sensational appeal helped to turn sympathy away from lunatics towards an attitude of community self-protection. The more eccentric and bizarre aspects of patient behaviour might be dwelt on\textsuperscript{49} or at least noted, as in the \textit{New Zealand Herald} report of a visit to the Whau Asylum in 1869:

\begin{quote}
We do not wish to be understood that there were not some grotesque and eccentric evolutions gone through, but these considered with reference to the character of the disorder in each case, were curious as matters for observation.\textsuperscript{50}
\end{quote}

\textsuperscript{43} Editorial, \textit{West Coast Times}, 30 April 1870. Cf. editorial of 29 August 1873. 'Little Peddington' referred to parochially minded local government.
\textsuperscript{44} Editorial, \textit{Star}, 27 August 1873.
\textsuperscript{45} Editorial, \textit{Colonist}, 10 September 1874.
\textsuperscript{46} \textit{New Zealand Advertiser}, Wellington, 26 March 1872.
\textsuperscript{47} E.g., \textit{Evening Star}, Dunedin, 28 October 1872; \textit{Otago Daily Times}, 7 October 1875; editorial, \textit{Colonist}, 10 September 1874.
\textsuperscript{49} E.g., "Crayon", 'Three Days in a Lunatic Asylum', \textit{Press}, 1 April 1873; \textit{New Zealand Herald}, 3 December 1868; Mary A. Colclough, letter to \textit{Wellington Independent}, 16 September 1871.
\textsuperscript{50} \textit{New Zealand Herald}, 14 January 1869.
Orderly conduct was therefore worth reporting. Although the *Nelson Examiner*’s reporter expected to find unusual and disturbed behaviour by some patients during his visit to the asylum in 1870, his overall impression was very different:

Entering into conversation with them, I confess to being much surprised at the rational way in which they spoke on general matters ... I merely mention for the information of those who may, perhaps, in common with myself, have been under the impression that no connected conversation could be sustained with individuals suffering from aberration of intellect.52

In 1873, a reporter wrote an account based on his experiences as a ‘patient’ for three days at Sunnyside Asylum. His motive?

There are very few persons who do not feel an irresistible interest in the question of insanity. It possesses for many people a horrible fascination which is powerfully increased by being morbidly dwelt upon. This unhealthy curiosity is fed by the perusal of many of the sensational novels of the day, in which madness is one of the most frequent elements introduced to satisfy the love of morbid excitement.53

This theme continued with emotive references to madhouse horror stories of the lunacy reform tradition typified as ‘dismal abodes of misery, resounding with the shrieks and groans of suffering humanity’.54

The commercial penny daily thrived on topical local, national and international news. A Saturday supplement of magazine-type articles from “Home” journals and the electric telegraph55 was critical to this function. The choice and the impressions conveyed can be gauged from the headlines of some of these articles, for example,

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51 E.g., *Canterbury Standard*, 21 April 1865; *Canterbury Times*, 2 September 1865; *Press*, 4 January 1866; *Wellington Independent*, 10 March 1873; *New Zealand Herald*, 11 November 1871; *Daily Southern Cross*, 8 March and 24 September 1869; *Evening Post*, 22 December 1873; *New Zealand Herald*, 16 October 1874; *New Zealand Times*, Wellington, 14 August 1874.
52 *Nelson Examiner*, 25 May 1870.
55 Day, p. 185. The two islands were connected by telegraph in 1866, and a reasonable telegraph network linked the country by the early 1870s. A trans-Tasman cable was laid in 1876.
Another Maniac at Windsor Castle, 56, ‘A Welsh Doctor’s Encounter with a Maniac’, 57, Murders by a Madman, 58, or ‘Shooting Down a Lunatic’. 59 Similar stories emanating within New Zealand were widely reported, like the ‘raving mad’ suicidal woman who lay across the railway tracks near Dunedin, threatening anyone who tried to intervene with a carving knife. 60 The need for four men to restrain one lunatic who tried to escape from a lock-up was also newsworthy. 61 The murder of one Whau inmate by another had news appeal. 62 A Nelson patient’s suicide was reported in Auckland and Wellington. 63

Sometimes the menace was greatly exaggerated. ‘The ban of lunacy’ drove an ex-patient of Karori Asylum ‘from human intercourse’. What danger to society did a ‘poor idiot’ pose when he passed through Featherston pretending that a rolled up piece of paper was a flute? He had no relatives, no means and probably nowhere to sleep. “One who has seen the Man whilst in Confinement” countered exaggerations about criminal intent ‘of the most atrocious kind’ because they had ‘all the malicious ingenuity of a tempter’. Sure, he was eccentric and had used ‘violent language’ before he was committed, but since then he had been quiet, orderly and perfectly sane. 64 The threat to public safety was exaggerated when patients escaped. An excursion to Sumner Beach was marred by press correspondence that condemned patients being ‘positively let loose amongst ladies and children’. There was a world of difference between perceptions of these people as a few ‘sickly’ women and ‘terrifying children by their gesticulations, the stare of vacuity’ and the ‘threat of

56 Wellington Independent, 27 June 1873.
57 New Zealand Herald, 13 April 1873 and Daily Tribune, 20 April 1874, reported from the North Wales Chronicle.
58 Evening Star, 30 January 1874; Illustrated New Zealand Herald, Dunedin, 12 February 1874; Nelson Colonist, 5 February 1874; New Zealand Times, 11 February 1875. The accounts came from the Australian newspapers, the Western Post, 13 January 1874 and the Golborn Herald.
59 Evening Post, 5 February 1876.
60 Evening Star and Otago Daily Times, 27 January 1875; New Zealand Times, 5 February 1875; Auckland Echo, 28 January 1875.
61 Daily Southern Cross, 13 February 1869.
62 Editorial, Daily Southern Cross, 31 May 1875; Evening Star, 15 June 1875.
63 Evening Argus, Wellington, 4 February 1876; Daily Southern Cross, 8 February 1876.
64 “S.G.”, “One who has seen the Man whilst in Confinement”, and T.A. Bowden, Inspector of Asylums, letters to Wellington Independent, 8, 10 and 19 July 1871.
destruction'. Whau officials factually countered claims about the purported threat from escapees.

The penny daily also imported contemporary suspicion about the goings-on in asylums overseas, thus reflecting the themes of *Hard Cash* and novels of a similar genre. Asylum fires and their aftermath provided good copy as did 'The Maniac's Appeal' against wrongful committal at a New York asylum. Reporting of public inquiries and their aftermath portrayed asylums in a negative light. In 1871, the *New Zealand Herald* used an article from the *New York Evening Post* headlined 'Madhouse Horrors. Terrible Cruelties Practiced [sic]. A Repulsive Picture.' Melbourne's Yarra Bend Asylum acquired a particular notoriety. Incidents like these were followed up with press claims of acting as a watchdog and some moralizing about the lack of public interest. Disgruntled staff or ex-staff sometimes manipulated the media to settle scores with asylum management.
Newspapers supported legislative safeguards against wrongful committal, although opinion was divided on the best way of providing these. Newspapers endorsed the principle of formal and thorough inspection of asylums to retain public confidence in asylum standards.

Newspaper reports also documented growing public apathy about asylums. Newspapers reported a lack of visitors only a few years after asylums opened. Official records confirm that. Reporters were satisfied provided asylums were clean, orderly, and had the semblance of domesticity. Asylum administrators fenced in their institutions to protect patients from public curiosity. Where walls could not be built, asylum staff had little choice but to keep their patients indoors. As the physical barriers went up, so did social barriers. "Respectable" people tended to avoid asylums and to keep their charitable concern at a distance. Public apathy and suspicion encouraged the press to play the part of public watchdog. Auckland's New Zealand Herald defended that role because the 'general public know little or nothing' about asylums.

letters to Wellington Independent, 29-30 April 1872; "Fair Play", letter to Evening Post, 30 April 1872; editorial, Evening Post, 4 May 1872.

Daily Southern Cross, 8 June 1868; Southern Mercury, 21 April 1876; editorials, Otago Daily Times, 11 and 16 December 1868, "W.P.", letter to Otago Daily Times, 19 December 1868. See also W. Lauder Lindsay, 'Lunacy Legislation in New Zealand', Journal of Mental Science, 18, 84 (1873), p. 513.

E.g., Canterbury Times, 25 October 1867; editorial, New Zealand Herald, 23 February 1871; editorial, Southern Mercury, 1 September 1874; editorials, West Coast Times, 30 June and 4 November 1876; "S." and "Ignoramus", letters to Otago Daily Times, 26 December 1866 and 7 June 1869; editorial, Otago Daily Times, 13 December 1871.

E.g., New Zealand Herald, 3 December 1868, 14 January 1869; Canterbury Times, 26 October 1867; West Coast Times, 8 February 1875; Nelson Evening Mail, 12 July 1875; New Zealand Times, 16 November 1874; Evening Argus, 12 December 1876.

E.g., Whau Asylum Inspector's report, 26 January 1876, AJHR, 1876, H-4, p. 3; Sunnyside Asylum Report, Canterbury Provincial Council Journal, 1867, 27, No. 52; Evidence of Drs A. Johnston and C. France, 19-20 September 1871, AJHR, 1871, H-10, pp. 4, 8.

E.g., Lyttelton Times, 5 January 1864; Evening Post, 30 November 1873; Canterbury Standard, 12 July 1865, from an article in the Waikouaiti Herald; Star, 14 September 1876.

E.g., Dunedin Asylum Keeper's Journal, 29 May and 11 September 1864, DAHI D 264/1; Medical Officer to Provincial Treasurer, 10 March 1870, Otago Provincial Archives, National Archives, Wellington, OP 7/61, L.11159/1; Inspector Cairns to Provincial Treasurer, 18 March 1870, OP 7/61, L.11159/2.

E.g., New Zealand Advertiser, 11 April 1865; Wellington Acts and Proceedings, 1866-7, 15, Asylum Report, p. 3; Wellington Independent, 7 June 1873.

E.g., Auckland Weekly News, 16 September 1871; Wellington Independent, 30 September 1873; Star, 22 December 1875.

Editorial, New Zealand Herald, 22 December 1871.
OFFICIALS AND POLITICIANS

The outer circle of doctors, newspapers, public meetings, philanthropists and grand juries certainly helped to shape mental health policy in the Crown colony and provincial eras, but its influence was not as great as that of the inner circle of officials and politicians. Within the legislative and administrative parameters of Crown colony government (1840-52), a skeletal civil service was set up with departments to administer different functions of government. The Crown colony administration was accountable through the Governor to the Secretary of State for the Colonies in London. The Colonial Office could not possibly prescribe 'at such a distance so many things to be observed in a society so uniformed'. Beyond general and fiscal instructions from London, colonial administrators were largely left to their own devices. Lieutenant-Governor Hobson (1840-2) was instructed to retain the spirit of English law whilst borrowing 'freely and safely' from the law of New South Wales and Van Dieman's Land. Those colonies had shown practical aptitude in adapting English law to colonial circumstances. Within this general instruction, governors had what McLintock assessed as 'immense and unfettered powers' over legislation and public administration. William Swainson, New Zealand's first Attorney General, said that in a Crown colony

the representative of the Crown both reigns and governs: he fills up all appointments to vacant offices, determines upon the policy and measures of the Government, and his officers carry them into effect. He is entitled to command their advice, but he is not bound to act upon it.

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87 Secretary of State for the Colonies to Governor, 9 December 1840 cited in McLintock, p. 102.
88 New Zealand later deemed itself subject to English laws pertaining at 14 January 1840 insofar as they were applicable to New Zealand circumstances. McLintock, p. 98; Peter Spiller, Jeremy Finn and Richard Boast, A New Zealand Legal History, Wellington, 1996, pp. 76-77.
89 McLintock, p. 117.
Governors controlled the agenda and membership of the appointed Legislative Council. Governor Grey (1846-52) initiated New Zealand’s first lunacy legislation as one of a range of measures of a ‘general character’ and affecting ‘only general interests’.

Governors had some say on day-to-day as well as general policy matters unless they delegated more routine tasks. Governor Fitzroy (1843-5) instructed A. Sinclair, his Colonial Secretary, ‘to settle, and decide on, as many matters of ordinary business as do not in his opinion, require the inspection or signature of the Governor’. Yet he personally issued directions for the proper care of a lunatic at Nelson in 1843. New Munster’s provincial Lieutenant-Governor E.J. Eyre (1846-53) and Governor Grey also intervened personally on matters of lunacy policy. Grey’s forthright views on lunacy matters were conveyed in various minutes on correspondence, the Lunatics Ordinance (which undoubtedly drew upon his previous gubernatorial experience), and in decisions on the placement of individual lunatics, as provided for under the Ordinance.

As the senior subordinate official and the administrative focal point of the Crown colony under the governor, the Colonial Secretary received a steady stream of...
memoranda, reports, requisitions and policy advice from officials, as well as general correspondence from the public. These were the usual channels by which civil servants in the Sheriffs, Gaol and Medical Departments, for which the Colonial Secretary was responsible, helped shape policy. Officials thereby highlighted the practical difficulties of managing lunatics and suggested improvements. Sometimes officials worked in concert or were directed to do so.

Crown colony administration set up a rudimentary but national policy-making process that continued into provincial times. General directions and some broad standards were set by colony-wide legislation. Those directions and standards were amplified and specified in greater detail during the provincial era. Colonial and provincial policies and policy-makers were mutually reinforcing because key decision-makers played multiple roles in national and provincial public life. This sparked inter-provincial rivalry, persistent inter-governmental tension, and pork barrel politics.

Elected politicians of provincial councils and the House of Representatives were susceptible to the influence of various interest groups and the press.

The personal style of public administration involving a small number of politicians and officials was carried over from the Crown colony into provincial administration.

A provincial lunatic asylum was run either as a separate provincial government department or as a unit within the medical department. Public boards or local committees were not set up as mediating influences between asylum management and ministers as sometimes happened with hospitals. Asylum superintendents or

98 Sheriff, Auckland to Colonial Secretary, 28 September 1847, IA 1/50, L. 47/1796.
99 Colonial Surgeon and Sheriff, Wellington to Colonial Secretary, 18 January 1853, NM 8/36a, L. 53/56. They proposed that a house in Hill Street be altered for asylum purposes and that a married couple be appointed as attendants.
101 New Zealander, 17 April 1851, and editorial, 12 August 1851; AJHR, 1873, H-23, p. 4.
medical staff usually reported to the provincial secretary or treasurer who acted as
the appropriate minister in the provincial council. In Westland, the Superintendent
communicated directly with the County Chairman or Provincial Superintendent in his
capacity as Governor's Delegate under the Lunatics Act 1868.

Official public inspection by 'visitors' or provincial inspectors of asylums provided
an independent check on institutional management. New Zealand drew from British
experience in adopting such a system. The Lunatics Ordinance 1846 provided for
the Governor to appoint 'visitors' of lunatic asylums to visit and to report to the
Governor from time to time in line with any directions from the Governor. After
1858, provincial superintendents were empowered to visit and inspect provincial
hospitals and asylums themselves, but their infrequent visits tended to be more
ceremonial than inspectorial. Inspection was lax at the Auckland Asylum-Annexe
and in the early years of Sunnyside and Dunedin Asylum but not at Karori. Wellington seemed to retain a system of visiting justices whose reports were first published by the Provincial Council in 1867.

Inspection was better regulated under the Lunatics Act 1868 which adopted in their
totality and specificity relevant parts of the English Lunacy Act 1845. Although it

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103 Lunatics Ordinance 1846, s. 8. Two of the three visitors initially appointed to Karori Asylum were Justices of the Peace. New Zealand Government Gazette (Wellington), 20 March 1854, p. 2. This role has survived in legislation to the present day under the name of official visitor. For the period covered by this thesis, the relevant legislation was the Lunatics Act 1868, s. 52; Lunatics Act 1882, s. 130; Mental Defectives Act 1911, s. 70.
104 Lunatics Ordinance 1846, s. 8.
105 Lunatics Ordinance Amendment Act 1858, s. 5.
106 Otago Votes and Proceedings, 1864, 17, Select Committee Reports.
107 In his report of 8 February 1870, J. King indicated that he held similar duties before he was appointed as Inspector of the Whau Lunatic Asylum with effect from 1 January 1869. AJHR, 1870, D-29, p.3; Canterbury Times, 26 October 1867; New Zealand Government Gazette (Wellington), 20 March 1854, p. 2.
108 Lunatics Act 1868, ss. 52-58. The Governor was authorized to generally appoint salaried inspectors and deputy inspectors and to appoint official visitors to particular asylums, hospitals and licensed houses. All were to be Justices of the Peace. Asylums could be inspected at any time and at least quarterly. Inspectors or official visitors were to inspect all parts of the premises, check committal papers for irregularities, properly account for any use of restraint, inquire about the physical and mental health, diet, and classification of the patients, examine statutory records, observe whether any system of non-coercion was in place and the type and effects of work, amusements and worship upon the patients, and check upon financial records. Action taken or not upon previous suggestions by the inspector or official visitor was to be recorded. Entries were to be made as appropriate in an Inspector's Book or Patients' Book. Inspectors had the power to summon witnesses to an inquiry (s.
took time before these provisions were fully implemented, the statutory requirements of this legislation have left a good record of official inspection and they accelerated public dissemination of information about asylums.

The appointment of inspectors lay in the gift of governors and ministers, but inspectors were usually diligent. They carefully described what they saw. Progressive practice was commended. Inspectors supported staff in their difficulties and outspokenly criticized shortcomings if necessary. H.D. Morpeth, in his first report on the Whau Asylum in 1875, was blunt. There was no ‘blinking the fact’ that until the Whau Asylum was fully completed, it could only be a pauper asylum. It was not for him to say where the resources should come from to complete the building. G.G. FitzGerald emphasized that the Upper Gaol at Hokitika had never been gazetted as an asylum and that the detention of lunatics there, apart from offending the inmates, was altogether illegal.

Inspectors’ ideas were adopted if they were inexpensive. J. Macandrew, in his capacity as Provincial Superintendent of Otago, assured the Inspector that his valuable suggestions would meet with due attention but, being an ardent provincialist, Macandrew disagreed with the notion of a national inspectorate. Wellington’s Provincial Superintendent called in the Visiting Justices to discuss their concerns. Larger problems, like overcrowding, a lack of classification, or short staffing, could

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63), to authorize trial leave (s. 66) and to recommend discharge (ss. 74-75). The Colonial Secretary had the power to direct an inspector to make a special inspection (ss. 53, 61).

109 Nelson, Taranaki and Hawke’s Bay had not made appointments by early 1870. The first national report on asylums contained no reports from Wellington and Canterbury. AJHR, 1870, D-29. The first report from Nelson was not published until 1875, AJHR, 1875, H-2A, pp. 1-2. No explanation was given for providing only the Medical Attendant’s report from Wellington in 1872. AJHR, 1872, G-27, p. 6, and 1873 H-23, pp. 12-13. Hawke’s Bay did not appoint an Inspector until April 1872, AJHR, 1873, G-27, p. 5.

110 AJHR, 1875, H-2, pp. 1, 3.


112 E.g., Inspector’s report, Westland County Council Proceedings, 1869, 6, p. xxviii, Provincial Superintendent, Otago to Colonial Secretary, 26 June 1872, AJHR, 1872, G-27, p. 15; Inspector’s report, Sunnyside Asylum, 20 February 1875, AJHR, 1875, H-2, p. 5.

113 Provincial Superintendent to Inspector, 26 June 1872 in AJHR, 1872, G-27, p. 21.

114 Wellington Independent, 21 October 1873.
not be fixed cheaply. An inspector, therefore, could simply 'hear, remonstrate and advise'. There was no formal system to follow up and act upon suggestions or to provide a satisfactory explanation for rejecting ideas. The central government would not exercise that role. Provincial superintendents might aver to issues of a national nature, such as a review of the legislation that allowed habitual inebriates to be detained in asylums, but the Colonial Secretary did not follow these up. H.H. Turton, Inspector at Auckland, was very frustrated by the obvious lack of provincial or central government funding to relieve the severe overcrowding and lack of classification at the Whau Asylum. No inspector, he said, could visit the asylum repeatedly without feeling 'intense disappointment and regret that such a state of things should be allowed to exist'. Turton resigned disheartened. Repeated expressions of concern by his successor, H.D. Morpeth, seemed futile, even if the Provincial Superintendent eventually checked out the situation for himself in the company of an architect. Morpeth was taken to task for comments made about stores procedures. He was fired on the pretext of general unsuitability and concern about payment.

Provincial policy involved decisions on the details that arose from the day-to-day management of asylums. Provincial legislation, for instance, involved such matters as land sites, authorization of loans for public works, and liability for the cost of lunatics' maintenance. Using the usual administrative channels available to them,
asylum superintendents or medical officers reported problems, raised matters for consideration and approval, commented upon points raised by superiors, and gave advice on a plethora of issues. These included improvements to living conditions, safety and security, staffing matters, treatment philosophy, classification of inmates, overcrowding, clothing and footwear, amusements or treats, special treatment needs, justifying actions, as well as the meatier topics of

122 E.g., W.B Sealey to Provincial Superintendent, 8 December 1859, Nelson Provincial Archives, National Archives, Wellington, NP 7/4a, L. 59/1011; Keeper to Provincial Secretary, 9 March 1866, NP 7/14B, L. 66/144; Provincial Engineer to Provincial Secretary, 4 January 1868, NP 7/18, L. 68/139; Keeper to County Chairman, 30 November 1871, Westland Hospital Board Archives, National Archives, Christchurch, CAHW CH 22/6, L. 457/1.

123 E.g., Dr Williams to Provincial Superintendent, 25 May 1861, NP 7/5a, L. 61/275; Provincial Surgeon to Provincial Secretary, 10 September 1863, Otago Provincial Archives, National Archives, Wellington, OP 7/7, L. 2423/5; Provincial Engineer to Secretary, Public Buildings, 9 and 23 October 1863, OP 7/7, L. 904/6 (52/63) and L. 1168/45; Steward to Provincial Secretary, 9 August 1854, Canterbury Provincial Archives, National Archives, Christchurch, CH 287 CP L. 2055/64; Keeper to Provincial Secretary, 5 September 1867, NP 7/17, L. 677/76; Keeper to Provincial Secretary, 4 October 1869, Nelson-Marlborough Adult Mental Health Service Records [NAMAMHS], Ngawhatu Hospital; Provincial Engineer to Provincial Secretary, 22 October 1869, NP 7/22, Unregistered Letter; Medical Officer to Provincial Treasurer, 10 March 1870, OP 7/81, L. 11159/1; Provincial Secretary to Keeper, 28 January 1872, NAMAMHS Records, Patient File No. 52; Keeper to County Chairman, 14 February 1872, 30 October and 1 November 1872, CAHW CH 22/6, L. 16/72, L. 116-772.

124 E.g., Provincial Surgeon to Provincial Secretary, 12 September 1863, OP 7/13, L. 2427/1 and 22 September 1863, OP 7/13, L. 2463/1; Keeper to Provincial Secretary, 21 September 1867, NP 7/17, L. 678/36; Keeper to County Chairman, 13 March 1872, CAHW CH 22/6, L. 297/2; Medical Officer to Governor’s Delegate, 27 March 1872, CAHW CH 22/6, L. 257/2; Keeper to Governor’s Delegate, 27 August and 21 September 1872, L. 897/8 and 94/72, and 1 April 1873, CAHW CH 22/6, L. 407/3; Keeper to County Chairman, 15 July 1873, CAHW CH 22/6, L. 137/3; Keeper to Provincial Superintendent, 28 June 1874, CAHW CH 22/6, L. 221/74, and 31 March 1876, L. 422/76.

125 E.g., Steward to Provincial Secretary, 5 October 1863, CH 287 CP L. 567a/63.

126 E.g., Sheriff, Lyttelton to Provincial Secretary, 22 August 1855, CH 287 CP L. 939/55; Provincial Surgeon to Provincial Treasurer, 10 December 1863, OP 7/7, Unnumbered Letter.

127 E.g., Gaoler to Provincial Secretary, 15 February 1864, OP 7/17, L. 3134; Provincial Surgeon to Provincial Superintendent, 22 October 1857, OP 6/3, L. 57/236; Steward to Provincial Secretary, 19 April 1864, CH 287 CP L. 1261/4; Keeper to Provincial Secretary, 3 March 1875, CH 287 CP L. 509/75; Resident Medical Officer to Provincial Superintendent, 20 May and 7 October 1875, Auckland Provincial Archives, National Archives, Wellington, AP 2/37, L. 160/75 and L. 309/75.

128 E.g., Steward to Provincial Secretary, 6 March 1865, CH 287 CP L. 315/65; Keeper to County Chairman, 15 November 1871, CAHW CH 22/6, L. 39/71.

129 E.g., Steward to Provincial Secretary, 24 February 1866, L. 360/66, and 30 July 1866, CH 287 CP L. 1175/66; Medical Officer to Provincial Secretary, 31 July 1871, OP 7/71, L. 1228/11; Keeper to County Chairman, 21 December 1871 and 11 April 1872, CAHW CH 22/6, L. 80/72 and L. 52/71; Steward to Provincial Secretary, 21 January 1873, CH 287 CP L. 111/73; Keeper to County Chairman, 20 June 1873 and 24 September 1873, CAHW CH 22/6, L. 120/73 and L. 187/73; Resident Medical Officer to Provincial Superintendent, 8 June 1876, AP 2/49, L. 1349/76.

130 Medical Officer to Provincial Secretary, 17 February 1867, NP 7/163, L. 67/80.

131 E.g., Provincial Secretary to Provincial Surgeon, 23 November 1855, NP 11/1, L. 55/431; Provincial Surgeon to Provincial Superintendent, 3 January 1866, NP 7/1b, L. 55/333; Keeper to Provincial Secretary, 28 December 1871, NP 7/3/a, Unregistered letter, and 16 September 1874, NP 7/36, L. 30/1243.
immigration restriction,\textsuperscript{132} the economics of repatriation,\textsuperscript{133} or building a special purpose asylum.\textsuperscript{134}

Officials, particularly gaolers, asylum superintendents, and colonial / provincial surgeons, lived with the constant tension of reconciling public and political expectations of an ideal world within the limited funds and staff provided to do the job. Officials sometimes made their case assertively. Otago's Provincial Surgeon would not be rushed to shift lunatics into the temporary asylum while the building remained uncompleted and unfit for occupation.\textsuperscript{135} E.W. Seager asked the Canterbury Provincial Secretary what he should do with any new admissions to an overcrowded Sunnyside Asylum.\textsuperscript{136} Gribben appealed to the Westland County Chairman when he thought that the County Secretary had acted unfairly.\textsuperscript{137} Keepers twice said they could not be held responsible for the safe keeping of patients unless improvements were made.\textsuperscript{138} Butler invited the Provincial Secretary to see for himself how bad conditions were at the Nelson Asylum before saying what should be done about it.\textsuperscript{139} Officials invariably used the customary channels but J.R. Ryley, County Surgeon at Westland, went further. In a case of what would now be called whistle-blowing, he wrote directly to the press.\textsuperscript{140}

Provincial superintendents sometimes visited institutions in inspectorial mode.\textsuperscript{141} After a visit to Sunnyside Asylum in 1873, the Provincial Superintendent criticized the intention of making the inebriates' ward a mixed ward.\textsuperscript{142} Nelson's Keeper was
admonished for purchasing an item without a requisition.\textsuperscript{143} He was also enjoined to take every possible precaution to prevent the conveyance of bed bugs into the new asylum.\textsuperscript{144}

During the provincial era, officials gained two new channels to convey their views. Adroit officials got free publicity when departmental reports were tabled or published by provincial legislatures. Seager respectfully ventured that

\begin{quote}
were it possible for the public to become more intimately acquainted with the working details of the Asylums for the Insane, and of the various and wonderful phases of mental disturbance, no amount of reasonable expense would be grudged.\textsuperscript{145}
\end{quote}

Seager was a great publicist. Newspaper correspondents at one time accused him of 'puffing' about his system of treatment.\textsuperscript{146} T.F. McGauran, Auckland's Provincial Surgeon, used his annual reports to demonstrate that his 'moral treatment' at the Auckland Asylum-Annexe was thoroughly up to date.\textsuperscript{147} Karori's lack-lustre medical officer used an annual report to try to dispel 'very erroneous opinions' about the 'much-abused' asylum.\textsuperscript{148}

As witnesses at select committee hearings or public inquiries, provincial officials gained another channel to identify shortcomings, press for improvements, or to defend their administration.\textsuperscript{149} Officials, and particularly medical officials, were

\textsuperscript{143} Provincial Secretary to Keeper, 9 July 1874, L. 74/557, NMAMHS Records.
\textsuperscript{144} Provincial Secretary to Keeper, Nelson, 24 February 1876, Patient's File 262, NMAMHS Records.
\textsuperscript{145} Steward's second annual report on Sunnyside Asylum, 30 November 1868, CH 287 CP L. 1363/68.
\textsuperscript{146} "Observer" and "Anti-Humbug", letters to \textit{Star}, 1 and 3 April 1873.
\textsuperscript{147} Provincial Surgeon's annual reports quoted in \textit{New Zealander}, 24 January 1857 and 16 February 1859; Annual reports, \textit{Auckland Provincial Government Gazette}, 12 February 1858, p. 18 and 28 February 1860, p. 17.
\textsuperscript{148} Report of 3 February 1872, \textit{Wellington Acts and Proceedings}, 1872, 22, pp. 27-29. Dr France maintained that a discharge rate of 50 per cent compared well with the record of larger English asylums.
\textsuperscript{149} E.g., evidence of Sheriff, Gaoler and Provincial Surgeon to Select Committee on the Gaol, \textit{Nelson Votes and Proceedings}, 1854, 2, pp. 203-7; evidence of Gaoler and Provincial Surgeon, Auckland, Minutes of the General Lunatic Asylum [Select] Committee, House of Representatives, 18-9 May 1858, LE 1/1858/4; Superintendent to Select Committee on Relief and the Hospital, \textit{Journal of the Auckland Provincial Council}, 1862, 22, A-2, pp. 4-5; Provincial Surgeon and Keeper to Select
influential advocates of lunatic asylums although medical practitioners had little more training than others in the field. France brought to his task ‘nothing beyond what he had read’, and hastily made it clear that his lack of experience did not mean that he resorted to head-shaving, blistering or purging patients. Like his counterparts in other provinces, E. Hulme’s professional training fitted him for a role as a well-qualified generalist in Dunedin. He may have studied mental diseases at the vaunted La Salpêtrière in Paris, but this was a general hospital, not a specialist lunatic asylum.

Some provincial officials communicated with their counterparts in other provinces and exchanged ideas. E.W. Alexander, from Dunedin, looked through the Whau. Hume and C. Hunter-Brown, Official Visitor, Nelson, visited Sunnyside Asylum. The Inspector at Wellington scrambled to collect examples of asylum rules from around the country and Australia to provide guidance when Mount View Asylum opened. Wellington was fortunate in availing itself of the Seager connection through the offices of J.E. Fitzgerald, who recommended E.W. Seager’s brother, Henry, as Keeper of Mount View in 1872.

Committee on the Gaol, Stockade, Hospital and Lunatic Asylum, *Journal of the Auckland Provincial Council*, 1862, 14, A-11, pp. 14-16, 22-24; evidence of Medical Officers (Nelson, Karori) and memoranda of Medical Officers (Karori and Seaview), Superintendents (Sunnyside and Dunedin) and Medical Superintendent (Whau) for Joint Parliamentary Committee upon Lunatic Asylums, *AJHR*, 1871, H-10, pp. 5-9, 11-13, 15-20.


*New Zealand Herald*, 26 October 1871.

Entries for 2 June 1872 and 18 January 1874 respectively, Sunnyside Hospital Visitors Book 1, CH 388/49.


Formerly Canterbury Provincial Superintendent (1853-7), Member of the Canterbury Provincial Council (1861-2), Member of the House of Representatives (1853-7, 1862-7) and Controller-General of central government accounts (1867-96). Fitzgerald was also briefly the Inspector of Karori Asylum. See Wendy Hunter Williams, *Out of Mind Out of Sight: The Story of Porirua Hospital*, Porirua, 1987, pp. 15-16.
Representative government brought new participants to the policy-making process. Political pressure by elected representatives was concentrated in ad hoc select committees which were set up to investigate options for services, to make recommendations on the site or design of an asylum, or to act as a public inquiry into aspects of care or management. In line with evolving constitutional custom, the executive branch also instituted public inquiries.

Politicians at national and provincial levels were influential but their consideration of lunacy was fitful, as an Auckland newspaper editorial noted in 1863:

> The requirements of both decency and morality were overlooked, because, we presume, the inmates of the prison and Bedlam were not likely to become potential at election times!

Dr A. Buchanan, M.L.C. wistfully confided to the alienist W.L. Lindsay in 1872:

> Unfortunately, I fear, there are not half-a-dozen members of the [General] Assembly who have it earnestly at heart to get these abuses remedied; hence the apathy of the Government. We are willing enough to 'go in' for reproductive Public Works. But, of course, the care of the Insane costs money, and does not 'pay.' I fear that, before anything like justice can be done to these unfortunate creatures, who cannot speak for themselves,
public opinion will have to be appealed to through the press. This I reserve as a *dernier ressort*.  

Buchanan illustrated the prevailing political apathy by referring to the decision of the Parliamentary Joint Committee to visit the Karori Asylum as a body. When the time came, Buchanan was the only member to turn up.  

Lindsay labelled these signs of political indifference an imaginary 'Prussic Acid Policy' or 'one vast holocaust' that would rid society of the insane. The *New Zealander* was kinder but still sarcastic. A new asylum had to wait till the Auckland provincial legislators' war against the Scotch thistle was over.

Buchanan thought that elected representatives were quite prepared to let the 'weakest [sections of society] to [go to] the wall' for the sake of retrenchment. The same could not be said of the Legislative Council at that time. The early 1870s were certainly a high point of effectiveness before the Council succumbed to institutional senescence. The Council balanced the cut and thrust politics of the lower House with a more consensual though elitist consideration of issues. Most members recognized that the Council should be free from parochialism and party politics. New Zealand followed the convention that money bills and important policy legislation were initiated in the House of Representatives, where most ministers sat and were able to shepherd measures. The Council, therefore, did not initiate lunacy legislation. It was free, however, to canvass the needs of groups in society who carried no political weight, and the Council made a solid contribution there.

National or provincial politicians with medical training were usually prominent in policy debates. Public statements were probably accompanied by some private caucusing.

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162 Lindsay, Lunacy Legislation, p. 500.  
163 Ibid., p. 500.  
164 Ibid., pp. 500, 502.  
165 *New Zealander*, 15 January 1863 in prefatory comments to a review of ‘Suggestions and Instructions in reference to Sites, Construction and Arrangement of Buildings and Plans of Lunatic Asylums’.  
166 NZPD, 17 October 1871, 10, p. 343.  
if Buchanan's diary entry on another medical topic is anything to go by. The political careers of two Nelson doctors, D. (later Sir David) Monro and T. Renwick also show the process at work in the 1850s. Monro and Renwick brought lunacy issues from Nelson when their careers moved to Parliament. Monro was added as a member of the House of Representatives Select Committee on the General Lunatic Asylum shortly after his election in 1858. He regarded as objectionable in principle any compromise with the concept of a central asylum. Renwick reactivated the question of a central asylum by calling for a return of correspondence on the matter from 1858-67. As a member of the Joint Committee, he asked the most questions of witnesses, after the Chair and Fraser.

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168 Drs Prendergast, Renwick and Menzies, pored over textbooks on medical jurisprudence in a back room to come up with a proper schedule of poisons for legislation. A. Buchanan diary, 14 August 1865, Hocken Library, Dunedin, Miscellaneous MS 773.

169 Monro was a Member of the Nelson Provincial Council (1853-63) and Member of the House of Representatives (1855-71). His election as Speaker of the House of Representatives (1861-70) precluded a more visible role in lunacy matters.

170 Renwick represented the Town of Nelson in the Provincial Council (1853-61) and was a Member of the Legislative Council (1863-70).

171 Renwick began by asking for information on the strength of which he persuaded the Nelson Provincial Council to form a select committee on the state of Nelson Hospital in 1854. Both Renwick and Monro were members (Nelson Votes and Proceedings, 4 January 1854, I, p. 75). The Committee called for a new hospital and must have prompted the Provincial Superintendent to seek advice from the Medical Attendant and other doctors on the value of attaching an asylum to the proposed facility. At this stage, neither Monro nor Renwick had any comment to make on the asylum question, though the Medical Attendant, J.F. Wilson, liked the idea. The Provincial Superintendent adopted the idea in principle. (Nelson Votes and Proceedings, 1854, I, pp. 143-4 and 23 November 1854, 2, p. 3; Provincial Superintendent to Medical Attendant, 26 October 1854, NP 11/1, L. 54/252; Provincial Superintendent to Provincial Superintendent Wellington, 14 December 1854, NP 11/1, L. 54/297; tender for alterations to adapt a house as a lunatic asylum, Nelson Provincial Government Gazette, 25 May 1855, p. 52.) During the second session, Renwick moved that the Select Committee be revived (Nelson Votes and Proceedings, 12 December 1854, 2, p. 22). That session Renwick also chaired a Select Committee on the Gaol, which strongly criticized the lack of classification there (Nelson Votes and Proceedings, 22 December 1854, 2, pp. 33, 202). Renwick kept up pressure on the government by asking questions in the Council (e.g. Nelson Votes and Proceedings, 21 February 1856, 3, p. 21 and 23 April 1857, 4, p. 33). Monro's efforts elicited official support for an asylum and helped rally the province to seek inter-provincial cooperation and national action (Dr D. Monro to Provincial Superintendent, 23 November 1855, NP 7/18, L. 55.327 and 8 December 1855, NP 7/18, L. 55/327, and reply 29 November 1855, NP 11/1, L. 55/327. See Day, p. 99.) Meanwhile, Renwick became a member of the Select Committee to consider the petition of the Provincial Surgeon who felt slighted by Monro's accusations. Renwick argued that debate about a central asylum should not preclude the development of a temporary local asylum. That view was also expressed in the report of the Select Committees on the Lunatic Asylum (1858 and 1861) whose membership included both Monro and Renwick. (Nelson Votes and Proceedings, 18 March 1856, 3, p. 49 and 20 January 1858, 5, pp. 33, 184, 15 May 1861, 8, p. 28 and report, p. 183; Nelson Examiner, 12 April 1856.)

172 NZPD, 16 June 1858, p. 531. Monro was elected the Member for Waimea District on 21 May 1858.

173 Nelson Examiner, 31 May 1862.

174 NZPD, 21 August 1867, I, pp. 510-11.
Renwick favoured the appointment of a national medical inspectorate to improve asylums.\textsuperscript{175}

The reformist politicians spoke authoritatively because they took the trouble to visit asylums in New Zealand or abroad.\textsuperscript{176} Three Members of the Legislative Council in particular should be mentioned. Buchanan used a member’s rights to ask for information, to investigate matters through select committees, and to debate legislation. Buchanan and his colleague Capt. T. Fraser, who was Inspector of Asylums in Otago, spearheaded reform with ideas of the central asylum and a national inspectorate. Buchanan drew heavily on the experience of E.W. Alexander, Medical Officer at the Dunedin Asylum.\textsuperscript{177} Another southern Member, J.A.R. Menzies (M.L.C. (1858-88) and Provincial Superintendent of Southland (1861-4)) was also active. He led the Council debate on the Lunatics Ordinance Amendment Bill 1858 and was a member of the Council’s team to confer with the House on the Lunatics Bill 1866.\textsuperscript{178} He approved of the main features of the legislation that became the Lunatics Act 1868. Menzies was familiar with the ideas of Conolly and believed in a ‘medical chief’ at an asylum. Based, no doubt, on his Southland experience, Menzies suggested that the Bill should be amended to allow for confinement of lunatics in gaols, especially for likely escapees.\textsuperscript{179} He supported Parliamentary intervention in lunacy policy and he favoured a network of provincial asylums and the Gheel system of boarding out.\textsuperscript{180}

Moves to establish the principle of medical management were always pressed.\textsuperscript{181}

Buchanan instigated the move to set up the Select (Joint Parliamentary) Committee

\textsuperscript{175} NZPD, 12 October 1871, 10, p. 345 and 7 August 1874, 16, p. 475.
\textsuperscript{176} E.g., T. Renwick, 24 May 1864 and D. Monro, 9 March 1874, Sunnyside Asylum Visitors Book, CH 388/49; A. Buchanan (Whau) 18 April 1873, Buchanan Diaries, Hocken Library, Dunedin, Miscellaneous MS 773; Capt T. Fraser (English asylums in 1873), NZPD, 7 August 1874, 16, p. 471. For other visits, see H. Sewell, 9 April 1864, Sunnyside Visitors Book I, CH 388/49.
\textsuperscript{177} R.V. Fulton, \textit{Medical Practice in Otago and Southland in the Early Days}, Dunedin, 1922, pp. 82-89.
\textsuperscript{178} NZPD, 13 August 1858, p. 139 and 1 October 1866, p. 1019.
\textsuperscript{179} NZPD, 20 August 1867, 1, pp. 500-1 and 15 September 1868, 3, pp. 326-7.
\textsuperscript{180} NZPD, 7 September 1871, 10, pp. 299-300.
of 1871. Other Members who were medically qualified (though not necessarily practising) - Grace, Menzies and Renwick - were included on the Joint Committee, and they were influential, as was Fraser. The Joint Committee was professionally self-serving. It solicited evidence primarily from doctors on the strength of which it made recommendations that led to the establishment of the specialized Department.182

**CONCLUSION**

In this chapter, I have shown that a number of interacting participants shaped lunacy policy in Crown colony and provincial New Zealand. Penal, justice and medical officials shaped policy to address day-to-day administrative and professional requirements. Organized government provided local officials and their superiors with a departmental structure within which memoranda, requisitions, reports, law drafting, budgets and evidence to public inquiries were tools for policy development. Honorary and independent inspectors, who also had some impact on operational policy matters, monitored their activities. Officials worked in an environment of personal and political management, a context that suited the small scale and scope of government before 1876. In Crown colony times, even governors helped develop day-to-day policy. Provincial superintendents also played a part, although many functions were delegated to their principal administrative and financial executives.

The small-scale and local orientation of government delayed the need to perceive lunacy policy and services from a national standpoint. Roles and boundaries were blurred because decision-makers held multiple offices in the public life of their province and colony. By the 1870s, New Zealand had adopted a comprehensive lunacy law, and the central government was pressed to extend its influence into the domain of provincial responsibility to tackle variable standards of care in provincial asylums. By then, transport and communication systems were breaking down the
isolation of New Zealand settlements that had earlier warranted a devolved system of government.

National level policy-making was influenced strongly by politicians, particularly medical members of the Legislative Council. Interested politicians used a range of parliamentary techniques to keep lunacy on the national agenda. Ideas such as the central asylum, comprehensive legislation, and a national inspectorate all emanated from the national political process, intertwined as it was with provincialism through some overlapping representation.

From the late 1860s, crusader-politicians in the Legislative Council spearheaded moves for national intervention in the interests of general improvement and consistent standards throughout all asylums. They drove policy in the direction of a national inspectorate and medical management, and away from a central asylum or asylums. These issues were clarified in the context of Vogel's bold move to abolish provincial administration altogether. Apart from a few crusaders, however, national and provincial politicians were influential but erratic in their consideration of lunacy. Members with medical training were usually prominent in the political consideration of lunacy, whether at national or provincial level. Indeed, the role of these medical members show just how interwoven were the strands of policy development. Some, like Monro, had newspaper interests that could be used to advance a particular political agenda. They had multiple roles in provincial and colonial assemblies. They could interact with or indulge in petty fights with the medical officials of their provinces.

The policy-making core was influenced by an array of pressures. Public watchdogs in the form of grand juries, coronial courts and asylum inspectors had quasi-official status and could be sharply critical of existing policy. Affordable suggestions were often adopted but systemic issues had greater financial implications and were not adopted so easily. An inspector could simply hear, remonstrate and advise. The central government would not check to see that suggestions were considered or acted upon.
Wider still, an outer circle exerted a direct and indirect influence on policy-making, particularly through the press and medical interests, but also through philanthropy and public meetings. These components interlocked periodically with the inner circle of colonial or provincial officials and politicians to make lunacy a political priority issue. Elected and appointed participants in the complex machinery of government had some advantage over outer circle participants once lunacy was deemed to be an issue of public policy.

Between 1840-1876, the foundations of a new country's mental health policy were laid. Like their counterparts in other settler colonies, officials in New Zealand pragmatically adapted British, and particularly English, precedents and ideas to suit local circumstances. The New Zealand policy was characterized from an early stage by three core elements - institutional care, direct government provision, and a distinctive system of organization and management. Problems and ideas converged with national and provincial politics at important times, which helped to ensure a broad consensus on the policy solutions.
PART TWO

1876-1947
5.

THE POLICY-MAKING ENVIRONMENT
1876-1947

'It would almost seem as if we had cast them out, and left them there forgotten.'

In this chapter, I will describe the political context of mental health policy and explain why the Lunatic Asylums / Mental Hospitals Department had such an influential role in policy-making. Under a Westminster type constitution, ministers were responsible to Parliament for policy decisions and for the manner of their execution. The ministerial charge of mental hospitals was never a prestigious position. It began as one of the multitudinous responsibilities of the Colonial Secretary. At one time a very powerful position, by the late nineteenth century the prestige of the portfolio diminished relative to the premiership, finance and works portfolios. Asylums were carved from the responsibilities of the Colonial Secretary and tacked on to other portfolios in 1891. A separate and named mental hospitals portfolio emerged in 1907 as a junior post. Incumbents were invariably of low or middling Cabinet status. Some ministers held the portfolio long enough to be rewarded with enhanced status and subsequent political advancement. Details are shown in shown in appendix 1.

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1 Editorial, Auckland Evening Bell, 18 February 1887.
5 Under the Liberals, annual reports were made to the Native Minister (1891), the Minister of Education (1892-1902, 1906-7) and the Minister of Public Works (1903-5). Separate ministerial portfolios of public health, and hospitals and lunatic asylums were created in 1900 and 1903 respectively and these responsibilities were aligned within the Cabinet in 1907. Until the mental hospitals portfolio became redundant in 1947, it was nearly always held in tandem with health. Departmental reports, Appendices to the Journals of the House of Representatives (AJHR), 1891-1907; G.A. Wood, ed, Ministers and Members in the New Zealand Parliament, Second Edition, Dunedin, 1996, pp. 3-39.
6 The notable exception was P. Fraser (1935-40). In addition to the health and mental hospitals portfolios, Fraser was Minister of Education, Minister of Marine, Minister in Charge of Police, Minister in Charge of the Inspection of Machinery Department and Deputy Prime Minister. Wood, p. 26.
Having a central government department to manage the state's interest in mental health made a great difference to the way national policy was made. For the first time and ever since, New Zealand governments could access a permanent and specialized group of experts for advice. Governments occasionally complemented the stream of ongoing advice from departmental officials with ad hoc formal inquiries, either of an investigative, policy oriented type or, more frequently, retrospective "inquisitorial" inquiries into the circumstances of an incident or tragedy. Inquiries had some impact on operational policy. Investigative inquiries were very rare and left the relationship between governments and officials undisturbed.

The Lunatic Asylums Department that was formed in 1876 survived various name changes and major restructuring of health administration in government in 1907, 1909 and 1920, perhaps because mental hospitals were seen as a specialized function. Mental hospitals certainly did not feature in the ambitions of mainstream government health administrators. They occasionally cooperated with the Department on matters of mutual concern but preferred not to upset the existing administrative arrangements. This situation would probably have continued save...
for the intervention of the Public Service Commission in 1946. An inspector there mooted plans to place the Health Department under "lay" management when Dr M.H. Watt retired as Director-General of Health. The coincidental retirement of the Director-General of Mental Hospitals in early 1947 opened the door to amalgamation. The Mental Hospitals Department was drawn into the scheme when information from two Australian states mentioned that mental hospitals were administered as part of state health departments. The Department became the Mental Hygiene Division of the Department of Health on 25 November 1947, when the Health Amendment Act 1947 became law. The position of Director-General of Mental Hospitals was reduced in status to a divisional directorship in the Department of Health, although he nominally remained a departmental head. The incumbent, J. Russell had probably wished the merger away and chose not to participate in the negotiations, which were clearly run by the Public Service Commission. The amalgamation was not well handled and Russell resigned on principle in early 1950. He later described the amalgamation as a 'colossal mess-up from an administrative point of view.'

12 The Public Service Commission was set up in 1912 with the aims of building a unified career service and promoting efficiency and economy in the Public Service. The Commission became a central agency (control authority) for the coordination of personnel administration throughout the Public Service, as the Civil Service was renamed, thereby fulfilling a function analogous to that of the Treasury in respect of government finance.


14 A.E. Galletly [Inspector, Public Service Commission], Memo to Public Service Commission, 25 November 1946, Deputy Public Service Commissioner to Chairman, Public Service Board of Victoria, 15 October 1946 (Confidential), Secretary, Public Service Board, New South Wales to Deputy Public Service Commissioner, 5 December 1946 and Public Service Commissioner, Western Australia to Deputy Public Service Commissioner, 2 December 1946, SSC 21/10/5. See also J.K. Hunn, Not Only Affairs of State, Palmerston North, 1982, p. 54.

15 Health Amendment Act 1947, s. 2.

16 Director to Public Service Commissioner, 12 December 1949, HMH 26/62.


18 Director to Secretary, Psychiatric Medical Officers Association, 3 November 1949, H 30/1/10 (34269). In 1956, Russell returned to England to resume clinical practice. The most likely explanation for Russell’s resignation was the appointment of Dr J. Cairney, as Director-General of Health over several possible internal candidates. Cairney’s appointment as a non-Public Servant was unprecedented. Personal communication, Dr G.M. Tothill, 11 August 1970. See also Dow, pp. 154-6.

19 Director to Secretary, Public Service Commission, 16 January 1950, HMH 26/62. The event was not even mentioned in the annual report for 1947. Even the Health Department’s report gave it the briefest mention as ‘a development of note’. AJHR, 1948, H-31, p. 60. Russell’s sentiments were shared as likely as not by many staff reminded of the painful amalgamation nearly 20 years later. Director’s Opening Address to Combined Conference of Divisional Medical Superintendents, Marrons, Head Attendants and Secretaries, 27 March 1966, H 30/7/2 (35251).
Between 1876-1947, the Department had seven leaders: F.W.A. Skae (1876-81), G.W. Grabham (1882-86), D. MacGregor (1886-1906), F. Hay (1907-24), Sir Truby King (1924-27), T.G. Gray (1927-47) and J. Russell (1947). Three administrators (MacGregor, Hay and Gray) ran the Department for 57 of its 71 years. During the same period, 25 ministers held responsibility for mental hospitals for an average of 2.8 years, but the 7 departmental heads held office for an average of 10.1 years. Each departmental head served at least two ministers, some as many as seven.

The Department provided stability and continuity amid the ministerial turnover. It was simply indispensable to policy making. Dr D. Pollen, a former Colonial Secretary (1873-77), suggested in 1886 that the private face of government, or 'the better part, the administrative, is done by the civil servants'. The symbiotic relationship between officials and ministers gave the Department privileged access to decision-makers at all times, irrespective of their physical proximity. Bureaucratic influence upon policy-making was strengthened through the effects of nineteenth century constitutional trends, namely the executive domination of the legislature and the consolidation of bureaucratic influence within the executive branch of government.

The Department was well organized to be the national policy leader. It was a state bureaucracy in the classic sense of the term, with its own functions, mandate, and rules. The Department's administration was based on expertise and discipline. Personnel and authority were organized hierarchically. Organizational continuity was secured through a career structure. Specialist expertise was concentrated within a

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20 NZPD, 16 July 1886, 55, p. 568. Pollen was also the father of the then Under-Secretary of the Colonial Secretary's Department.
21 Ministers and the head offices of the main government departments were accommodated in the Government Buildings in Lambton Quay, Wellington, following their completion in November 1876. By 1907, however, ministers customarily had their offices in Parliament Buildings during the parliamentary session. The present Parliament Buildings, which were opened in 1918, were planned with suites of ministerial offices. The Government Buildings accommodated the head office of the Department from 1876-1928, when the head office shifted to Kelvin Chambers, 16 The Terrace. Despite apparent assurances that separate accommodation would be continued, in about 1950, the Division of Mental Health moved to the State Fire Insurance Building, Lambton Quay, which had been the home of the Health Department's head office since 1942. Sharp, pp. 49, 59; Stone's Wellington, Hawke's Bay and Taranaki Directory, Wellington, 1925-45; Wise's New Zealand Post Office Directory, Dunedin, 1950; Director to Public Service Commissioner, 10 January and 12 December 1949, HMH 29/62; Dow, p. 129.
Dr Duncan Macgregor
Inspector-General of Lunatic Asylums, Hospitals and Charitable Institutions
(1886-1906)

(Author's collection)
Dr Frank Hay
Inspector-General of Mental Hospitals
(1907-1924)

(Author’s collection)
Sir Truby King
Inspector-General, Mental Hospitals Department
(1924-27)

(Author's collection)
DEPARTMENTAL HEADS

Dr Theodore G. Gray
Director General, Mental Hospitals Department
(1927-47)

(Theodore G. Gray, 'The Very Error of the Moon', Ilfracombe, 1958, Frontispiece)
department that had a virtual monopoly on providing psychiatric services. The Department held a powerful position. The head office made the policy, institutions implemented it, and the minister appointed district inspectors and official visitors\(^{23}\) as independent though sympathetic monitors. This external check on the system was important, but it was not perfect, as Hay noted in 1914. He said that the problem with district inspectors and official visitors was that they visited only occasionally and their visits were planned rather than a surprise. Hay thought that these officials were not sufficiently independent to speak 'without fear or favour' or for their word to carry weight in the community.\(^{24}\) Some of these public watchdogs used their reports to comment on operational policy matters such as patients' clothing, diet, or recreation. 

District inspectors could influence day-to-day policy with the findings of any formal inquiry they conducted to 'allay any fears that may have arisen in the public mind'\(^{25}\) following allegations or some tragedy. Reports of district inspectors and official visitors usually commented on the cleanliness, neatness, order and progress they observed, expressing some sympathy for the staff with the pressures they faced.

F.G. Ewington, Auckland's official visitor (1886-1919)\(^{26}\), went much further and once published a pamphlet on asylum reform. He called for a royal commission, resources to make mental hospitals more home-like, staff superannuation, after-care, and decentralized administration.\(^{27}\) Ewington's move was most unusual because official visitors' and district inspectors' reports were not usually published.\(^{28}\) After 1911, reports by these public watchdogs were filtered by the Department, which

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23 With the formation of a salaried national inspectorate in 1876, a respected local person was appointed as a deputy (1882) / district (1911) inspector to each institution. These watchdogs had full powers of inspection, investigation, self-initiated formal inquiry, and report. Because of these powers, legal practitioners were appointed as district inspectors under the Mental Defectives Act 1911, s. 41 (1). Official visitors had the power of inspection and report. No professional qualification was attached to that office and appointees were local citizens of good standing. See also Warwick Brunton, 'A Review of the Implementation of Recommendations from Mental Health Service Inquiries, 1987-1996', Unpublished Ministry of Health report, 1996, pp. 5-8, 19.

24 Inspector-General to Medical Superintendent, Sunnyside, 6 February 1914, HMH 1913/1350.


26 Paul Husbands, 'Ewington, Frederick George', Dictionary of New Zealand Biography (DNZB), Volume 2, 1870-1900, Wellington, 1993, pp. 136-7; F.G. Ewington to Minister, 13 May 1919, H 44/14 (28462). Ewington was a prominent Auckland estate agent and philanthropist. He belonged to many local charities. In addition to his asylum appointment, he was a visiting justice of the prison.

27 F.G. Ewington, Our Mental Hospitals, Dunedin, 1911, pp. 1-4. The date of publication is incorrectly given as c. 1898 in A.G. Bagnall, ed, New Zealand National Bibliography to the Year 1960, Volume II, Wellington, 1960, p. 396, but the pamphlet was a reprint of Ewington's letter to the Evening Star, Dunedin, 1 December 1911.

28 In the late 1880s, some reports on the Auckland Asylum were sent to the media, e.g., Auckland Star, 4 January and 12 April 1888; New Zealand Herald, Auckland, 28 January, 28 August, 1 and 4 September 1888 and 12 May 1890.
commented as necessary before sending them on to the minister. Prickly public watchdogs irritated management, so they were chosen carefully to avoid potential political embarrassment. Hay expected public watchdogs to be of fearless, discreet, and levelheaded. A 'faddy person or one impulsive in sympathy is very much worse than useless', he said. Some official visitors were appointed on the strength of their voluntary welfare service to hospitals. Hay pre-empted nominations from the Returned Services Association (R.S.A.) by asking the Medical Superintendent, Auckland, for the names of reputable citizens who were 'unlikely to cause undue trouble'. 'Like ourselves', wrote Sunnyside's Medical Superintendent in recommending someone for appointment, 'she has a horror of the 'officious visitor'.' Based on past acquaintance, Gray vigorously tried to block the appointment of Mrs. Mary Dreaver, a prominent local body politician and one-time Labour Member of Parliament, as an official visitor to the Auckland Mental Hospital after her electoral defeat in 1943.

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29 Lunatics Act 1868, s. 60; Lunatics Act 1882, ss. 144-5; Mental Defectives Act 1911, s. 77.
30 Medical Superintendent, Auckland to Inspector-General, 28 August 1918, Carrington Hospital Archives, National Archives, Auckland, YCAA 1079/6n, File 5/45/-. Medical Superintendent, Auckland to Director-General (private), 6 February 1929, HMH 7/1/5; Report of J. Hogben [Official Visitor, Auckland], 9 February 1943 and Director-General to Minister, 25 February 1943, HMH 7/1/8; Secretary, Auckland Mental Hospital Reform Association to Minister, 4 July 1944, Medical Superintendent Auckland to Director-General, 11 July 1944, H 30/39 (30288).
31 C.J. Parr to Minister (private and confidential), 30 March 1916, and Inspector-General to Minister, 4 April 1916, H 44/14 (28462). Blomfield later commented that F. Wake, the District Inspector, was a partner of Beattie's brother-in-law and had only visited the institution once in two or three years. E.C. Blomfield to Minister, 14 August 1923, HMH 7/1/4.
32 E.g., Medical Superintendent's report, Tokanui, AJHR, 1934, H-7, p. 4; (Mrs Teape) Medical Superintendent's report, Auckland, AJHR, 1940, H-7, p. 5; (A. Steven), Medical Superintendent's report, Seacliff, AJHR, 1940, H-7, p. 10.
33 Inspector-General to Medical Superintendent, Auckland, 23 January 1924, YCAA 1079/6n, File 5/45/-. Rev. D.C. Herron, M.C., was prepared to accept appointment as official visitor for twelve months but only in respect of returned soldiers because he disliked the work. Medical Superintendent, Auckland to Inspector-General, 7 May 1924, H 44/14 (28462).
34 Medical Superintendent, Sunnyside to Inspector-General, 17 December 1914, Sunnyside Hospital Records, Hillmorton, Christchurch, Administrative File 72, current whereabouts unknown. Cf. Inspector-General to Medical Superintendent, Sunnyside, 6 February 1914, HMH 1913/1350; Medical Superintendent, Auckland to Inspector-General, 6 February 1924, YCAA 1079/6n, File 5/45/-. Mrs Dreaver was Labour Member for Waitakura (1941-43). Dreaver had shown some prior interest in mental health matters. Rev. Mary Dreaver to Registrar, New Zealand Federation of Justices of the Peace, 6 March 1935, H 30/28/17 (32778); Auckland Star, 15 March 1935, HMH 26/39. Over Gray's strong protest, the Minister formally instructed Gray to appoint her. Gray insisted that the matter be referred to the Prime Minister, but the Minister correctly surmised that this would not shake Fraser's high opinion of Mrs Dreaver. Gray did not hide the fact that he was acting under ministerial direction. Director-General to Minister, 23 September 1944, Minister to Director-General, 2 October 1944 and 4 June 1948, Director-General to Mrs M. Dreaver, 16 October 1944, H 44/14 (28462). The appointment was short-lived. In 1946, Mrs Dreaver was appointed to the Legislative Council and her appointment as Official Visitor was cancelled.
THE POLITICAL ENVIRONMENT

As elected politicians, ministers' policies had to find favour with the people. Ministers then had to secure the necessary funds to meet those public expectations. Ministers, like politicians generally, were swayed by public opinion but, as MacGregor frankly admitted in 1888, public opinion about asylums was painfully divided:

The multitude, having the vaguest ideas on the subject, are liable to be stirred to the wildest excitement and indignation according as in Parliament and through the Press their feelings as taxpayers or their sentiments of humanity are appealed to. As taxpayers it is time for them to understand that, if their sentiments of humanity are to be fully indulged, then our asylums must be conducted in a very different manner.36

F.G. Ewington, an Auckland official visitor, ultimately blamed electors for the problems of mental hospitals. In a rare attempt to turn the deficiencies of mental hospitals into an electioneering concern in 1911, Ewington spared neither voters nor their elected representatives:

Were it not, therefore, double-eyed hypocrisy to affect pity for the thousands of insane men, women, and children in our mental hospitals if we fail now to do our utmost to elect able and suitable men to represent us and secure the welfare of the patients? Pitiless electors incur the condemnation of mankind if they lazily turn a deaf ear to the pleadings of the helpless insane.37

Ewington's pleas created one of those episodic press flurries38 that were a good indicator of public ambivalence about mental health matters. This ambivalence was marked, on the one hand, by feelings of humanity towards patients, and seen in criticisms of institutional shortcomings like overcrowding.39 Newspaper reporters

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36 AJHR, 1888, H-8, p. 2.
37 Ewington, pp. 1-2.
39 E.g., editorials, Press, 28 July and 10 August 1877, 26 June 1888; West Coast Times, 23 January 1879, 3 July 1889; Otago Daily Times, 24 August 1877, 14 October 1879, 17 August 1889, 15
occasionally visited institutions and their articles expressed satisfaction with the conditions and by the fact that the inmates seemed to act normally. Reporting incidents when officers responsible neglected or physically abused patients also showed the press acting as a public watchdog. On the other hand, newspapers reinforced social stigma or indifference by reporting (sensationally sometimes) relatively infrequent incidents of inmate violence, suspected improper detention, and the escape or premature discharge of patients considered to pose a risk to public safety. In Truby King’s view, such reports were 'prejudicial to the character of the asylum'. He thought that sensational reporting lent ‘colour to the element of

July 1890, 13 October 1911, 22 August 1878, 11 July 1882, 27 June 1890; Evening Post, 16 September 1878, 11 July 1882, 27 June 1890; Evening Star, 12 September and 10 October 1877, 5 August 1911; Nelson Evening Mail, 14 July 1890; Press, 24 September 1878, 10 October 1879, 15 August 1893, 18 September 1923; New Zealand Times, 27 August 1877, 27 August and 29 September 1878, and 15 August 1907; Globe, Christchurch, 18 September 1878; Lyttelton Times, 17 October 1878, 17 January 1879; Evening Chronicle, Wellington, 15 January and 30 September 1878; Nelson Colonist, 7 October 1878; Morning Herald, Dunedin, 11 October 1879; Auckland Star, 1 and 30 June 1886; New Zealand Herald, 24 June 1886, 7 August 1911; Sun, Auckland, 1 August 1928; Nelson Evening Mail, 14 July 1890; Press, 24 September 1878, 10 October 1879, 16 August 1893, 18 September 1923; New Zealand Times, 27 August 1877, 27 August and 29 September 1878, and 15 August 1907; Globe, Christchurch, 18 September 1878; Lyttelton Times, 17 October 1878, 17 January 1879; Evening Chronicle, Wellington, 15 January and 30 September 1878; Nelson Colonist, 7 October 1878; Morning Herald, Dunedin, 11 October 1879; Auckland Star, 1 and 30 June 1886; New Zealand Herald, 24 June 1886, 7 August 1911; Sun, Auckland, 1 August 1928, HMH 25/3.

40 E.g., Evening Chronicle, 16 April 1878; Star, 30 April 1900; Nelson Colonist, 30 December 1890; West Coast Times, 6 April 1905; 'How Lunatics are Treated: A Visit to Auckland Mental Hospital', Auckland Star, 18 June 1906, New Zealand Herald, 22 June 1935, HMH 26/39.

41 E.g., The G. case at Wellington Asylum, mentioned in editorial, Evening Post, 20 June 1877, Globe, Christchurch, and Press, 26 June 1877; suicide of a person conveyed under police escort to Wellington Asylum, Evening Post, 26 August 1878; suicide of a patient at the overcrowded Wellington Asylum, Evening Chronicle, 1 October 1878, Evening Post, 30 September and 1 October 1878; New Zealand Times, 1 October 1878; death of W.F., Nelson Evening Mail, 30 November 1880; fatal assault on C.T.M. at Sunnyside, Star, Christchurch, 26 July and 1, 4, 19, 22-3 August 1913; manslaughter charge against a Porirua attendant, editorial, Auckland Star, 12 February 1923, HMH 26/39; assault by a junior attendant at Porirua, Evening Post, 12-3 December 1928, New Zealand Truth, Wellington, 27 December 1928, and Dominion, 13 February 1929, HMH 26/39; assault by a Seacliff attendant, Otago Daily Times, 16 July 1938, HMH 26/39.

42 E.g., editorial, New Zealand Herald, 24 June 1886; editorial, Star, Christchurch, 26 December 1893; editorial, Hokitika Guardian, 31 May 1921; Governor-General reported in 'Hopeful', letter to Auckland Star, 6 May 1926, HMH 26/39.

43 E.g., the 'dangerous lunatic' who allegedly started the fire that gutted the Whau Asylum, editorial, Auckland Star, 24 September 1877; patient homicide at the Whau, Illustrated New Zealand News, Dunedin, 29 October 1883; attempted killing at Ashburn Hall, Star, Christchurch, 25 May 1884; patient homicide at Porirua, Dominion, 9 October 1911 and editorial, 14 October 1911, editorial, Evening Star, 9 October 1911, editorial, Evening Post, 9 October 1911.

44 E.g., New Zealand Truth, 17 January 1929, and Evening Post, 3 January 1929, Porirua Hospital Records, Porirua Hospital, Administrative File G 33; Minister to Mrs A.S. Wood, 3 February 1930, HMH 8/854.

45 E.g., Evening Post, 15 and 29 June, and 15 September 1877; Evening Argus, Wellington, 25 June 1877, reporting from the Marlborough Times; editorial, Star, Christchurch, 2 July 1877; Globe, 30 June 1877. also reported in Evening Argus, 29 June 1877; Globe and Lyttelton Times, 5 October 1882; Dunedin Illustrated New Zealand News, 27 October 1884; Star, Christchurch, 1 March 1885; Otago Daily Times, 28 March 1924, HMH 26/39; New Zealand Herald, 13 April 1937, HMH 26/39; New Zealand Truth, 19 May 1937 and 16 May 1940, HMH 26/39. Press reaction to the escapes of two of the most notorious patients, Lionel Terry and Reginald Matthews, is discussed in Chapter 8.

46 Medical Superintendent, Seacliff to F.R. Chapman [District Inspector], 28 November 1883 and Medical Superintendent to Inspector-General, 21 January 1889, Seacliff Hospital Letter Book, Health Care Otago Ltd Archives, National Archives, Dunedin, DAHI D 284/11.
mystery and possible abuse associated in the public mind with all refuges for the insane. MacGregor was also wary of a sensational press. ‘Nothing is easier’, he wrote, ‘than to get up a *fama clamosa* without any real justification.’ Hay thought it unwise to encourage press comment lest patients’ relatives become uneasy. Similarly, Gray insisted on approving all communications with the press. He thought many editors ‘poor in intelligence’ and likely to publish any ignorant criticism.

Low Cabinet rank was a sign of the low political importance of mental health. Set-piece government policy pronouncements - speeches from the throne, financial statements (budgets), and public works statements - provided limited comment on the general mental health policy of successive governments. In the overall priorities of government, mental hospitals were simply insignificant.

The speech from the throne at the start of each Parliamentary session sporadically mentioned mental health as part of the legislative agenda. Mental health legislation was substantively reviewed on average once a generation, which says something about the reluctance of politicians to tamper with complex issues.

Public expenditure on mental hospitals was always a very small percentage of total central government expenditure. Annual capital and operating expenditure on mental hospitals never exceeded two per cent, and rarely exceeded 1 per cent, as Table 2 shows. Although financial data for mental hospitals are reasonably consistent

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47 Medical Superintendent, Seacliff to Inspector-General, 11 September 1893, DAHI 15 D 264.
48 Inspector-General’s report, Ashburn Hall, 12 January 1900, AJHR, 1900, H-7, p. 11.
49 Inspector-General to E. Arnold, 21 May 1907, HMH 1907/461.
50 Inspector-General to J. Alexander, 21 February 1928, HMH 7/1/3; Director-General Circulars, 31 October 1932, HMH 8/1103 and 21 January 1946, H 30/27/3 (33642).
51 Director-General’s minute on Medical Superintendent, Seacliff to Director-General, 25 January 1944, HMH 28/39; Marginal note on cutting from Otago Witness, 27 March 1923, HMH 26/39.
53 The Lunatics Act 1868 fell within the ambit of the Statutes Revision Committee as a ‘consolidation Bill’ in 1881. The measure was delayed when the government heeded the Legislative Council’s advice that the Bill needed considerable amendment occasioned, most probably, by public disquiet after the Royal Commission of Inquiry into the Wellington Lunatic Asylum (1881). The Lunatics Act was passed in 1882. Colonial Secretary to Chairman, Royal Commission of Inquiry into Wellington Lunatic Asylum, 27 April 1881, IA 4/50; AJHR 1881, A-7, p. 1 and 1882, A-7, pp. 1-2. The Act was not substantially amended ‘for some considerable time’. Governor’s Speech, NZPD, 27 July 1911, 154, p. 4.
throughout the period, this is not the case for health care.\textsuperscript{54} Expenditure data, however, suggest that governments spent approximately twice as much on other hospitals than they did on mental hospitals until the 1920s, when the gap widened to a ratio of 3:1. The introduction of social security medical benefits virtually doubled government health expenditure (excluding mental hospitals) to 3.4 per cent between 1935-40, and to 6.4 per cent in 1947. Thorns and Sedgwick have endeavoured to identify major categories of government spending, drawing on Bloomfield's statistical compilation.\textsuperscript{55} Their figures need to be interpreted cautiously because of changes in the public accounts,\textsuperscript{56} and in the items included in particular accounts. Public works always took a significant proportion of government spending. Between 1878-88, they accounted for between 23-38 per cent of government spending. According to Thorns and Sedgwick's analysis, the lowest figure recorded was 6.9 per cent in 1891. Spending on public works fluctuated according to economic conditions and wartime priorities, but in the midst of post-World War II development, public works absorbed 14.6 per cent of government spending.\textsuperscript{57} Spending on police involved 3.2 per cent of total government expenditure in 1878 and peaked at 4.7 per cent in 1883. Police expenditure then slowly declined to two per cent by 1905 and generally continued to fall to one per cent by 1947.\textsuperscript{58} Defence spending patterns under peacetime conditions slowly rose from less than one per cent between 1880-5 to nearly five per cent by the outbreak of World War II. Defence needs preoccupied the government's spending programmes during the world wars and the immediate post-war periods. In 1947, defence took 21.6 per cent of government expenditure.\textsuperscript{59} In the social domain, education steadily rose from 6.1 per cent in 1878 and reached 16.2 per cent of government spending in 1926 before declining to 8.4 per cent in 1947.\textsuperscript{60}

\textsuperscript{54} Figures for the period before 1920 have been drawn from \textit{Statistics of the Colony / Dominion of New Zealand} and those for 1920-47, from the \textit{New Zealand Official Year-book}. Information on government subsidies for public hospitals is available from 1878. A truer picture could only be presented when data about hospitals (other than mental hospitals) run by central government are included. Public health expenditure is not easily identified before the Department of Health was formed in 1920. Military spending on hospitals is not included. Health care also needs to include expenditure on social security medical benefits after 1939.


\textsuperscript{56} E.g., Consolidated Fund, Public Works Account, Social Security Fund, War Expenses Account.


\textsuperscript{58} Ibid., pp. 105-6.

\textsuperscript{59} Ibid., pp. 108-9.

\textsuperscript{60} Ibid., pp. 110-11.
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<td>22,714.5</td>
</tr>
<tr>
<td>Year</td>
<td>Operating</td>
<td>Capital</td>
<td>Total M.H.</td>
<td>Total Govt MH as % TOTAL</td>
</tr>
<tr>
<td>------</td>
<td>-----------</td>
<td>---------</td>
<td>------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td>1911</td>
<td>97.1</td>
<td>12.7</td>
<td>109.8</td>
<td>19,373.6</td>
</tr>
<tr>
<td>1912</td>
<td>101.5</td>
<td>46.2</td>
<td>147.7</td>
<td>27,153.1</td>
</tr>
<tr>
<td>1913</td>
<td>113.2</td>
<td>26.0</td>
<td>139.2</td>
<td>25,328.5</td>
</tr>
<tr>
<td>1914</td>
<td>127.1</td>
<td>54.0</td>
<td>181.1</td>
<td>34,805.7</td>
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<tr>
<td>1915</td>
<td>130.8</td>
<td>54.9</td>
<td>185.7</td>
<td>44,398.5</td>
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<tr>
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<td>145.4</td>
<td>44.6</td>
<td>190.0</td>
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</tr>
<tr>
<td>1917</td>
<td>154.7</td>
<td>59.3</td>
<td>214.0</td>
<td>35,033.4</td>
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<tr>
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<td>160.3</td>
<td>46.6</td>
<td>206.9</td>
<td>43,866.7</td>
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<tr>
<td>1919</td>
<td>160.9</td>
<td>18.3</td>
<td>179.2</td>
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<tr>
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<td>261.8</td>
<td>27.4</td>
<td>289.2</td>
<td>62,267.5</td>
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<tr>
<td>1921</td>
<td>269.2</td>
<td>41.8</td>
<td>311.0</td>
<td>49,731.5</td>
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<tr>
<td>1922</td>
<td>255.2</td>
<td>26.5</td>
<td>281.7</td>
<td>43,768.7</td>
</tr>
<tr>
<td>1923</td>
<td>253.3</td>
<td>26.5</td>
<td>300.8</td>
<td>44,581.6</td>
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<tr>
<td>1924</td>
<td>244.4</td>
<td>68.4</td>
<td>312.8</td>
<td>57,379.6</td>
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<td>272.2</td>
<td>77.8</td>
<td>350.0</td>
<td>59,831.8</td>
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<td>275.1</td>
<td>68.6</td>
<td>343.7</td>
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<td>274.9</td>
<td>51.3</td>
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<td>153.0</td>
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<tr>
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<td>134.5</td>
<td>438.0</td>
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</tr>
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<td>264.4</td>
<td>46.6</td>
<td>311.0</td>
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<td>28.8</td>
<td>277.8</td>
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<td>233.5</td>
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<td>40,700.0</td>
</tr>
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<td>252.4</td>
<td>98.7</td>
<td>351.1</td>
<td>84,411.8</td>
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<td>1935</td>
<td>279.7</td>
<td>67.7</td>
<td>347.4</td>
<td>55,200.0</td>
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<td>334.6</td>
<td>142.5</td>
<td>477.1</td>
<td>57,300.0</td>
</tr>
<tr>
<td>1937</td>
<td>394.5</td>
<td>102.5</td>
<td>497.0</td>
<td>68,200.0</td>
</tr>
<tr>
<td>1938</td>
<td>417.4</td>
<td>128.8</td>
<td>546.2</td>
<td>75,000.0</td>
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<tr>
<td>1939</td>
<td>303.8</td>
<td>175.4</td>
<td>479.2</td>
<td>92,700.0</td>
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<tr>
<td>1940</td>
<td>425.7</td>
<td>126.6</td>
<td>552.3</td>
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<td>1941</td>
<td>440.6</td>
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<td>1942</td>
<td>474.4</td>
<td>15.5</td>
<td>489.9</td>
<td>218,300.0</td>
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<td>1943</td>
<td>503.9</td>
<td>88.7</td>
<td>592.6</td>
<td>213,987.9</td>
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<td>563.5</td>
<td>37.7</td>
<td>601.2</td>
<td>228,976.0</td>
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<tr>
<td>1945</td>
<td>863.8</td>
<td>209.0</td>
<td>1,072.8</td>
<td>774,797.0</td>
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<td>1946</td>
<td>976.8</td>
<td>264.5</td>
<td>1,241.3</td>
<td>161,810.9</td>
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<tr>
<td>1947</td>
<td>1,146.0</td>
<td>195.6</td>
<td>1,341.6</td>
<td>182,648.6</td>
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</table>
Notes:
1. Figures stated in nominal £ 000.
2. Expenditure relates to calendar years 1877-1894. The figures for 1895 represent 15 months expenditure to allow for the transition to the financial year ending 31 March, which was used thereafter.
3. Net figures used as standard accounting practice after 1924. For mental hospitals, this meant deducting revenue from patients' maintenance and the sale of farm produce from the operating expenditure.
4. Departmental operating expenditure was met by way of annual appropriation by Parliament and included within the ordinary revenue and expenditure of the Consolidated Fund.
5. Capital expenditure on mental hospitals is recorded in departmental reports, AJHR.
6. Total expenditure includes the Consolidated Fund, Public Works Fund, Social Security Fund and War Expenses Account. It does not include the accounts of certain trading departments such as the Government Insurance Department, Public Trust Office, Maori Trust Office, State Advances Corporation, State Fire and Accident Insurance Office, or Post and Telegraph Office.

Irrespective of the method of computation, the comparisons show that mental hospitals were a low budget priority.

Budget statements referred to mental hospitals either to announce works designed to deal with overcrowding\textsuperscript{61} or to explain increased departmental expenditure.\textsuperscript{62} In his capacity as Colonial Treasurer (1896-1906), R.J. Seddon was almost apologetic for the unfortunate increases in asylum expenditure, which he attributed to population growth.\textsuperscript{63} He announced that certain public buildings like asylums were necessary to meet requirements of the present generation. Future generations would have to make the same provision in their turn.\textsuperscript{64} No hint of more than a 'hand-to-mouth' policy, as Seddon called it in his public works statement of 1894,\textsuperscript{65} was given for another decade. Using a format that allowed for comment on various votes, Seddon announced that ample provision would be made to increase accommodation in 'hospitals for the mentally afflicted'. Priority would be given to constructing 'hospitals for first treatment', improved classification, and tighter admission controls.\textsuperscript{66} The lack of immediate follow-up suggests that these ideas may have been floated to test political opinion.\textsuperscript{67}

Financial statements of the first Labour Government (1935-49) tended to lump mental hospitals into wider expenditure categories of health or social services.\textsuperscript{68} The move was indicative of the way that mental hospitals were incidental but implicit to the national health insurance proposals. The Labour Party's 1926 manifesto had stated that medical services would be nationalized to provide free medical, dental and maternity care.\textsuperscript{69} Dr D.G. McMillan's pamphlet of 1934 fleshed out proposals to achieve this aim. McMillan did not specifically mention mental hospitals, although he

\textsuperscript{61} E.g., AJHR, 1912, B-6, p. xxiv, 1930, B-6, p. 9, 1934, B-6, p. 8, and 1936, B-6, p. 11.
\textsuperscript{62} E.g., AJHR, 1913, B-6, p. xxiii, 1914, B-6, p. xxv, 1917, B-6, p. v, 1918, B-6, p. vii, 1919, B-6, p. vi, 1920, B-6, p. vii, 1921-22, B-6, p. vii.
\textsuperscript{63} AJHR, 1900, B-6, p. vii, and 1905, B-6, p. xi.
\textsuperscript{64} AJHR, 1998, B-6, p. ix.
\textsuperscript{65} AJHR, 1994, D-1, p. ii.
\textsuperscript{66} AJHR, 1903, B-6, p. ix, and 1904, B-6, p. xii.
\textsuperscript{67} Burdon, p. 299.
\textsuperscript{68} E.g., AJHR, 1937, B-6, p. 22.
\textsuperscript{69} Campbell, pp. 9-10.
did comment on care for psychiatric patients. His ideas were substantially incorporated into the Labour Party's 1935 election manifesto. As a first step towards implementing the policy in 1936, Fraser, as Minister of Health, set up a government caucus committee to examine the proposals. Implementation costs were to be worked out by an interdepartmental committee of officials. The Mental Hospitals Department was not involved. The caucus committee's circular questionnaire to interested parties did not mention care and treatment in mental hospitals, but respondents all agreed that it should be a benefit available at the outset of the scheme. The caucus committee 'assumed' that mental hospitals would be included under the proposed hospital benefit, estimated to cost £150,000 of the total £940,000 spending on hospital benefits. The government accepted the policy and free care and treatment in state mental hospitals were included in the list of social security health proposals of the Parliamentary select committee of 1938. The select committee received no evidence on the matter of free mental hospital care, which, unlike other proposals, did not upset the organized medical profession.

The select committee recommended that the cost of maintenance in mental hospitals should become a charge on the whole community. Only six speakers, all but one government Members, mentioned the policy in Parliament, and then only in passing. Free care in state mental hospitals was the first "benefit" available under the social security scheme, on 1 April 1939.

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71 Campbell, pp. 19-21.
72 Campbell, p. 58. The Prime Minister, M.J. Savage, believed that all Labour Members of Parliament should be involved in the business of government and work with ministers to make and administer policy. Caucus teams were intended to replace royal commissions and appointed boards. B. Gustafson, From the Cradle to the Grave, Auckland, 1986, pp. 180, 220-1.
73 Report of the National Health Insurance Investigation Committee, Wellington, 1937, pp. 1, 2, 8, 61-3, appendix A (1).
74 The New Zealand Branch of the British Medical Association thought that free mental hospital care would not affect staff nor was it likely to affect patients either. The matter was regarded simply as a matter of finance. National Health Insurance Supplement to New Zealand Medical Journal, April 1938, p. 8.
75 AJHR, 1938, 1-6, pp. 2-3, 8. This was relatively simple to achieve by repealing those parts of the Mental Defectives Act 1911 that concerned the payment of maintenance. See Social Security Act 1938, s. 94; Mental Defectives Act 1911, s. 136; Mental Defectives Amendment Act 1935, s. 7.
Public works statements show that governments usually reacted to rather than anticipated the growth of patient numbers or modernized facilities.\(^{77}\) Most public works statements catalogued works planned for the year ahead. Very few took a long-term view.\(^{78}\) The format of these statements also emphasized ‘reproductive public works’ that would increase the ‘productive power of the colony’, as Hall-Jones, Minister of Public Works, termed infrastructure development in his statement of 1899.\(^{79}\) Annual plans for mental hospitals were tucked in the section on public buildings towards the end of each statement, after the sections on railways, roads, telegraphs and hydro-electricity schemes. Table 3 shows that capital projects in mental hospitals accounted for a mere 1.4 per cent of public works expenditure between financial years 1877 and 1947. Pork-barrel politicians concurred with that emphasis, none more so than A.W. Hogg, the Member for Masterton, who gloried in his reputation as a ‘roads and bridges member’.\(^{80}\) In 1895, Hogg attacked the constant capital expenditure on asylums that, he declared, was not of the same importance to the people generally as public works.\(^{81}\) Hogg need not have worried. Public buildings comprised only one-eighth of public works expenditure between 1876-1947. That expenditure pales beside the total spent on transport and communications or hydroelectric schemes.

Ministerial rankings and set-piece general policy pronouncements of successive governments show that mental health was a political backwater, with a clientele of disenfranchised committed patients and with few votes to catch.\(^{82}\) Grant reached a similar conclusion for the period 1945-55. She considers that politicians failed in their role as advocates for the mentally ill because among overall national priorities, governments essentially viewed them as unimportant and undesirable in the world of

\(^{77}\) E.g., AJHR, 1886, D-1, p. 16, and 1907, D-1, p. xii.

\(^{78}\) One exception was AJHR 1898, D-1, p. xiv which starkly said that the increase in asylum populations meant that a new facility must be built every five years. The 1936 Budget called for a long-term and extensive building programme, but the Public Works Statement of that year did not follow-up the idea. AJHR, 1936, B-6, p. 11 and D-1, p. xxii. AJHR, 1938, D-1, p. xxx promised that institutions ‘shall lack no modern conveniences’, but again the statement contained no long-term plan.

\(^{79}\) AJHR, 1899, B-6, p. xiii.


\(^{81}\) NZPD, 22 October 1895, 91, p. 573.

\(^{82}\) E.g., W.F. Massey (Opposition Leader, Reform, Franklin), NZPD, 4 August 1911, 154, p. 195, and G. Witty (Riccarton, Liberal), NZPD, 1 November 1921, 191, p. 989; editorial, West Coast Times, 8 August 1911 and 30 December 1911; ‘Common Sense’ in letter to Dominion, 18 February 1937, HMH 26/39. Committed patients were given the vote in 1975.
### TABLE 3
**CATEGORIES OF PUBLIC WORKS FUND EXPENDITURE, 1877-1947**

<table>
<thead>
<tr>
<th>Category</th>
<th>£ 000</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public Buildings</td>
<td>30689</td>
<td>12.5</td>
</tr>
<tr>
<td>Mental Hospitals</td>
<td>3552</td>
<td>1.4</td>
</tr>
<tr>
<td>Railways</td>
<td>77637</td>
<td>31.6</td>
</tr>
<tr>
<td>Roads</td>
<td>33324</td>
<td>13.5</td>
</tr>
<tr>
<td>Telegraph</td>
<td>13492</td>
<td>5.5</td>
</tr>
<tr>
<td>Goldfields</td>
<td>562</td>
<td>0.2</td>
</tr>
<tr>
<td>Hydro-electric Power</td>
<td>40499</td>
<td>16.6</td>
</tr>
<tr>
<td>Land / River Control</td>
<td>302</td>
<td>3.0</td>
</tr>
<tr>
<td>Housing</td>
<td>9876</td>
<td>4.0</td>
</tr>
<tr>
<td>Other</td>
<td>32290</td>
<td>13.1</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>245784</td>
<td>100.0</td>
</tr>
</tbody>
</table>

**Notes:**

1. Includes expenditure from the Public Works Fund General Purposes Account and separate subsidiary accounts set up at different times for special public works, such as school land and buildings, state forests and coal mines, war expenses, state housing, and main highways.
2. Public buildings include courthouses, prisons, police stations, post offices, agricultural buildings, and hospitals. At times, schools were included. Lighthouses and harbour works were included elsewhere.
3. Figures are for financial years.

reason. Further, much of the work of advocacy fell upon the Department because there was no other national voice to champion the cause of mental health. So Russell justified his work as a means of advocating for a disenfranchised section of the community. His predecessors thought likewise. MacGregor was paterfamilias to committed patients for whose welfare under proper detention he considered himself personally liable. In a letter of condolence to MacGregor's widow, G.M. (later Sir George) Fowlds, Minister (1907-11), praised him as a man who 'fearlessly upheld what he considered to be right and uncompromisingly denounced what he considered to be wrong. MacGregor's own reports set out clearly the dilemma faced by dedicated departmental officials who constantly had to reconcile their professional views of an ideal or even adequate mental health service with the closely controlled and limited resources allocated for the purpose. MacGregor stated the problem in 1898 and repeated it in 1903:

The Asylum Department in this colony has to face a choice of difficulties. On the one hand the public are very exacting in their demands for the proper treatment of the insane, but they are roused to indignant clamour only when some painful occurrence reveals the difficulties which their officers are daily confronted with, and almost despairingly struggle to overcome. In the intervals there is no sustained resolve that their representatives shall provide the means of proper classification and treatment. On the other hand, the Government are straining every nerve to open the country for settlement, with all the necessary expenditure that this involves; and it must be admitted that, to expect them to provide out of revenue for modern asylum requirements is very hard. By far the hardest and most unpleasant part of my duty is to induce the Government to give the means to meet the spasmodic demands of the people for rational treatment of those terrible nervous diseases that afflict so many of our fellow-creatures.

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84 Director to Minister, 22 March 1950, Mental Hospitals Department records, File MH 10/44/1, formerly held in Department of Health head office records storage, Wellington, but current whereabouts unknown.
85 Editorial, New Zealand Herald, 10 May 1890. MacGregor admitted in evidence on the Divorce Act Amendment Bill that he had broken the law because he was so convinced that it would be wrong to discharge some insane patients of reproductive age. New Zealand Times, Wellington, 21 September 1905.
87 AJHR, 1898, H-7, p. 3 and 1903, H-7, p. 3.
The contest between the professionally bearable and the politically wearable policies led to long periods when mental health policy developed slowly, incrementally, or even stagnated, followed by short bursts of overdue but significant policy overhauls, such as those of circa 1877-80, the 'new brooms'\textsuperscript{88} of Fowlds and Hay in 1907-11, 1925-8, and 1947.\textsuperscript{89}

**INTEREST GROUPS**

There was no sustained alternative policy voice to the Department throughout the period. The Auckland based Mental Hospital Reform Association (1923) and Physical and Mental Way (1935) looked to strengthen patients' rights, make mental hospitals publicly accountable, and develop psychiatric services away from mental hospitals. In 1946, the merged Auckland groups made contact with a kindred organization in Christchurch, the Physical and Mental Welfare Society or Mental Welfare Society (c. 1938), which was run by former psychiatric patients. Neither group made much headway with officialdom. Local pressure groups were fragile and too dependent upon eccentric personalities to have much impact. Their high points were A. Sainsbury's Parliamentary petition with 2092 signatures, and his damming criticism of existing policy in the pamphlet *Misery Mansion* (1946). The press picked up Sainsbury's alternatives,\textsuperscript{90} but the ideas got nowhere because the 'revised policy and plans by the health [mental hospitals] department were more practicable and will largely meet the requirements'.\textsuperscript{91} Gray reserved his fire for the sensational pamphlet, which he lambasted as a 'scurrilous slander upon those who minister to the needs of the patients'. The book was a contemptible 'farrage of nonsense and wild untrue statements from beginning to end'.\textsuperscript{92}

\textsuperscript{88} Editorial, *Evening Star*, 11 January 1907.
\textsuperscript{89} The important changes were introduced between 1947-9.
\textsuperscript{91} Petition 1946/19; AJHR, 1946, I-7, p. 1.
\textsuperscript{92} Director-General to Minister, n.d. [12 July 1946?]; draft Ministerial reply to H.E. Combs, M.P., 2 July 1946, H 30/10 (28737); Director-General to Clerk, Select Committee on Public Health, 30 July 1946, HMH 4/4/9.
By forming a fragile network in the mid-1940s, local reform groups found what other pressure groups had discovered two or more decades before: national organization helped ideas have political impact. National organizations usually kept their roots in local societies or branches but found that a national framework was vital to influence the growing power of the state. Each was a product of what Olssen calls 'the new spirit of organisation' in New Zealand between the 1870s and 1920s. Towns and cities, bureaucracy, specialization, organization, and a more complex social structure all characterized this, together with the integration of hitherto fragmented and isolated regions and localities.93

National associations or federations with an interest in mental health policy included the National Council of Women (1896-1906 and revived in 1916) and its affiliated organizations, the organized medical profession (1887)94, and hospital boards (1908)95. Institutional staff organized themselves through the Public Service Association (1912). They also had an interest in mental health but their main purpose was to improve working conditions. Organized hospital visiting gave some groups, like the R.S.A. (1916), information about conditions that their headquarters sometimes used to promote policy changes.96 Individual clerics occasionally used their observations to advocate through church courts for improvements, although denominations differed in their attitude to such agitation. Baptists97 and Presbyterians98 were politically more active than other denominations.99
National associations usually lobbied ministers to support resolutions passed at their national conferences and echoed by local branches. Action among the national associations of doctors, public hospitals, and women's organizations was complementary but not well coordinated. Mental health was also part of wider social concern exercised by these groups. For example, apart from enthusiastic individuals, the organized medical profession remained relatively indifferent and responded occasionally to mental health issues more from a sense of collegial obligation. A medical editorial claim that ‘we’ must lead public opinion in the cause of reform was hardly followed by the membership.  

D. Robb (later Sir Douglas) gave scant attention to psychiatry in two important works on health care organization published in the 1940s. Psychological medicine, as he called it, did not pay, and was only sustained by the ‘special temperament’, interest and determination of those who worked in that field.  

Robb’s proposals on comprehensive health care organization, probably be attributed to the influence of Rev. A.S. Wilson, a Baptist minister who formed the Auckland Mental Hospital Reform Association in 1923. See New Zealand Herald, 8 March and 2 May 1923, HMH 4/4/2; Auckland Baptist Auxiliary, Auckland Star, 10 June 1925; deputation of Auckland clergy reported in Dominion, Wellington, 2 May 1922, H 54/79; Auckland Anglican Diocesan Synod, New Zealand Herald, 19 October 1922, HMH 4/4/2; Secretary, Auckland Auxiliary Baptist Union to Minister, n.d., [March 1923?], HMH 4/4/2; Secretary, Baptist Union to Minister, 20 November 1923, H 54/79. 

In 1943, Rev. J. Chisholm took up cudgels on behalf of nurses about their living conditions at Seacliff and his views were raised in Parliament by W.J. Poison (National, Stratford), NZPD, 12 August 1943, p. 598. Chisholm’s concerns were also conveyed in resolutions of the Presbyterian Church General Assembly (Otago Daily Times, 15 October 1943, HMH 26/39). Chisholm was also reported in the Dominion and Greymouth Evening Star, 16 October 1943, HMH 26/39. The next year’s Assembly supported psychotherapy activities and lectures on social adjustment and psychological problems in theological training (Hawke’s Bay Herald-Tribune, 9 November 1944, HMH 26/39). On the motion of the Presbytery Clerk, Rev. E.C. Budd, in 1946, the Auckland Presbytery passed a resolution which called for early psychiatric treatment to be provided outside of mental hospitals; remedial treatment in all mental hospitals; publicity about the role of official visitors; and for greater community involvement in patients’ recreation. See New Zealand Herald, 10 July 1946, HMH 26/39; Clerk, Auckland Presbytery to Minister, 8 October 1946, H 30/10 (28737). 

The Roman Catholic Church presented strong views on the eugenics policy proposals of 1928. Archbishop Redwood reported in Evening Star, 25 July 1928, HMH 25/3. Anglicans also held misgivings though for different reasons (New Zealand Herald [?], 27 July 1928, HMH 26/39). The most notable political intervention by Anglicans occurred in 1921. At the behest of H.M. Buchanan, Medical Superintendent of Hokitika Mental Hospital, Bishop C. Julius, Anglican Bishop of Christchurch, told the media about the true state of the dilapidated and prison-like conditions at that institution. Julius’ action hastened the complete rebuilding of the hospital. Hokitika Guardian, 25 July and 1 August 1921; Lyttelton Times, 30 July 1921; personal communication, the late Dr H.M. Buchanan, August 1969; Warwick Brunton, Sivivatora 125: A History of Seaview Hospital, Hokitika and West Coast Mental Health Services, 1872-1997, Hokitika, 1997, pp. 33-34.
which were published in 1947, made no reference to mental hospitals. Very few presidential addresses or editorials dealt with mental health policy, and discussion on these matters was largely limited to asylum doctors, other doctors in the civil service, and academic physicians.

The interest of hospital and charitable aid boards, too, was also dependent upon a few enthusiastic individuals who could persuade their employing board to take up the issue with the national association. Proceedings show that mental health was of special concern to hospital boards when central government policy or practice threatened to upset the balance between taxes and local rates as a source of health care funding. The Mental Defectives Act was not among statutes considered relevant for hospital boards in 1926. Mental hospital care was not included in the joint proposal of the Hospital Boards’ Association and the New Zealand Branch of the British Medical Association for national health insurance in 1935.

As many of the issues that affected women entered mainstream politics, women tried to influence social policy through their own organizations and the umbrella organization of the National Council of Women. Efforts to remove political disabilities against women in late Victorian New Zealand gave an edge to calls for independent citizen control of mental hospitals as a means of reforming them. Women’s organizations also wanted separate services for temporarily deranged women. The National Council of Women also took an interest in the working and living conditions of mental hospital nurses when they were particularly short-staffed.

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108 Mrs M. Holroyd to Prime Minister, n.d. [May 1938]; Marlborough District Executive Committee, Women’s Christian Temperance Union to Minister of Internal Affairs, 20 May 1938, and Dominion Secretary, New Zealand Cooperative Women’s Guild to Minister, 9 May 1940, H 30/38 (30451).
109 *Otago Daily Times*, 21 October 1944.
National interest groups advanced common themes like diversifying services away from mental hospitals, improving classification, and separating the treatment of neuroses from psychoses. These ideas made a political dent because they came from respectable, middle class and national organizations that were part of the political and social fabric of New Zealand. Lobbying slowly produced a political mood for change, although officials sometimes treated such efforts lightly, as shown by Hay’s cynicism:

It is very doubtful if these organizations ... know what they are asking for - one [hospital] Board passes a resolution and every other Board in the Dominion is requested to similarly act, and they seem quite willing to do this without thought or discussion, beyond the idea that ... the local rates would be proportionately relieved.110

In the 1940s, the Presbyterian Church’s concerns about conditions for staff and patients at Seaciff were discounted as well meaning but ill informed.111 Each of the main pressure groups enjoyed some success in facilitating changes to mental health policy, but they did not develop a sustained, comprehensive, collective or concerted standpoint. The impact might have been greater had there been a national organization dedicated solely to mental health issues.

MINISTERS AND OFFICIALS

Mutualism between ministers and officials was intrinsic to Westminster constitutional systems and the Whitehall administrative system. Ministers were supported by a politically neutral career public service, staffed by anonymous officials. A framework derived from these conventions was enshrined in the Mental Defectives Act 1911.112 Top officials were on hand to brief ministers during crucial Parliamentary debates, such as the Estimates, when the government’s record had to be defended.

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110 Inspector-General to Minister, 12 September 1923, HMH 4/4/0.
111 Director-General to Medical Superintendent Seaciff, 18 October 1943 and reply, 26 October 1943, HMH 26/39; Minister reported in Evening Star, 7 November 1943 and Otago Daily Times, 8 December 1943, HMH 26/39; Director-General in letter to New Zealand Herald, 12 July 1946, HMH 26/39; Minister to Clerk, Auckland Presbytery, 25 October 1946, H 30/10 (28737).
112 Section 42(1) of the Act gave the Inspector-General general administration of the Act under the direction of the Minister. The Inspector-General was given control over the duties of other officers. For an earlier enunciation of the doctrine as it pertained to the Colonial Secretary’s Department, see AJHR, 1866, D-7A, p.5.
Public servants were anonymous because they made their experience, best judgment and departmental knowledge confidentially available to the minister and government of the day, and they put ministers' decisions into effect. Under the convention of anonymity, ministers took public credit for achievements and public servants did their best to brief ministers so as to withstand political criticism. Constitutional convention held (and still holds) that officials live with government philosophy and within their financial allocations. Institutions had to report "unusual occurrences" (such as escapes or suicides) and media comment to the Department's head office. The minister could then be briefed and potential political embarrassment averted. This was not always easy. 'One cannot fool all the people all the time', Hay confidentially told his minister when the Inspector-General had been 'fairly put to it to excuse and explain' why the Department was so short-staffed.

Ministers' comfort increased with the certainty that their advice came from expert officials. W.D. Stewart, who held several major portfolios between 1921-33, made the point generally in 1944. Stewart said that ministers regarded themselves as 'amateurs' who controlled 'staffs of experts'. General or specialist medical practitioners therefore ran the health related departments of state. That principle was questioned only once but then upheld. The Public Service Commission's attempt to introduce top-level lay management in 1946-7, although acceptable to the

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113 Progress in portfolio matters was reported so that ministers could use this information for electoral purposes. See Inspector-General to Minister, 25 May 1910, HMH 1910/542; New Zealand Herald, 8 December 1928, HMH 26/8; Director-General to Minister, 7 September 1935 and 25 July 1938, HMH 26/8.

114 Inspector-General, Circular, 8 November 1907, HMH 26/39. This reiterated a similar circular of 1 April 1891. Medical superintendents were expected to comment on or report press clippings. Inspector-General, Circular, 18 September 1922, Carrington Hospital Archives, National Archives, Auckland, YCAA 1079/1r, File 2/35/2.

115 Inspector-General to Minister (personal), 27 January 1921, HMH 8/62.


117 The Health Amendment Act 1947, s. 3 dropped the requirement for the Director-General and Deputy-Director-General of Health to have special qualifications in sanitary science.

118 It should be noted, however, that in the aftermath of the influenza pandemic, the Minister of Public Health, G.W. Russell, was adamant that administrative control of the Department of Public Health, Hospitals and Charitable Institutions should remain with a qualified doctor and not 'an expert business administrative officer'. Dow, p. 81.
Prime Minister and one health minister,\textsuperscript{119} was overturned by an incoming minister,\textsuperscript{120} even after the decision was announced publicly.\textsuperscript{121}

Politicians accepted and relied upon the expertise of specialist psychiatrists in the Department. New, inexperienced or weak ministers and incoming governments with little or no previous experience were particularly reliant upon public servants for advice and information.\textsuperscript{122} Every departmental head was chosen for his specialist experience and/or qualifications in psychiatry (see appendix 2). Moreover, the training or experience and the professional affiliation of all departmental heads provided a British reference point for progressive practice. The first two Inspectors-General were recruited from Britain\textsuperscript{123} but all subsequent appointments were made within New Zealand. The overseas appointments of Skae and Grabham had not proven long lasting. It was cheaper to recruit people locally.\textsuperscript{124} MacGregor's recent experience had been in the Otago asylums. After 1911, the law required the departmental head to be a medical practitioner\textsuperscript{125} although in practice, appointees were specialist psychiatrists. The position of Director, Mental Hygiene Division, retained that requirement.

\textsuperscript{119} Cabinet Minute, 19 February 1947, unauthored note of meeting with Minister, 19 February 1947, SSC 21/105.

\textsuperscript{120} Minister to Chairman, Public Service Commission, 8 April 1947, SSC 21/10/5; AJHR, 1943, H-14, p. 7; Dow, pp. 155-6. The Hospital Boards' Association may well have been crucial to the Minister's change of mind. \textit{Dominion}, 1 July 1947, HMH 26/39. The most senior administrative appointment was then made at the second level of management.

\textsuperscript{121} Minutes of Meetings of Public Service Commission, 20 February, 3 and 31 March 1947, SSC 21/105; \textit{Evening Post}, 13 March 1947, HMH 26/39.


\textsuperscript{124} As he left England, Grabham said that he had no intention of allowing his new job to kill him as it had his predecessor. Grabham undertook to return to Britain after three years if he did not find things satisfactory. \textit{Lyttelton Times}, 23 November 1882. He was true to his word. Little is known of Grabham's career after he returned to England in 1886. K.A. Simpson, 'Grabham, George Wallington (1836-1912)' in DNZB, Vol. II, 1993, pp. 174-5. MacGregor also owed his appointment to the patronage of a fellow Otagoite, admiring former student, relative by marriage, and Premier (1854-7), Robert (later Sir Robert) Stout. Stout's government did not accept Grabham's parting advice that his job should be divided, with an inspector of asylums and hospitals in each island. MacGregor did not figure in Grabham's advice. Inspector-General to Colonial Secretary, 26 October and 10 November 1885, HMH 1906/1176; NZPD, 27 June 1889, 64, p. 79.

\textsuperscript{125} Mental Delectives Act 1911, s. 41; Mental Defectives Amendment Act 1928, s. 5; Health Amendment Act 1947, s. 4.
Ministers familiarized themselves with the job by day-to-day contact with the departmental head, reports and briefings, and by visiting mental hospitals to see conditions for themselves. According to Dr D. Pollen, a minister provided the public face of a department - 'speech-making and Bill-constructing in the Assembly' – but this was a ‘very small and unimportant part of the public business of the nation'. Ministers, Pollen suggested:

did no more than represent what are called the walking-assistants in the draper’s shop, their business being to look pleasant, and make themselves agreeable to customers who have votes, and see that the shop is closed at the proper time.126

Pollen’s characteristic sarcasm127 belies the fact that a minister’s personality and personal interest in the portfolio could provide fresh insights and impetus for new policy. A minister’s ability to make a mark on the portfolio (or at least to take the credit for innovative policy) was affected by economic and fiscal constraints during recessions and years of depression, wartime pressures and post-war priorities. The energy levels of a new or a weary government, proximity of an election, the dominance of the prime minister, and whether or not a minister was intended to occupy the post temporarily, were other considerations.

Setting aside ministers whose appointments were clearly temporary or short-term, what is known about the impact and style of individual ministers? The way D. Pollen shepherded the establishment of the Department in the provincial era bears out the views of his political contemporary, W. Gisborne, that he was a skilful administrator, safe and cautious, but pliable, with a strong undercurrent of common sense.128 G.S. (later Sir George) Whitmore was reluctant to accept the office of Colonial Secretary, which he held from 1877-79.129 A political career was no real substitute for Whitmore’s thwarted military ambition. Used to a military command, Whitmore was notoriously difficult to deal with.130 He held strong views on the topic of asylum

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126 NZPD, 16 July 1886, 55, p. 568.
128 Gisborne (1886) in Sharp, p. 45.
architecture, and firmly believed that asylum buildings should be permanent in character, just as his principal adviser began to question the wisdom of building large institutions for chronic patients.

The colourful Whitmore stands out from his nineteenth century successors. The historian McLintock said that T. Dick (Colonial Secretary, 1880-84) distinguished himself more by an assiduous devotion to duty than by any display of brilliance. His policy was cautious and unimaginative, the true reflection of an estimable but dull character. P.A. (later Sir Patrick) Buckley (Colonial Secretary, 1884-7) was described by his biographer as an ‘administrator of his portfolios rather than an innovator of legislation’. As a minister, T.W. Hislop (Colonial Secretary, 1887-9) may have been more enterprising, but there is little to show for it in his charge of asylums. The gentlemanly W.R. (later Sir William) Russell, Colonial Secretary (1889-91) joined the list of careful administrators but reckoned himself soft.

Seddon’s lengthy premiership (1893-1906) was marked by his inordinate capacity for taking on additional portfolios. He became what Burdon called ‘the one-man Cabinet’ where ministers were seldom permitted to have opinions either on matters of policy or administration. Wary of intellectuals, Seddon surrounded himself with ministerial nonentities. Responsibility for asylums was simply tacked on to other portfolios. A.J. Cadman (Native Minister, 1891-2) worked hard at reforming the Native Department to achieve economies. The intellectual W.P. Reeves (Minister of Education, 1892-6) made educational reform and labour legislation, not asylums, his

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131 NZPD, 4 November 1879, 33, pp. 61-62.
132 AJHR, 1880, H-6, pp. 4-5.
135 At the time of MacGregor’s death, Hislop recalled how as minister, he and the Inspector-General worked together on a Bill to reform charitable aid in 1889. New Zealand Times, 17 December 1906. Hislop also introduced a series of labour Bills during the industrial crisis of 1890. They failed to pass but the measures were subsequently developed and enacted by the incoming Balance government in 1891. R.S. Burdon, King Dick: A biography of Richard John Seddon, Christchurch, 1955, pp. 84-85.
137 Burdon, op. 152, 174, 290, 299.
priorities.\textsuperscript{139} W. (later Sir William) Hall-Jones (Minister of Public Works, 1896-1906) was thoughtful but self-effacing, a careful and cautious administrator.\textsuperscript{140} The pace of domestic reform slowed down under the Ward ministry (1906-12). Ward seemed not to trust his colleagues nor would he delegate political power.\textsuperscript{141} D. Buddo (Minister, 1911-2) was less zealous than his predecessor, Fowlds. G.W. Rice described Buddo as a ‘middle-of-the-roader unlikely to evoke strong opposition’. He was a ‘diligent and efficient minister but made no great impact on national politics.’\textsuperscript{142}

Conservative led ministries between 1912-35 were preoccupied with the fiscal effects of World War I, chequered economic progress in the 1920s, and the calamitous great depression to appoint enterprising ministers to take charge of mental hospitals. W.F. Massey’s financial statement of 1922 summed up well the prevailing attitude of maintaining mental hospital treatment programmes on ‘established lines’.\textsuperscript{143} Safe ministers were a guarantee of that. Besides, public health and hospitals administration were the dominant part of their responsibility. G.W. Russell (Minister, 1912, 1915-9) deemed public health to be the most important portfolio in connection with the country’s public services.\textsuperscript{144} R.H. (later Sir Heaton) Rhodes (1912-15) was diligent, efficient and able, but his biographer says that he was ‘not forceful or ruthless enough to make a big difference in politics’.\textsuperscript{145} Modest and unselfish, he readily resigned his charge in the interests of a wartime national government in 1915.\textsuperscript{146} C.J. (later Sir James) Parr, Minister, 1920-3, entered national politics after several years of providing what he himself called ‘active leadership’ as mayor of Auckland (1911-5).\textsuperscript{147} There was less evidence of that zeal in his administration of the mental hospitals portfolio (1920-3) during the lame-duck phase of Hay's

\textsuperscript{141} Michael Bassett, Sir Joseph Ward: A Political Biography, Auckland, 1993, pp. 173-4.
\textsuperscript{142} Geoffrey W. Rice, ‘Buddo, David’, DNZB, Vol. Three, Wellington, 1996, p. 76. Dow, p. 70, cites evidence that the then head of the Public Health, Hospitals and Charitable Institutions Department begged Fowlds to continue or else to find a better minister than Buddo who could not grasp the health portfolio.
\textsuperscript{143} AJHR, 1922, B-6, p. xxiv.
\textsuperscript{144} Dow, p. 31. Elsewhere, Dow, pp. 85-120 gives a good account of these issues.
\textsuperscript{146} Scotter, p. 401.
inspectorate. Freed from that burden in late 1924, however, Sir Maui Pomare, Minister (1923-5), embarked upon major reform. In conjunction with Sir Truby King, Pomare set about an overdue and wholesale overhaul of the Department.¹⁴⁸ Pomare’s successor, J.A. (later Sir James) Young (Minister, 1926-28 and 1931-35) tackled the challenge of a controversial eugenics policy after several years of government pussyfooting in the 1920s. Young was virtually powerless to bring about major improvements for patients, like reducing the level of overcrowding, because of severe retrenchment in government services¹⁴⁹. Perhaps it is not surprising that Young seemed more interested in finding the ‘Waitate [sic] eucalypti’ than in visiting the overcrowded male wards at Seaciff in 1932.¹⁵⁰ A.J. Stallworthy was appointed Minister (1928-30) as a brand-new Member of Parliament.¹⁵¹ Certainly his scope for action was severely constrained by the strict economy of the depression. Gray thought Stallworthy so frugal as to live in Parliament House to avoid personal expense.¹⁵²

Ministers were quite capable of putting their personal mark on policy. Capital improvements at Porirua Asylum were expedited after the minister saw the problems first hand in 1900.¹⁵³ Overseas visits by W.C. Walker (1902) and W. Hall-Jones (1904) acquainted them with trends and helped sell ideas politically, including law reform,¹⁵⁴ the villa system, and the value of placing female nurses in charge of male wards.¹⁵⁵ A clear believer in eugenics, Fowlds managed to shepherd the Mental

¹⁴⁸ AJHR, 1925, H-7, p. 1. Pomare was one of two ministers who held a medical qualification. Sir Maui Pomare’s expertise lay in public health. It is not known whether he worked in mental hospitals. A recent biographical entry recalls Pomare’s ministerial contribution in terms of public health challenges of the day, even though he undertook a sweeping review of mental hospitals. Graham Butterworth, ‘Pomare, Maui Wiremu Piti Naera’, DNZB, Vol. 3, p. 407. The other minister was D. Pollen who ‘apparently’ held a medical doctorate and was invariably addressed as Dr Pollen. See G.H. Scholefield, A Dictionary of New Zealand Biography, Volume Two, Wellington, 1940, p. 172.

¹⁴⁹ AJHR, 1932-33, B-4A, p. 65.


¹⁵¹ Bassett, Ward, p. 271. Stallworthy was a journalist and newspaper editor who had taken an interest in health matters for many years.

¹⁵² Personal communication, Mr E.N. Titble, 22 December 1970.

¹⁵³ Medical Superintendent’s report, Porirua, AJHR, 1901, H-7, p. 8.

¹⁵⁴ Medical Superintendent, Seaciff to Minister, 28 May 1902, DAHI D 264 /24. Convincing the Premier of the timeliness of legal reform was another matter. According to one historian of the period, ministers other than Ward and Seddon were ‘mere cyphers’. By 1904, a contemporary political commentator thought that Seddon’s administration was paralysed because of the Premier’s constant procrastination. Bassett, Ward, pp. 127, 133.

¹⁵⁵ Press, 5 August 1904.
Defectives Bill, with its eugenics overtones, through the House in 1911 after six years of bureaucratic gestation. This was an exception to a political slow-down of domestic reform in the latter years of the Ward government (1906-12). A.H. Nordmeyer’s flying visit to Raventhorpe Hospital as Minister (1941-7) resulted in a direction that the Department investigate dropping the word ‘mental’ from the name of hospitals.\textsuperscript{156} The policy mirrors a much earlier incident when Fowlds complained that mental hospitals were still listed as lunatic asylums in telephone directories.\textsuperscript{157} P. Fraser, Minister (1935-40), took a keen interest in his health portfolios and energetically promoted changes within the reforming social and economic policy zeal of the first Labour Government. He was very circumspect about the experience of mental illness in his own family and his wife’s mental breakdown in 1934. Fraser’s wife, Janet, was an important and well-informed source of information for him about mental hospitals.\textsuperscript{158} Miss Mabel Howard, Minister (1947-1949), regarded the health portfolio as a woman’s job.\textsuperscript{159} She cared deeply for those with no political power or voice and she championed their rights.\textsuperscript{160} As ‘a woman and a housekeeper’, her astute observations of institutional drabness contributed directly to major refurbishment.\textsuperscript{161} She was horrified at the standard evening fare and personally ordered that patients be regularly supplied with fresh fruit.\textsuperscript{162} Howard’s extraordinarily productive partnership with Russell as the departmental head brought about improvements that were reminiscent of the Pomare-King collaboration in 1924-5 or the productive Fowlds-Hay years 1907-11.
Leaving aside personal policy initiatives, how did the policy-making role of ministers strengthen departmental influence? Ministers were easily bogged down in a 'mass of detail' referred by departments, about which ministers knew little. Much of this detail involved decisions required under the prevailing levels of administrative, financial and statutory approvals. Until 1912, for example, ministers wielded influence over civil service appointments. The volume of staff approvals meant that ministers usually rubber-stamped departmental recommendations. The notable exception was a clash between the Inspector-General and his minister, T.W. Hislop, in which ministerial prerogative and patronage triumphed over well-founded official advice.

If officials were meant to handle detail, then ministers were expected to concern themselves with big decisions. The Royal Commission of Inquiry into the Public Service (1912) declared that acting collectively through Cabinet, ministers were well suited to settle 'broad policy lines'. J.R. (later Sir John) Marshall, Minister of Health (1951-4), took that view and provided the clearest exposition of administrative practice. Marshall held that a minister was responsible for major policy decisions, especially those that changed or varied departmental functions. He suggested that ministers set the parameters of policy through the principles and philosophy of a political party or election manifesto commitments. Ministers determined collectively policy on expenditure control, legislative priority, and so on. Ministers exercised

163 AJHR, 1912, H-34, pp. 18-19.
165 At stake was the Civil Service Reform Act Amendment Act 1887, which enabled governments to by-pass recruitment by civil service examination and to appoint 'skilled persons' and 'extra clerks' on a temporary or casual basis. In this particular instance, the Inspector-General was instructed to check the suitability of a Miss Finch for appointment as an asylum matron. He was not impressed with her state of health. The Colonial Secretary, T.W. Hislop, persisted and reminded the Inspector-General of his powers. Over the additional protest of the Medical Superintendent, Miss Finch was appointed the Matron of Wellington Asylum in 1889. As foreseen by officials, the appointment was disastrous. The Inspector-General explained this to her on 6 June 1893, when he requested her resignation. Finch accepted the generous financial terms of the offer but then changed her mind on legal advice from Hislop, who had left national politics to return to law. Meanwhile the Matron's position had been filled. The Inspector-General was indignant that the ex-Minister had not helped him get 'rid of an incubus which he himself had saddled on the department.' Hislop took 'grave political offence' to such questioning of Ministerial authority but to avoid a personal quarrel, Hislop withdrew from the case. The then Minister (W.P. Reeves) directed the Inspector-General to formally give Finch three months notice and to have the papers tabled in Parliament, presumably to expose Hislop's behaviour. The full correspondence is contained in the Legislative Department Archives, National Archives, Wellington, File LE 1/1893/122. In September 1889, the Legislative Council censured Hislop for his use of patronage appointments. Judith Bassett, Sir Harry Atkinson, Auckland, 1975, p. 151.
collectively and individually considerable discretion over the allocation of government funds and public works. Ministers also established what Marshall called ‘circumstantial policy’, that was prompted by changes in economic, social or international conditions, successful lobbying, and ideas copied from overseas.\(^{166}\)

**THE ORGANIZATIONAL CONTEXT**

The Department was well organized to provide specialist policy advice. It was a core function from the beginning as the first Inspector-General’s job description made clear. Skae was to see that:

> the various provisions of the law with reference to lunatics and Lunatic Asylums in the colony are carried out, and to report from time to time upon the state and condition of the several Lunatic Asylums and the inmates thereof, and to render all assistance in his power to the Government in initiating and carrying out such measures as may from time to time be found necessary to promote the care and proper treatment and supervision of lunatics.\(^{167}\)

From the outset, departmental heads viewed policy as their professional domain. ‘Insanity is in all cases a bodily disease, and disease is the field of the physician,’ Skae claimed in the Department’s very first report. There was ‘uneasiness and distrust in seeing what is universally regarded as medical work performed by non-medical men.’\(^{168}\) Staying within the medical framework, in 1921, Hay confided to his minister that

> the ideally ruled State, like the ideally ruled Institution, needs a benevolent autocrat, and that would be the unquestioned government of the nations, were the combination not so rare.\(^{169}\)

Russell also jealously guarded this professional preserve,\(^{170}\) and chided medical superintendents as late as 1950:

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\(^{167}\) Articles of Agreement, 10 May 1876, AJHR, 1876, H-4c, pp. 4-5.

\(^{168}\) AJHR, 1877, H-8, pp. 4-5.

\(^{169}\) Inspector-General to Minister (Personal), 27 January 1921, HMH 8/862.
If the control of this Division is Medical [sic], and I consider it should be, with delegation to responsible officers wishful of carrying out what we consider necessary, then I would expect to be notified if it were obvious that my control in any respect was being “by-passed” ... No doubt would ever be in the mind of any of you as to my own attitude towards control in this Division ... I trust that a decision may be made that entire confidence may be assured between Medical Staff and their Director in the future.  

As the first Director, Mental Hygiene Division, Russell’s duties involved ‘medical administration’, a term that encompassed the general direction of professional, technical and statutory matters affecting mentally defective persons.

The professional basis of policy-making in the head office was strengthened in several ways. A library was begun during Grabham’s inspectorate. Medical superintendents were given the chance for some local input to policy through their annual reports (after 1896), and annual conferences (after 1913). The Department strengthened its complement of professional staff. ‘Driven’ as much by his breakdown in health in 1894-95 as by ‘recent social and political developments’

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170 Acting Director-General, Circular, 15 August 1947, HMH 25/21.
171 Director, Circular, 26 January 1950, Seaview Hospital Archives, held at Seaview Hospital, Hokitika, pending transfer to National Archives, Christchurch, CAHW CH 706, File 2/18/3 (241).
172 Minutes of Meeting of Public Service Commission, 31 March 1947, SSC 21/10/5.
173 This is based on the fact that the Ministry of Health’s series of the British Medical Journal, Lancet and Journal of Mental Science commence in 1881. The bound copies are stamped Inspector of Asylums. The Department / Ministry of Health disposed of another series, Brain, to the Wellington School of Medicine Library. The author possesses a few early titles from the original library when the Department of Health library disposed of surplus books.
174 Inspector-General, Circular, 3 February 1896, Inspector-General’s Letter Book 6, p. 315. This volume, the only surviving outwards letter book of the head office, was formerly held in the Department of Health’s head office along with some early mental health files. Its current whereabouts is unknown. Medical superintendents of the time used their reports to suggest new policy for admission procedures, general hospital psychiatry, professional nursing, and asylum design. All of these suggestions came to pass years later. MacGregor’s attitude was markedly different from that of Russell. In 1948, he admonished the Medical Superintendent, Porirua, for thinking that his report should be published for the benefit of the Minister, Parliament, the public, or anyone other than the Director. Medical Superintendent, Porirua to Director, 19 July 1948 and reply, 22 July 1948, HMH 26/40/1.
175 The first conference was held in 1908 and became an annual event after 1913. AJHR, 1914, H-7, p. 10. Examples of day-to-day policy obtained from early agendas include superannuation, fire safety and a new staff rule book (1908), dietary scales, stores purchase, staff probationers, and staff numbers (1919), and rules and regulations, staff: patient ratios, intermediate care, female nurses working in male wards, and the size of mental hospitals (1923). AJHR, 1909, H-7, p. 9; Inspector-General to Medical Superintendent, Auckland, 27 June 1919, YCAA 1079/1, File 2/10; Agenda, 20 June 1923, HMH 8/94/1.
176 AJHR, 1895, H-7, p. 2.
MacGregor sought ministerial approval to appoint Mrs Grace Neill to the newly established position of Assistant Inspector. Responsibilities for charitable aid investigations and hospital nursing services soon absorbed most of her energy, but Mrs Neill's contribution to asylums was valuable enough to ensure an intermittent nursing presence in the head office after she retired in 1906. A second senior medical position, Deputy Inspector-General, was established in 1904 and filled intermittently until 1926, and then it was made permanent. No further increases in professional staff took place until Gray took advantage of the absence on active service of his deputy, Russell, to set up a new position of Director of Clinical Services. He installed a rather conservative colleague, R.G.T. Lewis, whom Gray found more compatible than Russell. Lewis's position was part of a grandiose plan to strengthen professional direction in head office. Had the plan been approved, a matron-in-chief, architect, consulting engineer, and chief occupational therapist would also have been appointed.

By expanding the number of professional staff in the head office, Gray hoped to free himself and his deputy from the minutiae of administration so as to concentrate on the development of policy and plans. Gray's dilemma warrants some sympathy as it suggests that the Department's dual policy and significant management responsibilities had got out of balance - the culmination of a drift since events of 1881. At the risk of digression, these events should be explained. Skae likened his job to the inspectorial and technical advisory roles of the Lunacy Commission's in

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177 Inspector-General to Minister, 4 April 1895, H. 45/14 (no closed file number).
178 NZPD, 12 October 1906, 138, p. 251; New Zealand Times, 9 October 1906; AJHR, 1907 H-7, p. 15. Mrs Neill retired on 31 December 1906, which coincided with the interregnum in the central inspectorate. Neill's successor, Hester Maclean, held a joint nursing appointment to the Hospitals and Mental Hospitals Departments. AJHR,1907, H-5, p. 55. This joint appointment survived, at least in theory, until 1920 when Miss Maclean was appointed Director of the Nursing Division of the Department of Health. See Patricia A. Sargison, 'Maclean, Hester' in DNZB, Vol. Three, Wellington, 1996, pp. 309-11. Hay looked for someone 'thoroughly acquainted with the ways of patients and the domestic economy of mental hospitals' to spend time inspecting the women's side of these institutions. Miss E. Hanna was then appointed Inspecting Matron. AJHR, 1920, H-7, p. 5.
179 AJHR, 1904, H-7, p. 12. The position was established when MacGregor was seriously ill.
181 Director-General to Minister, 2 May 1944, HMH 8/0/1. Some senior hospital staff also had an advisory function to the head office during this period. Among them were the Supervising Occupational Therapist and the Farm Manager at Auckland Mental Hospital.
182 Director-General to Secretary, Public Service Commission, 14 December 1945, HMH 8/0/4.
Deprived of local inspectorial back-up from honorary deputy inspectors and official visitors until 1879, Skae’s workload was enormous even before the inspection of hospitals and charitable institutions was thrust upon him in February 1880. The way Skae perceived his job did not convince a royal commission set up to inquire into allegations of ill-treatment to patients at Wellington Lunatic Asylum (1881). The press called for his blood. Skae’s failure as a general manager cost him dearly. He was dismissed, but died while serving out his notice.

After the debacle, Dick, the Colonial Secretary, wanted an efficient department and proper advice. Grabham recast the Inspector-General’s job to be:

virtually the Manager of all the Asylums, performing all the duties which would devolve elsewhere upon Committees of Management. He is appealed to in every difficulty and

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183 Skae, evidence to Royal Commission on Wellington Lunatic Asylum, IA 101/1, 18 March 1881, p. 94. cf. 21 March 1881, pp. 38, 67-78.
184 Deputy inspectors were scrapped soon after Skae was appointed with savings equivalent to one-third of his salary. W.T.L. Travers [Deputy Inspector, Wellington] to Colonial Secretary. 11 January 1877, IA 1/347, L. 77/139; AJHR, 1877, H-8, p. 12 and 1880, H-6, pp. 3-4; Skae, evidence to Royal Commission on Wellington Lunatic Asylum, 21 March 1881, IA 101/1, p. 27; Report of the Royal Commission on Wellington Lunatic Asylum, IA 101/1 pp. 14-15; New Zealand Gazette, 22 May 1879, p. 689, 19 August and 14 October 28 October and 11 November 1880, pp. 1223, 1474, 1545, 1611. Another batch of appointments followed Skae’s death in 1881, if only because statutory responsibilities of inspectors had to be performed and to avoid the inconvenience of travel by one officer. NZPD, 18 May 1882, 41, p. 712; New Zealand Gazette, 9 June and 11 August 1881, pp. 732, 1046, 2 and 9 February, 30 March, 6 July and 23 November 1882, pp. 196, 223, 510, 930, 1751; Colonial Secretary’s minute on L. 82/5059, 25 November 1882, HMH 1910/1081.
185 Skae received no extra payment for these duties, although his contract allowed the Government to pay a gratuity. Colonial Secretary to Inspector-General, 23 February 1880, IA 4/47; New Zealand Gazette, 4 March 1880, p. 264; Agent-General to Hon. R.H. Meade, Colonial Office, 21 May 1875, AJHR, 1875, H-2b, p. 2; Articles of Agreement, 10 May 1876, AJHR, 1876, H-4c, pp. 4-5. Ministers also called upon Skae’s general medical expertise elsewhere within government. The Inspector-General was a standing member of the Central Board of Health. Skae undertook at least one sanitary investigation for the Board. In 1878, Skae also undertook a formal inquiry at Christchurch Hospital. F.S. McLean, Challenge for Health, Wellington, 1964, pp. 111-12, 118; AJHR, 1975, H-23, pp. 22-23. The Otago Guardian, in an editorial of 29 November 1876, criticised the fact that Skae was diverted from his proper duties.
186 Skae, evidence to Royal Commission on Wellington Lunatic Asylum, 18 March 1881, IA 101/1, pp. 92, 94 and 21 March 1881, IA 101/1, pp. 87-88, West Coast Times, editorial, 2 April 1881; Christchurch Globe, editorial, 18 April 1881; editorials, Evening Post, 19 April and 6 May 1881; Christchurch Star, editorial, 21 May 1881.
187 Skae was a scapegoat for the tragedy and he was tormented by the events that led to his dismissal. Skae died of ‘mental shock’ and erysipelas. I am grateful to the late Dr D.T. Clouston for furnishing details from Skae’s death certificate. Colonial Secretary to Inspector-General, 20 May 1881, IA 4/50, L. 80/712. Departmental officers and former Scottish colleagues subscribed to the cost of his gravestone in St Mary’s Burial Ground, Karori, Wellington, and an obelisk erected in memory of Skae at Wellington Asylum. The obelisk can now be found in the grounds of Porirua Hospital.
188 NZPD, 9 August 1881, 39, p. 397.
emergency, and controls the expenditure of every establishment down to the smallest details.\textsuperscript{189}

Grabham possibly exaggerated how closely he personally managed the Department to justify his status. He professed a desire to be relieved of office work in order to concentrate on the ‘more congenial duty of Inspector’, but said that only with the ledgers before him could he control expenditure down to the smallest details.\textsuperscript{190} Like MacGregor after him, Grabham faced a punishing annual schedule of inspections of asylums and hospitals.\textsuperscript{191} Institutional inspections remained important. The Inspector-General’s reports on visits to individual mental hospitals were summarized and published every year until 1924.\textsuperscript{192} As late as 1940, Gray used impressions from his inspections to alert medical superintendents to signs of institutional slackness.\textsuperscript{193}

In 1876, the clerk-accountant of the minuscule head office had to deal with much of the day-to-day administration of financial, personnel, and information systems and rules. Judging from the decennial charts of the Department’s organization (appendix 3), clerical staff numbers at the head office showed little change until the 1920s after which the Chief Clerk operated as a “super-secretary” of all the hospitals.\textsuperscript{194} The clerical team grew to process work generated by the expansion of departmental activities. Some administrative and technical functions were centralized, including the national patient registration system (1882),\textsuperscript{195} capital works (1910),\textsuperscript{196} and the collection of maintenance payments (1910).\textsuperscript{197} The administration of delegated financial, personnel, supplies and public works controls across government also

\textsuperscript{189} Inspector to Colonial Secretary, 23 July 1885, IA 4/3/30.
\textsuperscript{190} Inspector-General to Colonial Secretary, 20 July 1885, IA 4/3/30. How much attention he could personally devote to administrative and financial matters and how much he had to delegate to the Clerk / Accountant is hard to gauge from the few surviving records.
\textsuperscript{191} Grabham travelled 4158 miles in 1882-3 on his initial tour of inspection, and 6452 miles between April 1884-5. Simpson, pp. 174-5.
\textsuperscript{192} AJHR, 1924, H-7, pp. 5-6.
\textsuperscript{193} Director-General, Circular, 27 June 1940, HMH Institutional Circulars, 1940-42.
\textsuperscript{194} Personal communication, Mr J. Gilbert, 5 April 1971.
\textsuperscript{195} AJHR, 1885, H-10, p. 4. Committal papers were personally checked for legal accuracy. As late as the 1960s, the Deputy Director still undertook this duty, and returned documents for correction or amendment. By that time, a clerical officer made a preliminary check and referred papers about which there were questions to the Deputy Director. Personal communications, the late OrS.w.P. Mirams and Mr J.O. Mackie.
\textsuperscript{196} The Public Health, Hospitals and Charitable Aid Department and the Mental Hospitals Department under the direction of an architectural draughtsman formed a Works Section jointly. The move encouraged standard plans for mental hospital accommodation. AJHR, 1912, H-7, p. 8.
\textsuperscript{197} AJHR, 1912, H-7, p. 9.
consolidated clerical influence. Although the minutiae of administration still absorbed some of the attention that they believed should be given to policy and planning, departmental heads left much routine administration to clerical staff so that, as Gray told the first Chief Clerks Conference (1940), medical superintendents stayed on the right track. Such monitoring was irksome to independent and energetic local administrators. Years before, Truby King, bluntly told the Inspector-General:

The encroachment on my time and the mental paralysis brought about by having to make endless explanations and reports is reducing me to the level of lower grade German officials. I believe strongly in systematisation and reasonable uniformity, and I always welcome everything that makes in that direction; but I feel bound to protest against the wiping out of enthusiasm and personal responsibility which a spirit of uncompromising bureaucracy always brings to pass. It seems strange that so much detail and explanation should be exacted. Dickens' scathing pictures of the Circumlocution Office and the dying of chancery claimants before their assets were settled is the nearest parallel that occurs to me.

So far in this chapter, I have discussed how the Department acquired a prominent place in policy-making because of constitutional convention and by the desire of successive governments to access a core group of specialist advisers who could be entrusted with the detail. Bureaucratic organization facilitated the provision of a constant stream of advice that was informed by the Department's twin function of running nearly all of New Zealand's specialist psychiatric services. In that centralized system, information reported from institutions fed into policy advice and helped to monitor the way policies were implemented. These systemic processes and

198 The Treasury, Public Works Department, Public Service Commission (1912) and Government Stores Board (1922) held key roles in interdepartmental coordination and priority setting. For examples of financial delegations, see Prime Minister to Minister, 28 February 1929 and Minister of Finance to Minister, 28 September 1931, H 164/62 (31024); Chief Clerk, Circular, 16 May 1935, YCAA 1079/9J, File 721-.
199 Personal communication, Mr E.N. Tibble, 22 January 1971.
201 From 1877, annual reports published statistics on the percentage of recoveries and deaths on admissions, the percentage of deaths on the average number resident, the percentage of deaths on the number under care, and details of revenue and expenditure. The Medical Journal was the source of a comprehensive weekly report. It provided details on accommodation, the use of confinement, seclusion and restraint, employment and recreation, nursing dependency, and mortality. The Medical Journal was required to be kept by the Lunatics Act 1868, ss. 25, 43 and Fourteenth Schedule; Lunatics Act 1882, ss. 56, 99, Schedule No. 12. These returns were used to compare and comment on the proportion of workers at institutions, e.g. AJHR, 1881, H-13, p. 5.
structures should not be seen solely in mechanistic terms because they were devised and run (or at least tolerated) by departmental heads. The personality of the individuals who headed the Department therefore contributed to its influence on policy and policy-making.

Some departmental heads fitted better than others the mould of anonymous civil servants. Although not afraid to state their opinions in official advice and reports, Skae, Hay, Russell and most likely Grabham about whose personality so little is known, kept a low public profile. The likeable Skae, for instance, was remembered as ‘singularly sensitive and retiring.’ He exhibited diligence, modesty and diffidence about his own powers, almost to a fault. He was ‘thoroughly sensible, never in extremes’, well tempered, but with a keen sense of the ludicrous. Hay was reserved, thoughtful and artistic. He was also media shy lest institutions be ‘made copy’. Russell was remembered as a man of modest and retiring disposition, happier in clinical work than in the ‘broader, less personal field of administration at policy-making levels.’ Russell himself admitted that he was publicity shy but he ‘fought tenaciously’ in official circles for ‘spectacular’ material improvements in mental hospitals.

By contrast, MacGregor, Sir Truby King and Gray dominated their Department. MacGregor brought to the office a keen mind, zeal, stern and controversial views, a forceful personality, inordinate propensity for work, and a close and at times high-handed management style. In the early years of his administration at least, patients were drilled and paraded before the Inspector-General at some asylums before having the opportunity to personally discuss grievances or discharge prospects with the departmental head. In 1893, H.S. Fish, M.H.R. (City of Dunedin) criticized him

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202 *New Zealand Times*, 27 June 1881.
204 Personal communications, the late Dr H.M. Buchanan, 21 December 1970, and Mr I.M. Lilly, 22 December 1970.
205 Inspector-General to E. Arnold, 21 May 1907, HMH 1907/461.
206 Director to H. Palmer, 28 April 1949, MH 28/68.
208 Seaview Asylum Inspector’s Book, 19-20 December 1884, West Coast Hospital Board Archives, National Archives, Christchurch, CAHW 63 Ch 22; Medical Superintendent’s report, Sunnyside Asylum, AJHR, 1882, H-13, p. 13; Inspector-General’s reports, AJHR, 1885, H-10, pp. 7-9, and 1887, H-9, p. 10.
as 'untrammelled, except for official form's sake, by the Minister'. T. Fergus M.H.R. (Wakatipu) claimed that MacGregor could dominate his Minister as easily as he could turn his finger.\(^{209}\) According to the visiting Fabian, Sidney Webb, MacGregor's 'querulous railings'\(^{210}\) against the Liberal Government's social policy were fruitless, exceeded the tolerable limits of bureaucratic discretion, and aligned MacGregor with the Premier's political rival, Stout.\(^{211}\) As early as 1893 it was clear that the Inspector-General's views were politically unacceptable and brakes were applied. A Parliamentary critic encouraged MacGregor to go 'Home' to study modern treatment methods.\(^{212}\) The government provided additional help for inspections.\(^{213}\) By 1898, MacGregor's paterfamilial style and "super-superintendence" left Truby King wondering whether:

> there is an official head to the Seacliff Asylum outside Wellington ... Official etiquette and courtesy ... is the common basis of all official life. Your failure in such observances has I know been a cause of pain and worry to other superintendents and is liable at any time to give rise to serious misunderstandings. I have long since ceased to expect timely answers to letters though the whole sum of your correspondence with me probably does not exceed a couple of pages of foolscap per annum.\(^{214}\)

King, in turn, was strongly opinionated, dominating, eccentric, and egotistical.\(^{215}\) This national icon had years of practice as a professional ideologue and driving force

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\(^{209}\) NZPD, 1 September 1893, 81, pp. 559-60.


\(^{212}\) W. Maclean (City of Wellington), NZPD, 18 August 1893, 81, p. 199. He did not get the chance for his first leave since taking office until 1902, when he sought and was granted extended leave on health grounds. Inspector-General to Minister, 21 and 30 January 1902, HMH 1902/1176. The areas of particular interest to him occurred in Scottish asylums: cheap wood and iron buildings for consumptives in asylums, the toxic theory of causation of insanity, new nursing methods at Larbert, and hospital treatment of early forms of insanity. MacGregor ruled out any progress with these ideas until basic classification and overcrowding had been dealt with. AJHR, 1903, H-7, p. 4.


\(^{214}\) Medical Superintendent, Seacliff to Inspector-General, 3 February 1898, Plunket Society Archives, Hocken Library, 89-098-16.

\(^{215}\) R.M. Burdon, *New Zealand Notables*, Christchurch, 1945, Series 2, p. 46; Mary King, pp. 205, 224, 290; Margaret Tennant, *Children's Health, The Nation's Wealth*, Wellington, 1994, pp. 24, 71-73, 77; Barbara Brookes, 'King, Frederic Truby' in DNZB, Vol. Two, Wellington, pp. 257-8; personal communications, the late Mrs H.M. Prins, 10 December 1969, the late Dr M.B.M. Tweed, 7 December 1970. An anecdote by Dr Tweed also illustrates the point. Tweed was a relative by marriage of George Bernard Shaw. When Shaw visited New Zealand in 1934, Tweed arranged a meeting.
within health administration and as the founder of a major national voluntary organization, the Plunket Society (1907), before taking charge of the Department. Gray was of similar ilk but lacked King’s intellectual brilliance. Phrases used by senior staff of the Department recalled his forcefulness. Everyone had to ‘knuckle down’ to him. He ‘definitely ruled’ the Department. Gray was ‘somewhat feared’. 216

Both King and Gray played an active public role. 217

The personal contribution of departmental heads to policy was affected by the duration of their appointment. Until 1893, inspectors-general were appointed on a three or five year renewable contract. 218

After two such appointments, MacGregor argued that fixed-term arrangements were invidious and likely to render him ‘obnoxious to attach [sic]’. He requested and obtained the permanent job security of an ordinary civil servant. 219 This concession became the right of MacGregor’s successors who, under the Public Service Act 1912, were styled “permanent heads”.

Permanence, in the case of MacGregor, Hay and Gray, averaged 19 years in office. The administration of these individuals began enthusiastically enough with a range of policy initiatives but ended in weariness or broken health. By the time MacGregor took an overseas study tour in 1902, 220 a left-wing Parliamentarian described the New Zealand asylum system as ‘antiquated and rotten in the extreme’. 221

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216 Personal communications, the late Mr I.M. Lilly, 22 December 1970; Dr H.M. Buchanan, 21 December 1970, Mr E.N. Tibble, 22 December 1970 and 22 January 1971, and Dr G.M. Tothill, 11 August 1970.

217 Gray gave a lanternslide lecture on the evolution of mental hospitals in an attempt to break down public prejudice, and was commended for this by King. AJHR, 1926, H-7, p. 8. Some of the slides from this presentation are in the author’s possession. For Gray’s personal views on the treatment of mental defectives, see T.G. Gray, ‘Treatment of Mental Defectives’ in R. Lawson, ed, Public Lectures on Social Adjustment, Dunedin, 1928, p. 3.

218 Articles of Agreement, 10 May 1876, AJHR, 1876, H-4c, pp. 4-5; Inspector-General to Colonial Secretary, 20 July 1885, IA 4/3/30; Colonial Secretary to Dr MacGregor (telegram), 11 November 1885, MacGregor to Premier (telegram), 14 November 1885, MacGregor to Colonial Secretary, 30 November 1885, Cabinet Secretary to Colonial Secretary, 29 November 1888, L. 88/3763, HMH 1906/1176.

219 Inspector-General to Colonial Secretary, 7 December 1893, Minister’s minutes, 8 December 1893 and 10 February 1894, HMH 1906/1176.

220 Inspector-General to Minister, 21 January 1902, HMH 1906/1176.

221 H.G. Eli (Liberal, City of Christchurch), NZPD, 12 August 1902, 121, p. 283.
policy ideas MacGregor accumulated on his trip were implemented by his successor. MacGregor considered retiring at age 65, but he died in office.

Hay’s inspectorate started with major and overdue policy changes - the Mental Defectives Act 1911, the professionalization of mental nursing, the development of reception houses for new admissions, together with the establishment of Tokanui as a central institution for chronic patients. After 1921, however, Hay’s health deteriorated. He doggedly stayed in office until the middle of 1924 when he was granted 15 months sick leave. Hay intended to combine this with visits to British mental hospitals, but he was too ill for that. Hay died on the return voyage in 1925. Sir Truby King cited Hay’s illness as one reason why the Department’s standards had slipped and progress was retarded.

Gray’s administration began promisingly with new ideas brought back from an overseas study tour (1927). He wanted to amend legislation and he had great plans for villa type classification and new hospitals. Gray started his administration with new office accommodation, and a team of old colleagues placed in key positions. Wearyed by the severe resource shortages of the great depression and World War II, Gray got out of touch after 20 years in office. Faced with industrial strife from psychiatric nurses, Gray tendered his early resignation in 1946. By then, he had long since fallen out with his deputy, Russell, whose work ceased to be acknowledged in Gray’s annual reports after 1939.

Details of the careers of those people who advanced to the apex of a pyramidal organization generally show that the top appointments went to people of demonstrated initiative and progressive views, and who had made a name for

222 West Coast Times, 26 December 1906.
223 He suffered from dyspnoea. W.F. Croll to Mrs F. Hay, 29 and 31 January and 2 February 1925, Seddon Family Papers, Alexander Turnbull Library, Wellington, MS 1619.
226 Personal communication, the late Mr J. Turnbull, formerly General Secretary of the Public Service Association (1945-61). Turnbull recalled Gray’s surprise announcement at a meeting with the Prime Minister. According to Turnbull, the Prime Minister asked him what was needed to improve mental hospitals. Turnbull promptly replied that only the Director-General’s resignation would achieve that. Gray thereupon announced that he would retire. Under the rules of the day, Gray could have stayed in office until 1949.
themselves lower down the organization. In 1894, for instance, the enterprising Truby King, then Medical Superintendent of Seacliff Asylum (1889-1921), told his counterpart at Sunnyside that:

> your ideal of a set of inflexible asylums cast in a central mould is unattainable. The last man to approve of it would be Dr McGregor [sic] ... if we see anything in your asylum, or in some other asylums or place, which could with advantage be introduced here, we freely adopt it and feel obliged for the suggestion. That I submit is the only healthy kind of 'conforming to type' for such institutions as Asylums or Hospitals.\(^{227}\)

King enthusiastically set about making Seacliff Asylum the foremost institution in the country. His restless energies then turned to plant and animal husbandry and later to infant welfare. From 1907, when he founded the Plunket Society ‘to help the mothers and save the babies’\(^{228}\) according to his ideas, King’s active period of mental hospital reform was largely over. After several spells away from the hospital on infant welfare business, King left Seacliff in 1921 to be Director of Child Welfare in the Department of Health, and only returned to his old department to avert a crisis three years later.

Gray built his career on institutional reform at Nelson. During his superintendence there (1920-5), Gray oversaw plans to relocate patients from the old Nelson Asylum building to a new villa hospital at Stoke. Gray also started to differentiate the care of mentally subnormal children from other psychiatric patients, the precursor of strong ideas on the subject that he submitted to the ministerial Committee on Mental Defectives and Sex Offenders (1924). In 1925, Gray was then given charge of the Auckland Mental Hospital. He had a mandate to bring the place up to an acceptable standard from that left by the previous and long-serving medical superintendent, R.M. Beattie (1897-1925).

Innovation, rather than conformity, was a stepping-stone to promotion, but if people stayed for too long in the job at the apex of their career, they became inured to the hardships and lost the fresh vision of their early years. In an editorial after

\(^{227}\) Medical Superintendent, Seacliff to Medical Superintendent, Sunnyside, 13 March 1894, Plunket Archives, Hocken Library, 88-098-25.

\(^{228}\) Motto of the Royal New Zealand Society for the Health of Women and Children (Inc.), which was the official name of the organization. The popular name was taken from the Society’s original patron, Lady Plunket, wife of the then Governor.
MacGregor's death in 1906, the Christchurch Press criticized him for belonging largely to 'the old school' and for failing to grasp the advances of the previous 15 years. The paper also criticized a strong tendency for medical superintendents and their assistants 'to get into a groove and follow routine methods instead of keeping abreast of the latest discoveries.' The system was said to convert 'men of original scientific fervour into stereotyped administrators and routine traffickers in statistics.'

An eminent public servant of a later generation, J. Roberts, suggested that the public service offered modestly attractive careers to men [sic] of modest background and ambitions who became 'dutiful, diligent public administrators suitable for the maintenance of programmes to be defended in parliament [sic].'

To some extent, the Department's specialized national career service fostered a common career path in the Department rather than the wider Public Service, as shown by the career details of senior officials contained in appendix 2. This was particularly so for clerical staff. From D. Souter onwards, chief clerks were promoted internally and not from the wider Public Service. J.E. Russell, Chief Clerk (1920), was 'the much-esteemed senior clerk in the Service.' A typical career started with recruitment and career consolidation at the institutional level before moving to the head office in a senior role. Likewise, departmental heads usually began a career with clinical experience as an institutional medical officer, progressed to the medical superintendence of a smaller and / or larger institution, before promotion to deputy and permanent head. Thus, Hay's appointment as Inspector-General was a 'natural routine promotion.' King was brought in to run the Department at the end of his public service career. His mantle fell upon Gray, whom King described as energetic and a 'hopeful optimist [sic].' Gray was appointed Deputy Inspector-General (1925-7) before he succeeded his illustrious predecessor. Russell's career differed slightly from those of his immediate three
predecessors. He had never been a medical superintendent, but he served a very long term as Deputy Director-General before being promoted.

CONCLUSION

This chapter has studied the political, constitutional and bureaucratic context of mental health policy making between 1876-1947. I have suggested that mental health was a matter of minor importance within the overall scope of state activity. Politicians certainly accepted mental health as a matter of public policy, but a separate ministerial portfolio of mental hospitals was never highly ranked. The topic generally aroused little political excitement unless something went wrong. The complex medico-legal issues and technical nature of mental health policy meant that ministers left much of the detail to their expert departmental advisers.

These officials were experts because expertise and resources were concentrated in a department that ran virtually all specialized psychiatric services. No national organization was set up to offer alternative policy choices, although national organizations representing women, returned servicemen, doctors, hospital boards and mental hospital staff had some impact from the early 1920s. The personal links, networks and credibility of a few enthusiastic individuals were vital to effective political pressure. Although there was no sustained, comprehensive or collective standpoint among these various interests, some common themes converged. These included pressure for the development of general hospital psychiatry, separate treatment facilities for psychoneuroses, local management control of institutions, and improved classification and living conditions for mental hospital patients. The lobbying was intermittent but effective enough to underpin the King-Pomare reforms of 1925 and the eugenics policies of 1923-8. Interest groups certainly made gains in other policies as well as service development. Infrastructure constituencies secured national pay and conditions of employment, although enhanced professional status was still some way off for mental hospital doctors and mental nurses.
Various bureaucratic features of the Department also shaped the nature and pathway of national mental health policy between 1876-1947. Firstly, medical practitioners with experience or qualifications in psychiatry ran the Department. These psychiatrists regarded policy-making as their professional domain, with some technical and administrative assistance drawn from other disciplines and from the institutional memory contained in its records system.\textsuperscript{237} The head office's predominance in departmental policy-making was characteristic of bureaucratic centralization and hierarchy. On the other hand, centralized management cultivated a sense of fairness and consistency. New resources or policies were applied system-wide or else they were allocated in such a way as to spread from larger to smaller institutions until change had occurred nation-wide.

Secondly, the Department was durable, partly because politicians wanted the security of a permanent organization, but also because the Department became an inbred specialist career service. People who rose through its ranks gave the departmental bureaucracy its own institutional memory, precedents, traditions, ethos, and long-term view. Career progression relied upon thorough acculturation into an institutional ethos, respect for authority, rules and precedent. These factors helped build a policy pathway that was quietly incremental with occasional bursts of overdue major development such as those in 1877-80, 1907-11, 1925-8, and 1947. Scrutiny of those dates shows policy outbursts that were the product of solid partnership between enterprising ministers and departmental heads. A departmental head's most productive years were invariably those when the appointee was new to the job, before he grew tired or ill. The essential medical and institutional assumptions of policy were rarely challenged. Policies were the accumulation of past political and administrative decisions that had not been altered or overturned by subsequent decisions or law. The system itself created inertia that was hard though not impossible to break through, as the spasmodic bursts of overdue reform exemplify.

\textsuperscript{237} See the bibliographical and biographical note in the Bibliography for a brief account of the evolution of the Department's filing system.
6. THE OFFICIAL FRAMES OF MENTAL DISORDER

"The elastic term "insanity”.1

All mental health policy was based upon the codification of mental disorder. Statutory definitions that were contained primarily in the Lunatics Act 1868 and consolidated or revised in 1882, 1908, 1911 and 1928, determined those insane people in whom the state had an interest. Statutory definitions were the basis for assigning administrative responsibility within government. They were also the foundation for policies about care and treatment, institutional development and outreach, and staffing.

This chapter will look first at changes in the definitions and concepts of lunacy adopted by governments and Parliament between 1876-1947. Later in this chapter, I will explain why these changes occurred. Social pressures, medical ideas, and bureaucratic jurisdictional disputes all helped to differentiate the notion of lunacy into various classes. Decisions about individual cases resulting in 63,498 mental hospital admissions or readmissions between 1876-1947 both reflected and shaped the official concepts of lunacy or idiocy. These decisions were reflected in the continued upward trend in the average number of persons resident in mental hospitals relative to the total population of New Zealand between 1876-1941. Intervals when the rate was stationary or even dropped a little have been explained in terms of socio-economic factors influencing the size of the general population rather than as a result of changes in the mental hospital population. The average number of mental hospital residents peaked at 498.9 per 100,000 population in 1944, as shown in Figure 1. The downward pattern after 1944 showed the impact of treatment.2

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1 Appendices to the Journals of the House of Representatives (AJHR), 1881, H-13, p. 2.
FIGURE 1
MENTAL HOSPITAL POPULATION – AVERAGE NUMBER RESIDENT: RATES, 1876-1947

The Lunatics Act 1868, the relevant statute in force in 1876, defined the term lunatic as 'any person idiot lunatic or of unsound mind and incapable of managing himself or his affairs and whether found lunatic by inquisition or not'. Lunatic patient denoted that the person was detained in an asylum, hospital or licensed house (private asylum) under the Act.

Lunatic covered five groups of people. Persons discovered and apprehended under circumstances that denoted a derangement of mind and a purpose of committing suicide or some indictable crime were one group. Criminally insane persons were also included. Persons found wandering at large and deemed to be dangerous lunatics formed a third group. The fourth consisted of lunatics who were not under proper care and treatment or who were cruelly treated and neglected. Persons in private care who needed coercion or restraint were included too. The law also specified general criteria for admission, which were a corollary of the definition of lunatic. Suicidal behaviour, danger to others, inability to look after oneself, a person's own good, or the public interest were all statutory criteria for detention. The 1868 definitions of lunatic and lunatic patient were rolled into one definition of lunatic in 1882.

No change was made in the Lunatics Act 1908, which did not involve new policy.

The next substantive revision, in 1911, took a new approach. As the title of the new statute conveyed, 'mental defective' was substituted for the older terms of lunatic and idiot. Mental defectives were persons who, due to their mental state, required oversight, care or control for their own good or in the public interest. According to the nature of the mental defect and the degree of oversight, care or control needed, they fitted into one of six classes of mental defect. Class I consisted of 'persons of unsound mind' or persons who, due to mental disorder, were incapable of managing themselves or their affairs. Class II comprised 'persons mentally infirm' brought about by age or decay of their faculties and who were also incapable of managing

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3 Lunatics Act 1868, s. 3. The original statute was not punctuated, in keeping with law drafting practice of the time.
4 Lunatics Act 1868, s. 3.
5 Lunatics Act 1868, s. 5.
6 Insane prisoners or persons remanded and facing a charge, persons found insane upon arraignment or acquitted on the grounds of insanity. Lunatics Act 1868, ss. 7-9; Lunatics Act 1882, ss. 9-11. cf. Mental Defectives Act 1911, ss. 31-8.
7 Lunatics Act 1868, ss. 10, 50.
8 Lunatics Act 1882, s. 2.
9 The Lunatics Act 1908 was part of a general consolidation of New Zealand statutes.
themselves and their affairs. The next three classes—‘idiots’, ‘imbeciles’ and ‘feebleminded’ persons were gradations of the old term idiot. Idiot was then defined as a person so mentally deficient from birth or from an early age as to be unable to guard him/herself against common physical dangers and therefore requiring the oversight necessary in the case of young children. Imbeciles were persons who, although able to guard themselves against common physical dangers, were incapable of earning their own living because of mental deficiency existing from birth or an early age. Feebleminded persons may have been able to earn a living under favourable circumstances, but their congenital mental defect precluded them from competing on equal terms or managing themselves and their affairs with ordinary prudence. Epileptics comprised Class VI.¹⁰ The classification of 1911 prevailed until 1969 with one significant addition. In 1928, Class VII was added. ‘Persons socially defective’ were defined as persons who suffered from mental deficiency associated with anti-social conduct, and who by reason of such mental deficiency and conduct required supervision for their own protection or in the public interest.¹¹

Statutory definitions usually drew little comment in Parliament. They were not debated in 1882 and 1908. Both Houses were told of the extensive changes and novel features of the classification proposed in 1911.¹² The lack of debate on the classification of mental defect probably owes much to the presentation of the ideas as socially progressive, scientific, and authoritatively substantiated by the British Royal Commission on the Care and Control of the Feeble-minded (1904-8).¹³ Indeed, the Royal Commission’s classification was based upon recommendations by the Royal College of Physicians.¹⁴ The Bill was not regarded as a party issue.¹⁵ The 1928 amendment was also supposed to be a non-party measure,¹⁶ but the loose definition of social defective contained in the original Bill was strongly contested.

¹⁰ Mental Defectives Act 1911, s. 2.
¹¹ Mental Defectives Amendment Act 1928, s. 7.
¹² Sir John Findlay (Attorney-General), New Zealand Parliamentary Debates [NZPD], 6 September 1911, 155, p. 300; Minister, NZPD, 4 August 1911, 154, p. 188.
¹³ Not all classes envisaged by that body were incorporated into the New Zealand Bill. No reason was given why mentally defective deaf, dumb and blind persons, and mentally defective inebriates were excluded from the Bill.
¹⁵ W.F. Massey (Reform, Leader of the Opposition), NZPD, 4 August 1911, 154, p. 194.
¹⁶ H.E. Holland (Labour, Buller), NZPD, 25 September 1928, 219, p. 497.
Labour Members were concerned that it might be used to deal with political dissidents. The Opposition forced a division on the point.

PERSONS OF UNSOUND MIND

Changes to legal definitions arose because of a mix of social attitudes, medical thinking, and disputes among the central and local government agencies set up to administer health, welfare, education and penal services. The concept of unsound mind encompassed at different times neuroses and inebriety as well as what would nowadays be called psychoses.

New Zealand evidence points consistently to the decisive role of the applicant for a person's admission to a mental hospital in determining what constituted mentally disturbed behaviour. True, applications required supporting medical opinion, but the clinical evidence provided was not always of a high standard. In 1898, E.G. Levinge, Medical Superintendent at Christchurch, was highly critical of the standard of medical evidence:

... Certifying doctors apparently think that it should be sufficient for legal requirements to state that the patient suffers from such-and-such form of mental disease; it may be well here to remind medical men [sic] that a diagnosis may or may not be correct, and it is, to say the least, risky to certify a person as a lunatic and deprive him of his liberty unless he (the doctor) can afterwards produce the "facts observed by himself" on which he based his certificate.
Writing in 1921, Dr J. MacPherson, of Tokanui Mental Hospital, said that the average medical practitioner was ill equipped to recognise other than gross mental problems, least of all the early stages of mental disorder. The average doctor might only encounter one insane person who required control every 15 months. Very few of the 172 doctors who replied to a questionnaire circulated by the Committee of Inquiry into Mental Defectives and Sexual Offenders (1924) had actually dealt with a mentally defective patient. Holloway’s study of admissions to Seacliff between 1928-37 questioned the diagnostic competence of certifying doctors. This is understandable, given the limited teaching on insanity in the undergraduate medical curriculum. Appendix 4, which sets out a note on the undergraduate teaching of psychiatry in New Zealand, suggests that MacPherson’s assertion has some substance.

Relaxed admission procedures endorsed the pattern of socially determined definitions of insanity that were corroborated by doctors. The push for self-referral arose from asylum administrators who were anxious to break down persistent prejudice against asylums, lunacy and committal, or all three. The police and courts were often involved in committals and that involvement upset Truby King. He insisted that the insane should be seen as ‘sick persons and not as criminals’. Experience taught him that the stigma of committal was felt most keenly by the ‘more sensible and sensitive newly admitted patients’. Both King and his counterpart at Sunnyside, E.G. Levinge, advocated changes to reduce the association between insanity and law and order. King also tried to work around the law during the 1890s. On one occasion, he suggested that someone should stay privately with an

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22 AJHR, 1908, H-7, p. 3.
23 Robertson, p. 70.
24 Holloway, pp. 20-21.
26 Medical Superintendent, Seacliff to Minister, 28 May 1902, Healthcare Otago Ltd Archives, National Archives, Dunedin, DAHI D 264/14. Emphasis and double emphasis in original.
27 Medical Superintendent’s report, Seacliff, AJHR, 1898, H-7, p. 10; Medical Superintendent’s report, Christchurch, AJHR, 1900, H-7, p. 6; Medical Superintendent, Seacliff to Minister, 28 May 1902, DAHI D 264/14.
attendant at the local hotel or at a rented cottage near Seacliff. King occasionally treated people as private guests in his own home. A licensed institution was not subject to the same restrictions as public asylums so, from 1888 or maybe earlier, patients were admitted voluntarily to Ashburn Hall. Between 1897-1911, voluntary patients formed 13.5 per cent of admissions to Ashburn Hall.

Support of the New Zealand Branch of the British Medical Association for Truby King’s proposals brought these ideas into the Parliamentary arena, but the Seddon Ministry’s initial response was hardly enthusiastic. Yes, the Minister, W. Hall-Jones answered, the law could be changed to allow voluntary admission, but it was doubtful whether people would take advantage of it. Hall-Jones agreed that the outmoded legal nomenclature should be dropped, but the matter was not actively pursued. MacGregor took up the matter of voluntary admission in 1904 as a means of encouraging people to seek help for mild forms of mental disorder that were not certifiable. Voluntary admission was also seen as a method for enabling people to escape the life-long stigma of being ‘sent to an asylum’. A court appearance and ‘the idea of being tried suggests the ideas of unjust punishment, retards recovery, and often leaves a feeling of bitter resentment in after-life’, said the Inspector-General. The draft Mental Hospitals Bill of 1905 was expected to deal with the ‘barbarous practice’ of charging the insane in court. Voluntary admission featured when the Bill was resurrected the following year, a move that increased public awareness and demand.

29 Medical Superintendent, Seacliff to H. Gall, 14 March 1894, DAHI D 264/24.
30 Medical Superintendent, Seacliff to Minister, 28 May 1902, DAHI D 264/26.
32 New Zealand Medical Journal, 1 (1900), pp. 54-56.
33 NZPD, 17 August 1900, 113, pp. 71-72.
34 AJHR, 1904, H-7, p. 3.
35 AJHR, 1905, H-7, p. 4.
36 H.G. Ell (Liberal, City of Christchurch), NZPD, 15 September 1905, 134, p. 747. The Bill was circulated but not debated that year.
37 Deputy Inspector-General to J.T. Fowler, Masterton, 19 and 22 September 1906, HMH 1906/1123; Mental Hospitals Bill 1906, cc. 31-2.
38 E.g., Medical Superintendent, Sunnyside to Inspector-General, 3 September 1906, Mental Hospitals Department Records, File MH 1906/827, formerly held in Department of Health records storage, but current whereabouts unknown; Inspector-General to Mrs Whitehead, Dunedin, 1 August 1906, HMH 1906/696.
The provision for 'voluntary boarders' in public mental hospitals was an important innovation of the Mental Defectives Act 1911, although it was by no means the only one.\(^{39}\) Thereafter any person could apply to a medical superintendent for 'care and treatment' as a voluntary boarder. Voluntary boarders had some insight into their mental deterioration and referred themselves when they felt 'unstable', as Hay called it.\(^{40}\) The medical officer need only be satisfied that the case was a proper one for care and treatment or that a reception order was not more appropriate in order to admit the person. So self-referral joined committal, which had hitherto been the only legal means of admission, at least to reduce the association between insanity and law and order.\(^{41}\) Self-referrals to mental hospitals grew steadily from 2.7 per cent of admissions in 1912 to 32.9 per cent in 1947, as Table 4 shows. Gray explained this trend as meaning that voluntary boarders were more likely to recover and sooner than committed patients. Because voluntary boarders felt they were not being detained against their will, they cooperated with treatment.\(^{42}\)

Efforts to boost early admission seem to have been directed at more affluent families. Wanting to facilitate self-referral,\(^{43}\) medical superintendents opened their doors to people suffering from milder or different forms of mental disorder, especially neurasthenia,\(^{44}\) psychoneuroses or functional nervous disorders, at least among wealthier sections of the community. In 1904, Ashburn Hall, New Zealand's only licensed house (private mental hospital), near Dunedin, sought clients 'labouring under the lesser neuroses'.\(^{45}\) Newspaper correspondents in 1911 claimed that four-fifths of the inmates of the Auckland Mental Hospital merely suffered from 'nervous

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\(^{39}\) Mental Defectives Act 1911, s. 39. A licensed private institution was not subject to that constraint, and could admit patients who referred themselves. The Mental Defectives Act 1911, ss. 24-5 put in place special procedures to admit minors. Provision admission of a disturbed patient was authorized in an emergency, under s. 9. The number of patients affected by these procedures was relatively small. An alternative method of committal, which followed Scottish and Scandinavian precedents, was introduced by the Mental Defectives Amendment Act 1928, s. 8. This provided for committal procedures to be conducted at the mental hospital and not in open court. AJHR, 1928, H-7, p. 2.

\(^{40}\) AJHR, 1923, H-7, p. 5.

\(^{41}\) Medical Superintendent's report, Seaciff, AJHR, 1898, H-7, p. 10; Medical Superintendent's report, Christchurch, AJHR, 1900, H-7, p. 6; Medical Superintendent, Seaciff to Minister, 28 May 1902, DAHI D 264/14.

\(^{42}\) AJHR, 1928, H-7, p. 2.


\(^{44}\) AJHR, 1924, H-7, p. 2

\(^{45}\) Somerville, p. 54.
TABLE 4
VOLUNTARY BOARDERS AS A PERCENTAGE OF MENTAL HOSPITAL ADMISSIONS, 1912-1947

<table>
<thead>
<tr>
<th>Year</th>
<th>First Admissions</th>
<th>Readmissions</th>
<th>Total Admissions</th>
<th>V.B.s as % of:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>V.B.</td>
<td>V.B.</td>
<td></td>
<td>1st Admissions</td>
</tr>
<tr>
<td>1912-15</td>
<td>128</td>
<td>10</td>
<td>3440</td>
<td>4.7</td>
</tr>
<tr>
<td>1916-20</td>
<td>266</td>
<td>95</td>
<td>4679</td>
<td>7.4</td>
</tr>
<tr>
<td>1921-25</td>
<td>462</td>
<td>173</td>
<td>4861</td>
<td>13.1</td>
</tr>
<tr>
<td>1926-30</td>
<td>886</td>
<td>342</td>
<td>6127</td>
<td>21.5</td>
</tr>
<tr>
<td>1931-35</td>
<td>1159</td>
<td>438</td>
<td>6900</td>
<td>25.9</td>
</tr>
<tr>
<td>1936-40</td>
<td>1093</td>
<td>591</td>
<td>7365</td>
<td>23.1</td>
</tr>
<tr>
<td>1941-45</td>
<td>1287</td>
<td>753</td>
<td>8436</td>
<td>19.9</td>
</tr>
<tr>
<td>1946-47</td>
<td>996</td>
<td>422</td>
<td>4360</td>
<td>29.5</td>
</tr>
</tbody>
</table>

Note: V.B. = Voluntary Boarders
breakdown', not lunacy. D. McLaren, M.P. (Wellington East) used that terminology in his speech on the Mental Defectives Bill 1911. Neurasthenia also entered the professional medical and nursing journals of New Zealand. Once “shell shock” or war neuroses were recognised as genuine medical conditions during the First World War, these conditions were “civilianized”. Nerves, nervous breakdown, nervous strain or the borderline / borderland became popular sobriquets between the wars. The country's leading medical proponents of psychoanalysis and psychotherapy regarded neurones or psychoneurones as widespread but minor mental disorders. Hay interpreted ‘borderland’ to mean ‘sensitive persons with very recent and curable Mental Disorder, but not yet certifiable as Mental Defective’. King used the word ‘borderline’ when he meant nervous and neurasthenic cases. Gray understood nervous breakdown to mean the incipient stage of mental disorder. In 1943, Kingseat's medical superintendent accepted that there was no sharp dividing line between psychoneurones and psychoses.

46 “Sympathy” and “Visitor”, letters to Auckland Star, 27 May and 9 June 1911.
47 NZPD, 4 August 1911, 154, p. 211.
49 Inspector-General to Chief Health Officer 11 May 1916, and Director-General of Medical Services, Circular, May 1916, HMH 8/163, Minister of Defence to Minister, 23 February 1917, HMH 8/284.
51 E.g., Secretary, Auckland Branch Returned Servicemen’s Association to Commissioner of Pensions, 13 June 1934, HMH 4/4/1; Secretary, Women’s Division Federated Farmers to Minister, 4 August 1936, HMH 4/4/0; A. Hamilton (National, Wallace), NZPD, 5 November 1937, 249, 210; ‘Mother Machree’ in letter to Press, 3 March 1938; editorial, Wairarapa Standard, 7 September 1938; A. J. Hern, letter to Manawatu Evening Standard, 4 August 1939.
52 E.g., W.D. Lysnar (Reform, Gisborne), NZPD, 19 August 1924, 204, pp. 169-70; G. McKay (Liberal, Hawke’s Bay), D. Buddo (National, Kalapoi) and M.J. Savage (Labour, Auckland West), NZPD, 11 September 1925, 208, pp. 264-5.
53 S. Moore, ‘Mental and Physical Causes of Abnormal Behaviour’ in University of Otago, Public Lectures on Social Adjustment, Dunedin, 1928, p. 13; M. Bevan-Brown, Mental Illness and Personality Disorder, Christchurch, 1961, pp. 8-10. This refined Bevan-Brown’s earlier thoughts published in Nerves, Nerviness and Neurosis, [originally published Christchurch, Lighthouse Series No. 2, 1945 and reproduced in the above book, pp. 65-75] that terms like nerves, nerviness, nervousness, neurosis and psychoneurosis should be recognised as disorders of the whole person’s self or soul, and not of any part alone. Bevan-Brown was concerned about the distress caused by the assumption that sufferers must be insane or psychotic.
54 Inspector-General to Minister, 9 April 1923, HMH 4/4/2.
55 Dominion, Wellington, 3 January 1925, HMH 26/39.
56 Director-General to Minister, 17 October 1929, HMH 8/1041.
Borderline cases were certain to be admitted so there was no reason why they should not be treated at Queen Mary Hospital.\textsuperscript{57}

Psychoneuroses were a good example of the way medical knowledge refined the notion of insanity with gradations from mania and dementia, as the grossest forms of insanity, the most visible and socially problematic, to melancholia, moral insanity and monomania, as finer shades of disorder. Donnelly suggests that forms of insanity without a clear organic basis were labile and susceptible to changing definitions of content.\textsuperscript{58} Some disease entities entered the psychiatric lexicon while others went. Moral insanity, monomania, masturbatory insanity, alcoholism, puerperal psychoses, neurasthenia and hysteria all had their day.\textsuperscript{59} Several eminent British psychiatrists devised their own schema in the late nineteenth century. One of them, Mercier, declared that 'the number of different classifications of insanity is the same as the number of writers on the subject'.\textsuperscript{60}

Individual and tentative classifications were gradually systematized,\textsuperscript{61} as in the international standardization of diseases and causes of death listed in appendix 5. This schema was used to present New Zealand's vital statistics from 1908\textsuperscript{62} and replaced the classification of British origin that was first used in New Zealand in 1873.\textsuperscript{63} The list passed through five revisions before 1948.\textsuperscript{64} Most mental disorders grew from one category of 'Insanity, General Paralysis of the Insane' (G.P.I.) under the order 'Diseases of the Nervous System'. By 1948, most conditions were still listed as a subset of 'Diseases of the Nervous System and Sense Organs, including

\begin{itemize}
  \item \textsuperscript{57} Medical Superintendent, Kingseat to Director-General, 19 May 1943, HMH 26/46.
  \item \textsuperscript{59} Busfield, pp. 53-59.
  \item \textsuperscript{60} C.A. Mercier, \textit{Sanity and Insanity}, New York, 1890, p. 283.
  \item \textsuperscript{61} E.g., G.H. Savage, \textit{Insanity and Allied Neuroses: Practical and Clinical}, London, 1884, pp. 10-15.
  \item \textsuperscript{63} \textit{Statistics of New Zealand 1873}, Wellington, 1874, p. 4. The classification can almost certainly be attributed to W. Farr, the first medical statistician of the General Register Office for England and Wales, who was invited by the first international statistical conference to prepare such a scheme. Farr's general arrangement still prevails, using the principle of classifying details by anatomical site. See World Health Organization, \textit{Manual of the International Statistics Classification of Diseases, Injuries and Causes of Death}, Volume I, Geneva, 1977, pp. IX-XI.
  \item \textsuperscript{64} Kelley Lee, \textit{Historical Dictionary of the World Health Organization}, Lanham, Md., 1998, pp. 146-7. This list was not applied to mental health statistics in New Zealand until 1953.
\end{itemize}
Mental Disorders', but some forms of mental disorder were listed under infectious diseases (G.P.I.), chronic poisonings (e.g., alcoholism), or other and ill-defined conditions.

Medical perceptions helped shift inebriety into a separate disease entity, and New Zealand law followed. The Lunatics Acts 1868, 1882 and 1908 applied to 'habitual drunkards', or persons addicted to the habitual excessive use of intoxicating drink and who failed to support a family or who habitually or repeatedly threatened or used violence towards family members. Habitual drunkards could admit themselves to an asylum or they could be committed if excessive drinking led to family neglect, habitual or repeated threats, or domestic violence.

The disease model of inebriety influenced changes in the management of this problem. MacGregor articulated his thinking on the problem as early as 1876. He believed that helpless drunkards were not so much 'vicious and criminal' but victims of disease and hereditary neurosis. As Inspector-General, he expected that asylums should receive dipsomaniacs and persons found to be certifiable, even though asylums found it virtually impossible to meet legal stipulations for separate facilities and treatment. MacGregor then expected hospitals to treat delirium tremens as the law provided, but hospitals often bundled these noisy patients off to an asylum. The limitations of the policy became apparent in 1896 when one

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65 J.S. Madden, '[Substance Use Disorders] Clinical Section' in Berrios and Porter, pp. 658, 660-1; E.M. Brown, pp. 669-75.
66 Lunatics Act 1868, s. 21; Lunatics Act 1882, s. 42; Lunatics Act 1908, ss. 40-6.
69 Lunatics Act 1882, s. 43; Superintendent, Hokitika to Inspector-General, 18 January 1886, CAHW CH 22/7; AJHR, 1886, H-6, p. 3; Star, Christchurch, 27 March 1893; Inspector-General to Messrs Boriasse and Barmicott, 10 May 1897, Inspector-General's Letter Book 6, p. 654, formerly held in the Department of Health head office but current whereabouts unknown; Superintendent to Deputy-Registrar, Supreme Court, Reefton (telegram), c. 30 September 1897, CAHW CH 22/13, p. 648; J. MacGregor (Otago), NZPD, 1 September 1898, 103, p. 437. Consequently, only a handful of dipsomaniacs were committed to state-run asylums - eight in 1885 and six in 1886, AJHR, 1886, H-6, p. 3, and 1887, H-9, p. 3.
70 AJHR, 1887, H-9, p. 3. The Police Offences Act 1884, s. 21 allowed persons arrested in a state of helpless drunkenness to be remanded to a 'hospital, infirmary, or other fitting place for curative treatment and care.'
71 Editorial, Star, Christchurch, 4 January 1888; editorial, Evening Herald, Dunedin, 6 January 1888.
patient had to be discharged under a writ of habeas corpus because he had not been kept apart from lunatics as the law required.\textsuperscript{72}

The Inebriates Institutions Act 1898 effectively superseded the habitual drunkard sections of lunacy law. ‘Inebriate’ was defined in that Act as ‘any person who, not being amenable to any jurisdiction in lunacy is, notwithstanding by reason of the habitual use in excess of intoxicating liquor or drugs, at times dangerous to himself or to others, or incapable of managing himself and his affairs’.\textsuperscript{73} Distinctions were still made between criminal and non-criminal inebriates.\textsuperscript{74}

The Department retained administrative responsibility for the legislation and for the state-run Orokonui Inebriates Home at Waitati (1901-04), which was set up to give effect to the Act. Truby King, who as Medical Superintendent, Seacliff, had oversight of this nearby venture, predicted accurately that the home would become a dumping ground for ‘indigent, hopeless, chronic drunkards’ without regard for curability. He also guessed that families would despatch embarrassing relatives there at little cost to themselves.\textsuperscript{75} Although King still recognised alcoholism as a ‘disease or vice’, he took a more moralistic view because of his experience. A similar attitude underpinned new legislation in 1906 and 1909 that brought inebriety within the administrative responsibility of the Minister of Justice. That legislation was derived from a philosophy of detention and reform rather than treatment.\textsuperscript{76} Legal references to habitual inebriates were then expunged from mental health law in 1911 and the Department ceased to have official responsibility in that field.

OTHER FORMS OF MENTAL DEFECT

Other socially determined mental conditions emerged as effects of demographic characteristics and trends in society in the late nineteenth and early twentieth

\textsuperscript{72} J. MacGregor (Otago), NZPD, 1 September 1898, 103, p. 437.
\textsuperscript{73} Inebriates Institutions Act 1898, s. 2. The statutory definition of drugs included opium, morphine, chloral, cocaine and any other drug capable of producing mental aberration.
\textsuperscript{74} E.g., C.C. Bowen (Christchurch), NZPD, 1 September 1898, 103, p. 439; F.T. King, ‘Inebriety as a Disease’, New Zealand Medical Journal, 4, 11 (1904), pp. 310-29; AJHR, 1904, H-22B, pp. 1-3.
\textsuperscript{75} Medical Superintendent, Seacliff to Inspector-General, 30 January 1903, Seacliff Hospital Letter Book, DAHI D 264/65, p. 218; King, pp. 310-32; editorial, Press, 15 June 1904; editorial, Evening Post, Wellington, 16 June 1904.
centuries. (Society definitely meant Pakeha society; Maori were disregarded from policy purposes throughout the period." As natural increase superseded immigration as a source of population growth, age-sex pyramids acquired a broader base, a less tapered apex, and better gender balance. Pakeha life expectancy of both males and females increased at all ages. The dependency ratio increased from that of colonial frontier society.79

These demographic changes meant that congenital or hereditary forms of intellectual disability and epilepsy appeared in the children of settler families. Older generations encountered mental deterioration or infirmity. Without respite, looking after a family member who suffered from intellectual disability, epilepsy,80 dementia, with or without physical disability at home, could simply wear out the carers beyond the point of endurance. Asylum officials did not always see the problem that way. 'It is not alone the state of a man's mind which settles [sic] the question of whether he is to be considered a lunatic,' Skaehinted.81 By implying that some applications for reception orders were financially motivated, administrators sometimes confused non-contributing patients or relatives who would not pay for care with those who could not pay.82 Hay and his contemporaries bandied phrases like 'convenient shirking of responsibility', 'filial ingratitude', 'less than sorrowfully' or 'a desire to shirk home responsibility'83 to convey their displeasure. According to MacGregor, such social pressure placed magistrates and certifying doctors in a 'very painful position'.

77 Maori rarely exceeded one per cent of the resident mental hospital population until the 1920s, when it slowly climbed to reach 2.7 per cent in 1947. Table showing 'Native Countries', Departmental reports, AJHR, 1879-1948. The majority of Maori, living in the Auckland province, were sent to Auckland Mental Hospital if they became insane. The number of Maori was still small enough in 1924 for the Minister, Sir Maui Pomare, to be provided with a list of full-blooded and half-caste Maori, complete with individual details, so that he could answer inquiries at hui (gatherings). Of the 82 Maori patients in mental hospitals at the time, six were prisoners and 18 were half-castes. Inspector-General to Minister, 9 September 1924, Health Department Archives, National Archives, Wellington, File H 30/28/22 (34243).
80 Reed, pp. 13-15, 19.
82 MacGregor, when Inspector of Hospitals and Charitable Institutions, also crusaded untiringly against the social expectation that access to public hospital care was a right for all. See, for example, AJHR, 1888, H-9, p. 2, 1892, H-3, p. 2, 1897, H-22, pp. 2, 29, 1906, H-22, p. 1, 1975, H-23, pp. 36-40.
shrank from the 'outcry' of refusing to certify cases that could be brought within the legal definition of insanity. Truby King labelled such cases 'technically insane' especially 'old, infirm, or hopeless patients'. Two certifying doctors (especially a family doctor) played a secondary and confirmative role to the applicant's view of insanity. Magistrates or justices of the peace weighed up the evidence, examined the subject of an application, and decided the fate of people.

However limited and imperfect, census information off-sets the sweeping claims of asylum administrators that families shirked their responsibility to care for disabled relatives who suffered from mental infirmity, idiocy, or epilepsy. The census information gives some support to Thomson's revisionist view of welfare in nineteenth century New Zealand. Earlier interpretations like that of Olssen suggested that traditional welfare systems, based on the individual or the family, began to fragment as the family became 'smaller and more introverted' in late Victorian New Zealand. Olssen considered that individuals and families were still deemed largely responsible for their own welfare, but the gap between ideal and reality was filled by a combination of state and voluntary activity. Thomson would not dispute the legal position. In 1877, 1883, 1894, 1908 and 1910, the law imposed a clear familial obligation upon a widening circle of extended relatives to meet the cost of a greater range of support. By 1910, relatives were responsible for providing or meeting the cost of sustenance, lodging, clothing, teaching, training, medical, nursing, and surgical care, and the funeral of an impoverished relative. Thomson challenges the perception that the welfare state was an inevitable if monolithic outcome of social progress in this country. He posits that responsibility did not shift

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84 AJHR, 1898, H-7, p. 3.
85 Medical Superintendent's report, Seacliff, AJHR, 1896, H-7, p. 5; Medical Superintendent, Seacliff to Inspector-General, 3 September 1898, DAHI 20 D 264.
86 Medical Superintendent's report, Seacliff, AJHR, 1910, H-7, pp. 15-16; Holloway, p. 37. In the same report, King gave several reasons why families and their medical advisers were reluctant to seek specialized help at an early stage of mental unsoundness. These included the 'humiliation' of admission to mental hospital, the social discredit of mental malady, and prejudice against handing over a person to the care of the state.
87 After 1911, the family practitioner was expected to be one of the two certifying doctors. Mental Defectives Act 1911, s. 5(2).
88 Labrum, p. 129; Holloway, p. 19; Somerville, pp. 88, 90.
89 After 1911, justices could act only when there was no resident or stipendiary magistrate available within ten miles. Mental Defectives Act 1911, s. 130.
from the family to the welfare state until 1938. Information on departmental revenue shows that most families readily accepted their financial obligations. In 1906, the Department was paid something for 27.6 per cent of patients. Efficient collection systems raised that figure to 52.5 per cent in 1923. Despite the effects of the great depression in the 1930s, payment was received on behalf of 40 per cent of patients. Only about a dozen cases were taken to court each year.

MENTAL INFIRMITY

Pakeha New Zealand gained an elderly population quite suddenly between 1871-1901. The proportion of persons aged 65 and over more than doubled from 1.2 per cent to 3.0 per cent between 1874-1896, doubled again to 6.4 per cent by 1936, and reached 8.6 per cent of the total in 1945.

The peculiar population structure of colonial society left many elderly people without family support in New Zealand. Such individuals would have been well represented among the 249 harmless patients (or 17.7 per cent of the average resident population) resident in asylums in 1884 and who were deemed fit for care by their relatives, had they any. Veterans of frontier occupations - single men with no relatives in New Zealand - were one of the first problem groups identified. This reflected the gender imbalance and a very high proportion of bachelors in the male population of New Zealand prior to World War I. In 1878, 44.6 per cent of adult

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92 Thomson, pp. 24-6.
93 AJHR, 1907, H-7, p. 13.
94 Inspector-General to Secretary, New South Wales Royal Commission on Lunacy Administration, 26 February 1923, HMH 26/23.
95 AJHR, 1939, H-7, p. 4.
96 Inspector-General to Secretary to the Treasury, 11 August 1926, MH 2/11/3; Director-General’s talk to Wellington Branch, New Zealand Institute of Public Administration, 11 June 1936, HMH 4/4/0.
97 Thomson, p. 155.
98 ESCAP, p. 37.
99 Appendices to the Journals of the Legislative Council, 1884, No. 8. The proportion jumps to 19 per cent if the 16 patients who paid the maximum rate of maintenance (£1 per week) is added.
males had never married. That proportion stayed above 40 per cent until 1911 then fell sharply to about 30 per cent between 1916-36 and to 22 per cent in 1945.\footnote{101}

According to MacGregor in 1896, pioneers were experiencing the natural and premature deterioration of ageing and the ravages of exposure to 'other causes incidental to the life of colonial communities'\footnote{102} (such as drink or syphilis). Rural areas, such as old goldfields, were particularly affected by the problem of ageing bachelors. In 1898, Hokitika's admissions were mostly 'old and broken down people'.\footnote{103} Thirty of the 40 admissions to Hokitika in 1898 were men, two-thirds of them single or widowed, and 11 over the age of 60.\footnote{104} At Seacliff, the proportion of persons over 60 in 1895 was more than double what it had been a decade earlier. 'Contrasting forcibly' with 'legitimate asylum cases', the Medical Superintendent bitterly resented the increasing tendency to certify and commit to the asylum 'moribund persons, worn out by old age and other causes, and who, though technically insane, are so only as a symptom of approaching death.'\footnote{105} Although the gender imbalance at Seacliff in 1896 was less obvious than at Hokitika two years later, marital status was comparable, with 64 per cent of the males admitted being bachelors or widowers.\footnote{106}

Magistrates were placed in a quandary about how best to dispose of elderly people who really only needed supervised residential care. In 1888, H.G. Seth, the Resident Magistrate at Auckland, complained about the 'frequent' appearance before the bench of persons with no friends in the colony who suffered from senile dementia and delusions. These people were "dangerous" only insofar as they could not take care of themselves. Seth knew that such individuals needed some restraint, but the local charitable aid board\footnote{107} could not exercise the necessary control over them.

\footnote{101}{Census and Statistics Department, \textit{New Zealand Population Census 1945}, Volume IV, Wellington, 1949, p. 38.}
\footnote{102}{AJHR, 1896, H-7, p. 1.}
\footnote{103}{Inspector-General’s report, Seaview, 23 November 1898, AJHR, 1899, H-7, p. 10.}
\footnote{104}{AJHR, 1899, H-7, p. 15.}
\footnote{105}{Medical Superintendent’s report, Seacliff, AJHR, 1896, H-7, p. 5; Medical Superintendent, Seacliff to Inspector-General, 3 September 1898, DAHI 20 D 264.}
\footnote{106}{AJHR, 1896, H-7, p. 13. Unfortunately the published statistics do not allow a comparison to be made between age and marital status.}
\footnote{107}{Charitable aid boards were set up in 1885 as part of the system of local government. Like hospital boards, whose functions were sometimes exercised jointly, charitable aid boards were funded by a mix of local rates, government subsidies, patients’ fees and, to a diminishing extent, voluntary
Such individuals could not be jailed if they had lawful means of support. Magistrates like Seth therefore had no option but to commit them to the asylum. Another device was to imprison old people charged with vagrancy, more from pity than for punishment. The police were more likely to bring single men than family men to official attention for unacceptable behaviour or mental aberration. W.S. Haselden, Wellington’s magistrate in 1900, encountered problems disposing of men ‘who are not model paupers and yet are not deserving of a pension’. Some were the sort of men whom Tennant calls ‘characters’, ‘nature’s gentlemen’ and ‘poor old chaps’. Their mental state could make them ‘troublesome, and often dirty in their habits, and difficult to manage’.

Asylum and prison officials were powerless to stem the traffic referred by the courts. Virtually every Prisons Department report between 1882-1907 contained an ‘annual protest’ against the inappropriate use of prisons to look after lunatics pending certification, cases of delirium tremens, and destitute elderly or infirm people, simply because there was nowhere else to send them. Outside of those centres with a mental hospital, police processed persons were held in custody pending their committal although on a diminishing scale once alternative provision was made by health and social services for those classes whose presence prison authorities resented. In 1941, the last year the information was published, 14 lunatics, as they...
were still officially described, were received in the country’s gaols, half of them in minor prisons or police gaols.\textsuperscript{117}

Asylums faced similar constraints because they could not legally deny admission to any committed patient:\textsuperscript{118}:

The Stipendiary Magistrates have the power of admission on the certificate of two medical men [sic], while the officers of the General Government [Lunatic Asylums Department] cannot venture to discharge unsuitable admissions unless they previously can provide some means of providing for them, either with friends or in some local refuge. Thus it comes that our insane are steadily increasing, especially in times of depression, at a far higher rate than the real increase of our population warrants ....\textsuperscript{119}

Elderly infirm people without relatives fell between the cracks because the state’s administrative responsibility for cure, care, custody and welfare was fragmented among many agencies and, more particularly, divided between the levels of central and local government. In the post-provincial carve-up of state responsibilities, the mandate for law and order, and custodial institutions remained solidly with the central government. Responsibility for hospitals and welfare services was dispersed, although it took from 1877-1885 to implement a national system of hospital and charitable aid. In a bid to distance central government from direct and total responsibility for funding or providing indoor and outdoor relief, this system was built upon principles of voluntarism and localism, with various subsidies from central government. In return, the voluntary organizations and ad hoc local authorities that provided hospitals or charitable institutions were granted considerable autonomy and limited accountability.\textsuperscript{120} Grabham was largely responsible for designing this system, which politicians of the day subjected to parochial fragmentation\textsuperscript{121}

Colonial aversion to a coordinated British style poor law administration, along with

\textsuperscript{117} AJHR, 1942, H-20, p. 5.
\textsuperscript{118} Medical Superintendent’s report, Porirua, AJHR, 1904, H-7, p. 11; Inspector-General to Public Service Commissioner, 10 September 1920, Carrington Hospital Archives, National Archives, Auckland, YCAA 1079/8c, File 6/26/-.
\textsuperscript{119} AJHR, 1895, H-7, p. 1.
\textsuperscript{120} AJHR, 1975, H-23, pp. 16-18, 193-235; Tennant, pp. 23-32; Thomson, pp. 28-33.
\textsuperscript{121} AJHR, 1975, H-23, pp. 242-3.
some denial of social problems, made for patchwork development of specialized residential institutions for different forms of disability in the late nineteenth century. Benevolent refuges or old people’s homes built at public expense were constantly recommended or promised but progress was slow, patchy, unplanned, and reluctant.

Grabham left New Zealand before the full effects of the chaotic tension between the multitudinous special purpose local authorities, voluntary organizations and the Asylums Department were felt, although he could have read and heeded Skae’s prophetic misgivings about the way divided administration was producing even by 1881,

- a strong inducement to allow the elastic term “insanity” to be applied with the utmost latitude, and to place many persons in lunatic asylums who might be well enough or better provided for elsewhere.

As Grabham’s system of hospital and charitable aid boards settled down, its muddle and flaws irritated MacGregor:

Owing ... to the extent to which we have succeeded in developing local administration and responsibility for the maintenance of the poor, while the insane are provided for entirely by the central Government, there has arisen a strong tendency to throw every case that can be brought within the definition of insanity off the local rates on to the general taxation of the colony. The officers of the Charitable Aid Boards and Hospital Trustees, especially in the larger centres ... make every effort to get them removed.

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122 Olssen, p. 262.
123 Tennant, pp. 45 ff.
125 Tennant, pp. 150-3; Thomson, pp. 94-97.
126 AJHR, 1881, H-13, p. 2.
According to MacGregor, by 1888, the admission of people who only needed ‘kindly treatment and safe-keeping’ was already undermining the ‘proper’ or curative function of lunatic asylums.\textsuperscript{128} Faced with similar a functional difficulty in the same year, the Inspector of Prisons pointedly asked:

What are the hospitals for? Are the staff to have no troublesome patients? ... In the New Zealand hospitals it appears that whenever a patient gives a little trouble, or evinces any noisy tendencies, they are at once turned over to a gaol or lunatic asylum.\textsuperscript{129}

Crucial to the battle between central government departments and local authorities, with their vigilant protection of taxpayers’ and ratepayers’ interests respectively, was the legislative authority given to the boards of public hospitals and separate institutions to make by-laws on a range of matters, including the regulation of admissions to their institutions.\textsuperscript{130} Extending a practice apparent even before the Asylums Department was formed, many boards exercised this power to exclude patients who, by the standards of the day, would have been economic or therapeutic risks. These typically included lunatics and persons more suited to care in a benevolent refuge.\textsuperscript{131}

Whether or not the definition of lunacy included mental infirmity became the source of confrontation between central government departments and hospital and charitable aid authorities.\textsuperscript{132} In 1888, a judgement on the case of R.G.F. established that it was...
illegal to detain harmless patients in a public asylum. Legal resolution was a Pyrrhic victory for MacGregor. When the Auckland Charitable Aid Board received the handsome Costley bequest in 1886, MacGregor suggested that the proposed home should provide a ward for 'harmless and friendless people, who are merely suffering from senile decay'. In early 1888, in a move that was almost certainly sanctioned by superiors, the Auckland Asylum authorities advised the Board that 86 patients, including legally sane persons, should not be there. The Board was unfazed. Next, the Board refused to admit Mrs C., who had a 'mild craze' on some subject but felt intensely degraded by being in the asylum. In August 1888, MacGregor tried to sort out the problem when he visited Auckland, again without success.

MacGregor's exasperation reached breaking point when the Costley Home finally opened in April 1890. Within days, the Inspector-General despatched an ultimatum to the Board on 25 April 1890 but he apparently gave no indication that he expected a reply by return mail. By then, all corridors at the Whau Asylum had been turned into patient accommodation. Dormitories were more than one-third overcrowded. There was a real risk of epidemic. The ultimatum having expired before the next board meeting, MacGregor struck. Said to be acting upon instructions from the government, on 2 May 1890, MacGregor told the medical superintendent to discharge six harmless senile patients to the Board's care. At 3 p.m., they were duly delivered to the Board's offices by cart. MacGregor justified his stance on the grounds of his personal responsibility for insane persons in
asylums. These people did not meet the legal definition.\textsuperscript{142} The Board still refused to accept these hapless people, and eventually the Salvation Army and Sir George Grey made arrangements for their care. MacGregor's 'strenuous' move, as he recalled the incidents at Auckland, and at Dunedin a few months later\textsuperscript{143} completely misjudged public opinion. The press generally sided with the local authorities and angrily condemned the high-handed intervention.\textsuperscript{144}

The events of 1890 clearly established senile decay as a form of insanity that was, of course, a central government responsibility.\textsuperscript{145} A strong-minded judge, like the Stipendiary Magistrate at Wanganui, might override the wishes of hospital management by remanding suspected lunatics to the hospital irrespective of the type of insanity,\textsuperscript{146} but he was exceptional. The fuss over an elderly woman who was left in a Christchurch police cell for most of a day in 1906 before she was taken to Sunnyside was insufficient to change general practice. The hospital board refused to take responsibility for incurable or senile patients who did not need the medical care of a public hospital. The Premier, R.J. Seddon, would not intervene but took the Board's side, arguing that a public hospital was supposed to provide only acute care.\textsuperscript{147} Legal recognition of mental infirmity as a specific form of mental defect in 1911 compounded the problem. City based mental hospitals in Auckland\textsuperscript{148} and Christchurch\textsuperscript{149} continued to complain about inappropriate admissions of aged persons. By 1929, Gray claimed that less than 40 per cent of the 462 elderly persons in mental hospitals actually required that level of care.\textsuperscript{150}

\textsuperscript{142} Editorial, New Zealand Herald, 10 May 1890.
\textsuperscript{143} Evening Herald, 16 and 25 July 1890; Evening Star, Dunedin, 17 July 1890; Otago Daily Times, 2 August 1890.
\textsuperscript{144} Evening Herald, 17 July 1890; Otago Daily Times, 18 July and 2 August 1890; editorial, Auckland Star, 14 June 1890; editorials, New Zealand Herald, 6-7, 10, 15 and 23 May 1890; editorials, Evening Post, 5-6 and 17 May 1890; Lyttelton Times, 5 May 1890.
\textsuperscript{145} Editorial, Evening Post, 17 May 1890; editorial, Auckland Star, 14 June 1890.
\textsuperscript{146} Stipendiary Magistrate, Wanganui to Minister of Justice, 29 October 1906, HMH 1906/1012.
\textsuperscript{147} Editorial, Lyttelton Times, 28 and 30 July 1906.
\textsuperscript{148} Medical Superintendent's report, Auckland, AJHR, 1916, H-7, p. 3.
\textsuperscript{149} Medical Superintendent's reports, Christchurch, AJHR, 1911, H-7, p. 16, 1917, H-7, p. 7, 1919, H-7, p. 11; Medical Superintendent, Christchurch to Inspector-General, 22 November 1915 and 6 May 1918, HMH 8/112.
\textsuperscript{150} Director-General to Minister, 17 October 1929, HMH 8/1041.
The hospital and health system started to see senility as a national problem in the 1920s. As a result, the Rest-homes Act 1929 was passed as a government measure. The Act was designed to deal with 'destitute persons unable by reason of age and infirmity to look after themselves'. This definition was accepted as meaning virtually the same thing as mental infirmity under the Mental Defectives Act 1911. It seems probable that this legislation was developed on the advice of the Mental Hospitals Department. The Department certainly hoped to benefit from the transfer of patients who were not troublesome to other institutions. Prisons also stood to gain from the law because section 14 provided a way to commit persons charged with offences involving vagrancy to a rest home without the charges being pressed.

Any good intention of the government fell victim to the great depression. The energetic post-depression Labour Government made no move to implement the statute of its predecessors. Then came the priorities of a wartime and post-war economy. Hospital boards were said to be responsible but governments took no action to enforce that viewpoint. The Rest-homes Act was never implemented, so mental hospitals continued to handle mental infirmity. By 1932, 350 of the 500 mental hospital patients aged 70 years or more were senile. The Department's report for 1947 referred to the absence of suitable homes for mentally infirm people who only needed 'sympathetic care and supervision, along with guidance into a more orderly and routine life'. A 'large proportion' of the 2299 committed patients in the mental hospital system in 1947 were aged 60 years or more and did not require specialized treatment for their mental condition. Those persons, who constituted 26 per cent of the total patient population, were said to be very largely responsible for the overcrowded state of mental hospitals.

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151 Tennant, pp. 158-9.
152 Minister, NZPD, 6 November 1929, 223, pp. 1284-5; Rest-homes Act 1929, ss. 11-14.
153 Director-General, Circular, 11 November 1929, HMH Institutional Circulars. The Act resembled the Mental Defectives Act 1911 in many of its features, e.g. committal procedures, licensing and inspection procedures.
154 Prime Minister to Minister, 30 September 1932, HMH 3/6/4; Director-General to Minister, 24 November 1944, MH 2/20; Journal of the Hospital Boards Association of New Zealand, 7, 10 (1937), 43 and 7,12 (1937), p. 22.
155 E.g., Director-General, Circular, 19 August 1933, YCAA 1079/5h, File 5/2/3; Minister, NZPD, 1 September 1934, 239, p. 635; Director-General of Health to Minister, 3 August 1936, HMH 53/977 (42346); Director-General to Minister, 24 November 1944, MH 2/20. The Rest-homes Act 1929 was repealed in 1968.
156 AJHR, 1932, H-7, p. 2.
157 AJHR, 1948, pp. 2-3.
IDIOCY

Quinquennial census data from 1874 provide clues about ‘specified infirmities’ or various physical and mental disabilities, among them lunacy, idiocy, and epilepsy. Although the term lunatic in the census was virtually synonymous with persons in institutional care, that did not apply to persons classed as idiots. Indeed, the number of lunatics maintained privately by friends was very small, evidently chiefly young children' reported in the 1886 census probably referred to idiot children. By adding children under the age of 15 in asylums (who are assumed to have suffered from congenital mental conditions, or epilepsy) to census returns for idiocy in general, Table 5 shows that the great majority of idiots and imbeciles lived outside institutions. This pattern continued. Mental hospital doctors told the Committee of Inquiry into Mental Defectives and Sexual Offenders (1924) that doctors were reluctant to certify children in the face of parental opposition and unwillingness to part with their offspring. That suggests that many families cared for mentally defective offspring at home until financial circumstances or parental health deteriorated. Intervention was rare except in extreme situations of neglect. Hay did not want to ‘set forth rounding up all the unnotified cases’ lest the

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158 Information was collected about persons in the non-Maori population who were deaf, deaf-and-dumb, lunatics, idiots, persons suffering from epilepsy or paralysis, crippled or deformed in any way, or suffering from debility or infirmity.
159 Census and Statistics Department, Results of a Census of the Colony of New Zealand taken for the Night of the 16th March, 1874, Wellington, 1875, pp. 17-18.
160 Census and Statistics Department, Results of a Census of the Colony of New Zealand taken for the Night of the 3rd of March, 1878, Wellington, 1880, p. 17; Results of a Census of the Colony of New Zealand taken for the Night of the 3rd April 1881, Wellington, 1882, p. 15; Report on the Results of a Census of the Colony of New Zealand taken for the night of 12th April, 1896, Wellington, 1897, General Report, p. 57; Report on the Results of a Census of the Colony of New Zealand taken for the night of 29th April, 1906, Wellington, 1906, General Report, p. 52; Census of New Zealand, 2nd April, 1911, Wellington, 1912, General Report, p. 55. After 1916, the assumption was so strong that mental hospital populations only were included. Census and Statistics Department, Results of a Census of the Dominion of New Zealand taken for the Night of 15th October, 1916, Wellington, 1918, p. 77.
162 Reed, pp. 33-34, comments on the high proportion of children and adolescents among those admitted for epilepsy to Seaciff between 1880-1915.
163 See Robertson, p. 73.
164 Holloway, p. 42.
165 John O’K. was one the most distressing cases reported. This 24-year-old Waitahunaman was found in a very dirty and unkept condition, with his hair and finger nails very long. He could not speak but barked like a dog. As Hay reported the case, the ‘poor and ignorant’ parents were unaware of their legal obligation to notify the Colonial Secretary of John’s insanity after three months. Deputy Inspector-General to Minister, 1 October 1906, HMH 1907/87.
## TABLE 5

**HOME AND INSTITUTIONAL CARE OF IDIOTS IDENTIFIED IN CENSUS REPORTS, 1878-1916**

<table>
<thead>
<tr>
<th></th>
<th>Lunatics &lt;15 yrs in Asylums</th>
<th>Census identified Idiots &lt; 15 yrs</th>
<th>Census Idiots 15+ Years</th>
<th>Total Idiot</th>
<th>% in Asylums</th>
</tr>
</thead>
<tbody>
<tr>
<td>1878</td>
<td>7</td>
<td>26</td>
<td>44</td>
<td>77</td>
<td>9.1</td>
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<tr>
<td>1881</td>
<td>15</td>
<td>19</td>
<td>39</td>
<td>73</td>
<td>20.5</td>
</tr>
<tr>
<td>1886</td>
<td>13</td>
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<td>63</td>
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<td>12.7</td>
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<td>16</td>
<td>35</td>
<td>99</td>
<td>150</td>
<td>10.7</td>
</tr>
<tr>
<td>1901</td>
<td>26</td>
<td>21</td>
<td>84</td>
<td>131</td>
<td>19.8</td>
</tr>
<tr>
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<td>46</td>
<td>10</td>
<td>58</td>
<td>114</td>
<td>40.4</td>
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<tr>
<td>1911</td>
<td>67</td>
<td>122</td>
<td>655</td>
<td>844</td>
<td>7.9</td>
</tr>
<tr>
<td>1916</td>
<td>17</td>
<td>163</td>
<td>599</td>
<td>779</td>
<td>2.2</td>
</tr>
</tbody>
</table>

Note: The large increase recorded in 1911 occurred because the category changed from idiot to feeble-minded. The loose definition of feeblemindedness made for 'two maxima', one about age 15 and one at advanced age, which means that mental infirmity was included. Census and Statistics Department, *Results of a Census of the Dominion of New Zealand taken on the night of the 15th October, 1916*, Wellington, 1920, p. 77.

Sources: Census reports, 1878-1916, Table showing Infirmary.
influx 'crowd our overtaxed accommodation'.

Idiocy, like epilepsy, was exposed to official gaze in the late nineteenth century through contact with the primary school system and when the dull child passed from the education system into the working years. Compulsory primary education was introduced in 1877, before an adequate infrastructure was developed for disability. In prosperous times, the abundance of work (particularly around farms) made it easier to employ such persons. Depressed conditions dried up those work opportunities. Urban drift and economic conditions during the long depression made it harder to “hide” harmless lunatics or idiots or to keep them economically productive. During the long depression, the population moved to the towns.

The admission of idiot children to lunatic asylums was noted from 1879. Their mental state was often deemed to be hopeless. Idiot boys at Dunedin were ‘mere animals devoid of all sense’, a statement which suggests that they were totally dependent, being profoundly if not multiply handicapped. The Department unequivocally accepted responsibility for these ‘really bad’ cases, as Hay called them in 1915. Not all cases of congenital mental defect, however, fitted that description. By 1904, the number of asylum inmates under the age of 21 had swollen to 92. By the following year, asylums were clearly accepting the ‘more promising of the boy imbeciles’, for whom the Department wanted to make special provision. Hay’s use of the terms imbecility and feeblemindedness in this...
context show how the practical definition of idiocy was expanded several years before the Mental Defectives Act 1911 was passed.

Official recognition of the problem of congenital mental defect was clearly linked to physical and intellectual disability encountered in the school system. From 1892, school inspectors and truancy officers had identified "backward" or dull children whose progress through the educational "standard" system was retarded by sensory, physical or mental defect. Other cases must have come to light when the School Medical Service was set up in 1912. Hay concluded similarly:

Compulsory education of imbeciles and idiots (though in many cases it may reach no higher than training for the performance of simple necessary acts) is a natural sequence of the education system, and in asking for it we are assisted by precedents in the special case of deaf-mutes and the blind.

The Asylums and Education Departments then rationalized their respective responsibilities. Special schools and special classes in ordinary primary schools were mandated for backward children in 1907 and 1914 respectively. Hay thought that a special school should train 'the lower stratum of school life and the higher grade imbeciles', with the latter class being the responsibility of the Mental Hospitals Department. Hay could not convince the Minister general hospitals should care for imbeciles 'from failures in the above class to the highest grade idiots', and idiots, most of whom, he argued, would become 'better conducted'. In 1910-11, the Mental Hospitals Department was given primary responsibility for imbeciles and idiots or, as Hay later called them, the Education Department's rejects. The

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Defectives, near Nelson in 1905 to deal with this group. The Education Department was aware of the Richmond Home project but was apparently not involved. Official Visitor's report, 27 November 1903, Nelson Asylum Inspector's Book.  
AJHR, 1907, H-7, p. 12.  
Ralph Winterbourn, Educating Backward Children in New Zealand, Wellington, 1944, pp. 20-34.  
Winterbourn, pp. 20-34; Robertson, pp. 13-18.  
Deputy Inspector-General to Minister, 11 September 1906, HMH 1906/844.  
Education Amendment Act 1910, ss. 11-3; Mental Defectives Act 1911, s. 30.  
Inspector-General to Minister, 11 December 1916, HMH 4/6. For the Education Department's perspective, see Secretary of Education to Commissioner of Police, 13 May 1914, Minister of Education to Prime Minister and Cabinet, 16 May 1914, CW 40/5/7. According to that Department,
Mental Defectives Act 1911 set up a special procedure for parents to apply for the committal of minors.\textsuperscript{162}

Apart from social and bureaucratic factors, medical thinking played a major role in expanding the definition of idiocy. The 1911 classification of mental defect was consistent with contemporary psychiatric nosologies. These, in turn, were guided by hereditarian and degeneracy theories, both overseas\textsuperscript{183} and in New Zealand.\textsuperscript{184} These influences, a mix of soundly based and ideologically prescribed ideas, flowed into the influential intellectual current of eugenics.\textsuperscript{185}

In eugenics thinking, segregation of congenitally mentally defective adults helped prevent national decay through the propagation of the mentally and socially unfit. MacGregor believed that 'weakness' was transmissible from one generation to the next and might be manifest in insanity, feeble-mindedness, epilepsy, or a tendency to be 'otherwise neurotic'. Such persons were inherent paupers. Anxious to prevent 'filling society with human debris and wastrels',\textsuperscript{186} towards the end of his inspectorate MacGregor admitted publicly that he did not hesitate to take the law into his own hands by continuing to detain some patients of reproductive age.\textsuperscript{187} Hay also used 'moral suasion' to keep some patients in hospital when they could have established a

when the Otakeike institution was opened, the Education Department was besieged by applications for admission but owing to 'lack of action' by the Mental Hospitals Department, they had to be taken in. Most were of 'disgusting and disagreeable habits, deformed, and misshapen or partially paralyzed or subject to epilepsy.' They were termed 'derelicts' who should not have fallen within the scope of that Department. Officer in Charge, Special Schools Branch to Director of Education, 22 June 1920, CW 40/5.-

\textsuperscript{162} Mental Defectives Act 1911, s. 24.

\textsuperscript{183} Edgar Miller, '[Mental Retardation] Clinical Section - Part I' in Berrios and Porter, pp. 214-16.

\textsuperscript{184} MacGregor was an early and passionate proponent of eugenics thinking in New Zealand. See for instance, D. MacGregor, 'The Problem of Poverty', \textit{New Zealand Magazine}, 1 (1876), pp. 60-75; 2, (1876), pp. 207-16, and 3 (1876), pp. 310-21; AJHR, 1898, H-22, p. 7, and 1898, H-7, pp. 3-4. See also W.A. Chapple, \textit{The Fertility of the Unfit}, Wellington, 1903; Presidential Addresses, \textit{New Zealand Medical Journal}, 9, 37 (1911), p. 35, and 11, 41 (1912), pp. 4, 7; Hon. General Secretary, Australasian Medical Congress to Prime Minister, 11 June 1914, CW 40/5/-.\textsuperscript{185}

\textsuperscript{185} Eugenics originated with nineteenth century debates about population and evolution overlaid with the doctrine of state intervention, imperial sentiment, hygiene, and notions of Anglo-Saxon racial superiority. Eugenists contended that civilisation had thwarted natural selection by the survival and fecundity of the unfit, or problem groups in society. Mike Hawkins, \textit{Social Darwinism in European and American Thought 1860-1945: Nature as Model and Nature as Threat}, Cambridge / New York, 1997, pp. 216-48 is a good recent account of the rise and fall of the eugenics movement internationally.

\textsuperscript{186} Inspector-General to Clerk, Parliamentary Public Petitions Committee (A-L), 3 October 1906, H 30/28/21 (35252).

\textsuperscript{187} Editorial, \textit{New Zealand Times}, Wellington, 21 September 1906. He did not disclose whether these were males and / or females.
legal right to discharge. After 1911, medical officers or medical superintendents had to certify that continued detention was necessary for a committed patient’s ‘own good or in the public interest’. The meaning of neither term was spelled out in the Act so, although actual practice is not clear, it is possible that the provision may have been used for eugenic purposes.

Segregation in special institutions or colonies was important. Hay explained why in 1915:

Generally speaking, idiots, imbeciles and feeble-minded children are happier in association than as solitary weaklings in a home much indulged by a mother and much teased by the other children of the family and neighbours. So far, for the child’s own good, it may be said to be better in an institution. Also, the constant presence is somewhat blighting to the other young members of the family.

The turning point for many distressed families came when they realized that the constant burden of caring would be lifted and their afflicted relatives better off ‘comfortably housed and humanely tended’ in an institution. Under Gray’s leadership, the Department actively promoted institutional care. Idiots and imbeciles were the focus of mental hospital populations but as Robertson has pointed out, the failure of the Mental Defectives Act 1911 to distinguish between feebleminded children and adults left a gap between the education and mental hospital systems. The problem initially centred upon special school “graduates” who were unloaded on to mental hospitals.

After the First World War, officials of the Mental Hospitals Department, supported by school medical officers, bickered with the Education Department about the relative merits of psychological and medical approaches to assessment, classification and

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188 AJHR, 1910, H-7, p. 3.
189 Mental Defectives Act 1911, s. 15.
190 Inspector-General to Minister, 8 November 1915, CW 40/5/-.
191 AJHR, 1903, H-7, p. 3.
192 Director-General to Director of Education, 18 June 1929, CW 40/5/5; Director-General to Medical Superintendent, Auckland, 2 April 1929, YCAA 1079/7g, File 5/64/-.
193 Robertson, pp. 20-24.
194 Inspector-General to Minister, 8 November 1915, HMH 4/6. Cf. Inspector-General to Minister, 11 December 1916, HMH 4/6; Inspector-General to Secretary for Education, 10 February 1916 and Secretary for Education to Minister of Education, 30 June 1916, CW 40/5/-. 
care. The rivalry peaked between 1929-32 and saw the demise of the Eugenics Board that had been set up under the Mental Defectives Amendment Act 1928. Nevertheless, the struggle secured for Gray partial jurisdiction over feeblemindedness. Referrals to the Board's clinics from various official agencies inevitably led to admissions to the Department's showpiece 'colony school for feebleminded children', Templeton Farm Colony, near Christchurch. Few children admitted there were said to have benefited from time in ordinary or special classes in the community.

As the original and successive Templeton Farm Colony intakes grew up, conditioned for an institutional existence, an adult division was needed. Between 1920-45, the proportion of feeble-minded patients grew from 24.8 per cent to 37.2 per cent of the total of all other legal classes of mental defect other than unsound mind. There was an upsurge between 1930-5, shortly after the high water mark of eugenics policies in 1928.

**EPILEPSY**

In the nineteenth century, epilepsy was still the subject of deep-rooted prejudice. It was often associated with mental disorder, although the nature of any link remained a matter of clinical debate. Limited census information makes it difficult to draw firm conclusions about home or institutional management of epilepsy in New Zealand, although Reed's long essay is useful. As with idiocy, Reed notes that difficulties in the management of epileptic children at home, in industrial schools or other welfare institutions sometimes precipitated committal. The number of epileptics stated in the census doubled to 320 between 1878-1896 but then dropped markedly to 113 in 1901 and 86 in 1906, the last census for which the information

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195 Robertson, pp. 44-46.
196 See in particular, Director of Education to Mr Cowles, 25 July 1929 and 7 April 1930, CW 40/5/5; Eugenics Board Minutes, 2 March and 21 August 1930, CW 40/5/5; T.B. Strong to Director of Education (confidential), 7 October 1930, CW 40/5/5; Winterbourn, pp. 62-63.
200 Reed, pp. 19-20.
was collected. The 1896 census noted that the return was imperfect because people objected to giving the information. However, a figure resembling the 1896 census return can be derived by adding to the 86 epileptics reported in the 1906 census the 214 epileptics noted in inspection reports on public mental hospitals during 1907. These were probably patients whose epilepsy was associated with major organic brain damage, behavioural disorder and mental and emotional disturbance. The numbers involved were small and never reached above 6 per cent of Seadliff admissions between 1880-1915. But 71 per cent of those admitted for epilepsy died there.

Sane epileptics were very occasionally admitted to asylums in the nineteenth century. By 1907, there were sufficient male epileptics who were 'keenly sensitive' to their confinement in asylums and who could appreciate an improved environment to warrant special provision nationally. The inclusion of a very broadly defined Class VI in the Mental Defectives Act 1911 therefore seems to have sanctioned past practice. As Reed notes, the potentially all-embracing Class VI also indicated the uncertain state of medical knowledge about epilepsy at the time — whether it was a cause or a form of insanity. Sane persons with epilepsy, however, who were looked after in ordinary wards, were distressed by the vagaries and behaviour of other patients who, in turn, were disturbed by the sight of epileptic fits. By 1925, some doctors refused to certify persons suffering from epilepsy because of the lack of special facilities to treat them.

AJHR, 1907, H-7, pp. 18, 21, 24, 26-28, 30.
Reed, pp. 11, 28.
Reed, p. 31.
Reed, p. 67.
Evidence, R. v. Maxwell, 31 August 1893, Mental Hospitals Department file MH 1891/2511, p. 104, formerly held at the Health Department head office, but current whereabouts unknown.
Inspector-General to J. Ritchie, 7 May [?] 1907, HMH 1907/495.
Superintendent, Hokitika to Inspector-General, 25 April 1905, Seaview Hospital Letter Book, Westland Hospital Board Archives, National Archives, Christchurch, CAHW CH 22/16, L. 89/05.
Reed, pp. 22-23, 25-27.
AJHR, 1926, H-7, pp. 5-6; NZPD, 6 August 1926, 210, p. 281; Director-General to Medical Superintendent, Seaciff, 22 March 1929, HMH 8/1183.
Department of Health, Mental Defectives and Sexual Offenders, Wellington, 1925, p. 15.
SOCIAL DEFECTIVES

Refinement of the concept of idiocy into three classes in the 1911 Act was associated with the measurement of intelligence. The Act made no provision for a group that British medical opinion considered should be included in a comprehensive schema for mental defect. These so-called moral imbeciles were mental defectives who from an early age had shown strong vicious or criminal propensities upon which punishment had little or no deterrent effect. Here the test was antisocial conduct, not intelligence. New Zealand’s Attorney-General thought at the time that the ‘jungle of the tests of moral responsibility’ would imperil the administration of justice, so the class was omitted from the Mental Defectives Bill 1911.

The omission was first noticed before the First World War. In 1913, Hay noted that feeblemindedness did not stretch to women of low average mental calibre who had ‘fallen into vice through an ill upbringing or through misfortune’ or who had deliberately chosen ‘the primrose path of dalliance’. These women did not meet the statutory criteria of feeblemindedness but ‘having a blunting of the moral sense and a decided pliancy under temptation, are a manifest danger in the community, and should be placed out of harm’s way until they become harmless’ at the menopause. ‘Empty-headed youths and larrikins at our street corners’ were the male equivalent, in Hay’s opinion. These lads were not empty-headed enough to be classed as feeble-minded or bad enough for gaol, but they were ‘of no use to anybody.’ In officials’ parlance, the women were moral degenerates or moral.

213 NZPD, 6 September 1911, 155, p. 303.
214 Feebleminded women of reproductive age were another group of special concern to official and voluntary welfare organizations between 1910-4. Inspector of Police to Senior Inspector Herd, Auckland, 3 March 1910, Manager, Mount Albert Industrial School to Secretary for Education, 14 April 1910, Inspector, Industrial and Special Schools to Inspector-General of Schools, 7 May 1913, Minister of Hospitals and Charitable Aid [conveying resolution of hospital and charitable aid boards] to Minister of Education, 8 July 1913, CW 40/5/-; Christchurch Women’s Committee cit. New Zealand Times, 21 April 1913; annual report, Auckland Door of Hope cit. Star, 5 September 1913; Robertson, pp. 28-31.
215 Inspector-General to Minister, 5 May 1913, CW 40/5/-; Minister of Education to Hon. Secretary, Wanganui Branch, Women’s Christian Temperance Union, 13 August 1913, CW 40/5/-.
216 AJHR, 1913, H-7, p. 6.
217 Inspector-General to Minister, 8 November 1915, CW 40/5/-.
218 Inspector-General to Minister, 5 August 1913, CW 40/5/-.
imbeciles.\textsuperscript{219} Hay thought that the problem might need to be dealt with through special legislation and permanent confinement.\textsuperscript{220}

After the Great War, the focus shifted towards more serious criminal behaviour, such as sexual offending. Pratt mistakenly suggested the issue involved the criminally insane.\textsuperscript{221} Prison authorities named feebleminded inmates as a problem group in prisons along with the criminally insane and sexual offenders.\textsuperscript{222} Robertson’s study correctly traces the growth of interest in the association between persons who committed unnatural offences and mental deficiency or disorder. A Prisons Board resolution of 1920 made the first link.\textsuperscript{223} The terms of reference and recommendations of the Committee of Inquiry into Mental Defectives and Sexual Offenders (1924-5) followed up the connection,\textsuperscript{224} followed by the report on Gray’s overseas study tour in 1927.\textsuperscript{225} After 1929, a special national programme was set up at New Plymouth Prison for sex offenders that was run by a psychiatrist and administered fully within the penal system.\textsuperscript{226}

By the time legislation was drafted, the nomenclature of “moral” defect did not appeal to the Minister. ‘Sexual obliquity’ was implied by the reference to moral defect and detracted from the need to address ‘anti-social conduct’ – a wider concept than the prevailing English law, which referred to vicious or criminal propensities.\textsuperscript{227} By anti-social conduct was meant:

\textsuperscript{219} Medical Superintendent’s report, Christchurch, AJHR, 1925, H-7, p. 12. ‘Moral imbecile’ was used slightly differently in the English Mental Deficiency Act 1913 for ‘persons who from an early age display permanent mental defect, coupled with strong criminal or vicious propensities, on which punishment has little or no deterrent effect.’

\textsuperscript{220} Minister to Minister of Education, 6 August 1913 and Minister of Education to Inspector-General of Education, 9 August 1913, CW 40/5/-.

\textsuperscript{221} Pratt, p. 229. He may have reached this conclusion from the memoirs of B.L. Dallard, Controller General of Prisons (1925-49) which were written when Dallard was 90. Dallard, however, was referring to difficult prisoners who were ‘emotionally disturbed and feebly inhibited’. B.L. Dallard, Fettered Freedom: A Symbiotic Society or Anarchy?, Wellington, 1980, p. 75.

\textsuperscript{222} AJHR,1921, H-20, p. 6.

\textsuperscript{223} AJHR,1921, H-20a. The Inspector-General was a statutory member of the Board. He also served an honorary role as Inspector of Prisons until pressure of mental hospitals work obliged him to relinquish the office. AJHR,1914, H-20, p.2.

\textsuperscript{224} Department of Health, Mental Defectives, pp. 15, 23.

\textsuperscript{225} AJHR, 1927, H-7a.

\textsuperscript{226} This programme has been studied by P. Boston, ‘Re-examining the Pervert : Eugenics, Psychiatry, and the Sexual Offender in New Zealand, 1928-52’, unpublished paper presented at the History Here and Now Conference, Victoria University of Wellington, 11 February 1996.

\textsuperscript{227} Minister, NZPD, 24 July 1928, 217, p. 697.
sneak-thieving; purposeless mischief; for instance; silly practical jokes involving danger to life; incendiarism; interference with the safety of railways; and an utter absence of responsibility towards society. Punishment as criminals has no effect on them whatever .... 228

The 1928 Bill proposed that this class of persons be called social defectives. It was the Government's intention to establish special institutions for this class, which would prevent them being sent to prisons, borstals, child welfare institutions or mental hospitals. 229 In the face of continued unease about the pernicious potential of the definition and its admitted limitations, 230 the Minister agreed to review it. 231 The proposed definition was not changed. Gray was not entirely happy with the outcome and in 1932 he consulted his colleagues to clarify the meaning. 232 Perhaps because of lingering disquiet, the label of social defective was applied very sparingly. 233

CONCLUSION

Changes in the official definition and technical interpretation of the concepts of lunacy and idiocy, as expressed in statute law between 1868-1928, determined the patient composition of mental hospitals. In this chapter, I have argued that the clientele determined both by statutory definitions and the construction placed upon the applicants, certifying doctors and magistrates were the starting point of national mental health policy. These changes reflected medical thinking about the forms of mental disorder, such as neuroses or inebriety, which were eventually incorporated into international classifications. As the avowed experts, doctors acted individually through certification and clinical judgment, collectively through advocacy for policy

228 Minister, NZPD, 19 July 1928, 217, p. 608.
229 Minister, NZPD, 24 July 1928, 217, pp. 697, 704.
232 This produced a broad explanation that included 'emotional deficiency' manifest in childhood with relationship problems with parents, incorrigible theft and lying. The condition then led to cruelty to animals and children. Crimes were wanton and purposeless and the social defective often stood to gain nothing from them. Offending began at an early age and persisted in spite of reward or punishment. Foolishness and antisocial conduct by ordinary criminals did not constitute social defect. Director-General to Medical Superintendent, Hokitika, 19 September 1932, CAHW CH 707, File 7/20/2 (569); AJHR, 1935, H-7, p. 2.
233 Holloway, pp. 16-17.
change, and bureaucratically through their grip on the management of psychiatric services.

The most important changes occurred in 1911 and 1928 when the notions of lunacy and idiocy were transformed into six, then seven, medico-legal entities constructed around the concept of mental defect. What lunacy, idiocy or mental defect meant was determined both by statutory definitions and by their interpretation in the individual circumstances of every application for admission to an institution. In turn, individual decisions must be placed in the contexts firstly, of demographic changes in Pakeha society in the late nineteenth and early twentieth centuries, and, secondly, in the slow development of an infrastructure for disability and elderly populations. Families sought help, whether to seek respite, superior care, or to find relief from the economic pressure of care giving. Disputes among agencies involved in the fragmented administration of social programmes compounded the problems, especially in the fields of mental infirmity and idiocy. Asylum administrators had little redress against the volume of patients committed to their care, however inappropriate they thought such admissions.

Departmental medical staff and administrators made three contributions to the official framing of mental disorder. By raising public expectations about the merits of their facilities and by supplying specialized programmes for different groups of patients, they generated some demand. Medical staff made a clinical decision to admit voluntary boarders with a variety of mental conditions, states and behaviours. Medical superintendents’ interpretations of statutory criteria for continued detention, that was legally required every year after 1911, intangibly included the so-called “institutionalized” patient. A long-stay psychiatric patient’s adjustment or resignation to institutional life and routines can produce unusual or bizarre behavioural traits and mannerisms that would have been socially intolerable. Mental infirmity (senility) of some such patients must have masked the original form of insanity. Other but largely undocumented considerations may also have subtly influenced the review.

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234 Russell Barton, *Institutional Neurosis*, Bristol, 1959. The behaviour described as institutional neurosis resembles behaviours in cases of advanced schizophrenia and for this reason Barton’s ideas were soon discarded.

235 AJHR, 1904, H-7, p. 4.
process, including the utility value of 'free labour' by patients around the hospitals, and an exaggerated perception of the risk of some patients to public safety.

By 1947, the official framing of mental disorder left the mental hospitals system with exclusive administrative jurisdiction over the most severe forms of mental disorder, and moderate and profound forms of mental handicap. Without upsetting medico-legal traditions, justice, penal and mental hospital authorities had a modus operandi for the management of the criminally insane, sex offenders and inebriates. The boundary of responsibility between the education system and mental hospitals in the management of congenital mental defect was settled painfully in the case of feeblemindedness. Boundaries between the services of hospital boards and mental hospitals were sometimes fragile, especially in the management of mental infirmity. Shared jurisdiction in the nebulous and euphemistic field of minor mental disorders was demonstrated after 1921.

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236 Medical Superintendent's report, Christchurch, AJHR, 1899, H-7, p. 6.
238 AJHR, 1905, H-7, p. 2.
EXPANDING INSTITUTIONS LIKE INDIA-RUBBER BALLOONS

Policy-makers identified the residential asylum or mental hospital as the primary therapeutic environment for the care and treatment of mental disorders. These facilities were institutions in Jones and Fowles' meaning of the word, that is, long-term provision of residential care on a highly organized basis with the expressed aims of care, treatment or custody. This chapter will explain why institutions were the central feature of a system of mental care, how they grew, and how they followed trends in architectural design, décor and furnishings.

THE THERAPEUTIC PURPOSE OF THE INSTITUTION

The Department regarded the specialized lunatic asylum or mental hospital as therapeutically indispensable throughout the years 1876-1947. New Zealand's first Inspector-General of Asylums, F.W.A. Skae, said in 1880 that:

however simple may be the treatment of ordinary insanity, it implies such formidable expense that it cannot generally be secured, except by comparatively rich people, anywhere but in a special institution such as an asylum.

Even before Skae emigrated, he thought that institutional care was appropriate for the long-term management of chronic mental patients because it would:

2 Appendices to the Journals of the House of Representatives (AJHR), 1880, H-6, p. 2.
provide suitably for their wants, engage them in useful occupations, and render them as happy and comfortable as their condition will admit of.  

Skae offered advice on the alternative, of boarding out chronic patients, in 1881 when there was still some public interest in the idea. Skae had made good use of boarding out in Scotland, but he did not recommend its adoption in New Zealand. The asylum had a social role, he claimed, if there was nowhere else to send some classes of patient. The absence of friends to take charge of such persons, and the lack of government incentives, were other reasons why Skae advocated a policy of institutional care.

Skae’s views were shared by his successors so boarding out was never adopted as a general policy. G.W. Grabham, Inspector-General (1882-6), saw little likelihood of success with the idea. D. MacGregor, Inspector-General (1886-1906), inquired about practice in Victoria but there, as in New Zealand, he found that there was ‘an unreasonable aversion to have anything to do with persons of unsound mind’. New Zealand also lacked ‘the class with whom the insane are boarded in Scotland, at any rate in sufficient numbers sufficient to establish a system,’ MacGregor said dismissively. Superintendents commented that patients could not be immediately discharged if they had no home to return to or people to care for them. Gray liked the systems he saw in Norway, Scotland and Belgium in 1926-7, but even there, he observed, boarding out was in decline. Gray did not urge its introduction, partly because he thought New Zealand farmers were reluctant to accept patients as

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3 [F.W.A. Skae], First Annual Report of the Medical Superintendent of the Stirling District Asylum, February 1869 - February 1870, [Stirling?], p. 22, kindly provided by the Secretary, Bellsdyke Hospital, Royal Scottish National Hospital, Larbert, Stirlingshire.

4 E.g., W. Hutchison in letter to Evening Chronicle, Wellington, 18 January 1879, citing Maudsley; editorials, New Zealand Times, Wellington, 25 November and 2 December 1880.

5 Appendix of the Seventeenth Report of the General Board of Commissioners in Lunacy for Scotland, 1875, p. 216, kindly provided by the Secretary, Bellsdyke Hospital, Royal Scottish National Hospital, Larbert, Stirlingshire.

6 AJHR, 1881, H-13, p. 2. Boarding out children was not so fraught. In 1899, 16 physically and mentally disabled children were boarded out. F.K. de Castro to Inspector-General of Schools, 16 October 1899, Child Welfare Division Archives, National Archives, Wellington, File CW 40/25/21.

7 AJHR, 1885, H-10, p. 2.

8 AJHR, 1892, H-4, p. 2.

9 AJHR, 1905, H-7, p. 2. Truby King took notes on several boarded out patients whom he visited in Scotland but his notebook gives no hint of King’s views. See Notebook on Mental Defectives, n.d. [1894?], Plunket Society Archives, Hocken Library, 89-098-26.

10 E.g., Medical Superintendent’s report, Sunnyside, AJHR, 1882, H-9, p. 12; Medical Superintendent’s report, Wellington, AJHR, 1905, H-7, p. 15.
workers. The lack of a general invalidity benefit was another impediment before 1939.

The absence of a general policy on boarding out, however, did not preclude institutional administrators from trying to place suitable patients. In 1888, for instance, T. Radford King, Seacliff's Medical Superintendent (1887-9), tried to interest a local Presbyterian minister in looking after tractable males as 'patient boarders'. The asylum would pay 8s. per week per person and it would provide their clothing. In 1930, Gray noted with satisfaction that medical superintendents were making more frequent use of probationary leave to place patients with relatives and guardians. Incurable patients could thereby enjoy a 'holiday' when they were relatively well. Probation was generally 'a precursor to discharge' for recent and recoverable cases. Gray also thought that with institutional training, feebleminded adults could be paroled to work for local farmers.

Without a system of grant-aided boarding out, institutions were the main vehicle for care and treatment throughout the period. Mercier's comprehensive treatise on the management and organization of lunatic asylums (1894) was a good guide to the therapeutic value of such institutions. According to Mercier, the ideal lunatic asylum was a healthy, bright, cheerful and comfortable residence for its inmates. It provided for complete and continuous supervision, facilitated treatment, and allowed patients to be classified or separated into small groups. The ideal asylum was designed to minimize opportunities for self-harm or violence. These objects were to be attained

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11 Inspector-General to J. Hooper, 22 November 1927, HMH 4/4/1; Director-General to Minister, 17 October 1929, HMH 8/8041. This file contains Part II of his report on an overseas study tour that, unlike Part I, was never published.
12 Commissioner of Pensions to Director-General, 13 May 1930, HMH 3/7/1; AJHR, 1930, H-7, p. 2.
13 Rev. J. Christie diary, 16 November 1888, Otago Settlers Museum Archives, Dunedin, AG 102-1-3. I am grateful to Ali Clarke for pointing out this reference to me. Christie was not convinced about the merits or the economics of the proposal. He thought that 8s. barely met the cost of food let alone board and lodging, unless the patient was a very good worker and could make his board "profitable". Christie noted that persons of a similar stamp had been boarded in the locality at a weekly rate between 15s. and £1.
15 Précis of Reports from Institutions Caring for Young Mental Defectives, 18 June 1929, Mental Hospitals Department File, MH 25/15, formerly held in Health Department records storage but current whereabouts unknown.
with strict regard for economy of capital and operating expenditure. Institutional care was efficient because it concentrated patients to make best use of specialized staff who were invariably in short supply. The Department ordered a copy of this book from England. The direct impact of the text on official thinking is not clear from the surviving records, but general policy was certainly consistent with Mercier's ideas.

The classic asylum function of the institution freed patients 'from all ordinary cares and responsibilities' and ensured that they were 'well-fed and well looked after and given suitable occupation and recreation', as Sir Truby King, Inspector-General (1924-27), remarked in 1925. The institution was also deemed to be therapeutic for persons whose chronic forms of mental disorder were unlikely to benefit from short-term respite. Writing at the outset of his inspectorate in 1907, F. Hay, considered that:

in the absence of organic disease, when the constitution has adjusted itself to its disabilities, the mental manifestations becoming quiescent, undoubtedly life is prolonged by the regular habits, wholesome food, and prompt attention to minor disorders which form the routine of an institution.

This might involve long, even life-long, refuge for chronic patients or 'mental cripples', as they were later called.

During Hay's administration (1907-1924), the Department regarded residential care as vital for other classes of mental defect, especially congenital or acquired mental defect (mental retardation). The number of patients with those conditions, which largely corresponded to the legal classes III-V under the Mental Defectives Act 1911, nearly quadrupled between 1920-45. These classes increased rapidly from 12.7 per cent to 27.4 per cent of the resident patient population, as shown in Table 6.
### TABLE 6
CLASSIFICATION OF MENTAL HOSPITAL PATIENTS, 1920-45

<table>
<thead>
<tr>
<th>Year</th>
<th>Unsound Mind</th>
<th>Mentally Infirm</th>
<th>Idiots</th>
<th>Idiots</th>
<th>Inbectics</th>
<th>Feeble-minded</th>
<th>Epileptics</th>
<th>Social Defectives</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>1920</td>
<td>3222</td>
<td>485</td>
<td>72</td>
<td>371</td>
<td>146</td>
<td>350</td>
<td></td>
<td></td>
<td>4646</td>
</tr>
<tr>
<td>1925</td>
<td>3348</td>
<td>628</td>
<td>58</td>
<td>550</td>
<td>189</td>
<td>422</td>
<td></td>
<td></td>
<td>5095</td>
</tr>
<tr>
<td>1930</td>
<td>3712</td>
<td>636</td>
<td>122</td>
<td>740</td>
<td>333</td>
<td>570</td>
<td></td>
<td>24</td>
<td>5141</td>
</tr>
<tr>
<td>1935</td>
<td>4313</td>
<td>664</td>
<td>128</td>
<td>876</td>
<td>588</td>
<td>811</td>
<td></td>
<td>61</td>
<td>7241</td>
</tr>
<tr>
<td>1940</td>
<td>4946</td>
<td>696</td>
<td>130</td>
<td>1107</td>
<td>691</td>
<td>450</td>
<td></td>
<td>28</td>
<td>8002</td>
</tr>
</tbody>
</table>

### Percent

<table>
<thead>
<tr>
<th>Year</th>
<th>Unsound Mind</th>
<th>Mentally Infirm</th>
<th>Idiots</th>
<th>Idiots</th>
<th>Inbectics</th>
<th>Feeble-minded</th>
<th>Epileptics</th>
<th>Social Defectives</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>1920</td>
<td>69.4</td>
<td>10.4</td>
<td>1.6</td>
<td>8.0</td>
<td>3.1</td>
<td>7.5</td>
<td></td>
<td></td>
<td>100.0</td>
</tr>
<tr>
<td>1925</td>
<td>63.8</td>
<td>12.3</td>
<td>1.1</td>
<td>10.8</td>
<td>3.7</td>
<td>8.3</td>
<td></td>
<td></td>
<td>100.0</td>
</tr>
<tr>
<td>1930</td>
<td>60.5</td>
<td>10.3</td>
<td>2.0</td>
<td>12.1</td>
<td>5.4</td>
<td>9.3</td>
<td></td>
<td>0.4</td>
<td>100.0</td>
</tr>
<tr>
<td>1935</td>
<td>59.6</td>
<td>9.2</td>
<td>1.8</td>
<td>12.1</td>
<td>8.1</td>
<td>8.4</td>
<td></td>
<td>0.8</td>
<td>100.0</td>
</tr>
<tr>
<td>1940</td>
<td>61.7</td>
<td>8.2</td>
<td>1.6</td>
<td>13.8</td>
<td>8.7</td>
<td>5.6</td>
<td></td>
<td>0.4</td>
<td>100.0</td>
</tr>
<tr>
<td>1945</td>
<td>60.3</td>
<td>7.2</td>
<td>1.6</td>
<td>15.5</td>
<td>10.2</td>
<td>4.9</td>
<td></td>
<td>0.2</td>
<td>100.0</td>
</tr>
</tbody>
</table>

The rate of increase in classes III-V far exceeded that of class I in each quinquennium.

Officials believed that institutional care should aim for 'good citizenship' by these patients in an institutional community, to quote T.G. Gray, Director-General (1927-47). Training for this life-long destiny had to begin in youth, as Hay argued in 1922-3:

The answer which common-sense dictates is to place them [mentally deficient children] in an environment where with their little comprehension they will not feel their disability; where they will be as happy as possible; where they will be trained for, and engage in, simple employments according to their capacity; where, as children, they will not, by association, prejudice the outlook of their normal brothers and sisters; and where, as adults, they will not have the opportunity to come in conflict with the law or to reproduce their kind. ... To the environment above indicated, much less complicated than that beyond their colony, they can in a measure adjust themselves; and for the vast majority, in its interest and the public's, this should be the permanent home.

Sir Truby King shared this goal of training. J. Russell, Acting Director-General in 1947, espoused more generally a similar goal for chronic patients: the Department should provide the 'best institutional care possible' for patients not expected to recover.

With the exception of one “licensed institution” (the legal term for a private mental hospital), institution meant a public mental hospital. This private institution, Ashburn Hall, near Dunedin, was set up in 1882, 14 years after lunacy law first authorized the establishment of licensed institutions. The reasons behind this move are complex, but Ashburn Hall sought a market among people able to pay more for greater

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21 Director-General to Director of Education, 18 June 1929, Child Welfare Division Archives, National Archives, Wellington, File CW 40/5/5, used with permission of the Department of Social Welfare.


24 Acting Director-General, Circular, 15 August 1947, Health Department, Mental Health Division Archives, National Archives, Wellington, File HMH 4/4/1.
personal care and attention and the comforts of a private country house. Ashburn Hall was (and remains) New Zealand's only licensed institution.

By 1895, however, MacGregor opposed the opening of more licensed institutions. There are four possible reasons why. The first was the English precedent of 1830 that forbade new licences or any expansion of existing ones. A second explanation was the swing towards state-run social programmes during the Liberal era (1891-1911). MacGregor discouraged one proposal for a private inebriates asylum in 1896 because the state intended making such provision itself. Thirdly, a formal inquiry in 1896 into the suicide of a patient at Ashburn Hall showed lax standards of supervision by the aging lay superintendent. Although the subsequent formal inquiry suggested that overcrowded state asylums ensured a niche for a state-licensed institution, the report criticized Ashburn Hall for being so far from town.

The medical profession advanced a fourth possible explanation in 1903 – that the government had no right to depute the civil liberties of committed patients to a third party. The policy of not granting further licences then became hallowed by time. Even applications from experienced former departmental staff were invariably

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25 E.W. Alexander, evidence to Inquiry into Charges against the Management of Ashburn Hall, 1 April 1896, Legislative Department Archives, National Archives, Wellington, LE 1/1896/102, p. 211. In her thesis, J.C. Medlicott suggests that Ashburn Hall was set up to offer alternative and superior facilities to those available in state asylums and to relieve pressure on accommodation there. The government of the day wanted to appoint a medical superintendent at Dunedin Lunatic Asylum, and that meant ousting J. Hume, the long serving lay superintendent. Granting a licence for Ashburn Hall could also have helped solve a potentially difficult management problem. J.C. Medlicott, 'The History of Ashburn Hall 1882-1947', MA Thesis, University of Otago, 1972, pp. 15-21.
26 Ashburn Hall changed its name to Ashburn Clinic in 2000. Statutory provision for licensed institutions was discontinued under the Mental Health (Compulsory Assessment and Treatment) Act 1992, s. 138. That section contained special provisions to facilitate the transition of Ashburn Hall to regulation as a private hospital.
27 Inspector-General to Mrs K.F. Reading, 3 May 1895, Inspector-General's Letter Book 6, pp. 91, 325.
30 Hume, the Superintendent, was diffident about disclosing his age but eventually agreed with the inquiry that he was 70. J. Hume, evidence to Inquiry into Charges against the Management of Ashburn Hall Private Asylum, 31 March 1896, LE 1/1896/102, p. 157. See also Inspector-General’s report, Ashburn Hall, 14 March 1896, AJHR, 1896, H-7, p. 10.
31 Report of the Inquiry into Charges against the Management of Ashburn Hall Private Asylum, 25 June 1896, LE 1/1896/102, pp. 2-3. The reasoning was debatable. Ashburn Hall, at Halfway Bush, on the outskirts of Dunedin, was 2.75 miles from the city centre whereas Seacliff Asylum was an hour's train ride away. Ashburn Hall did not have a telephone connection.
32 New Zealand Medical Journal, 2 (1903), pp. 54-56, 206.
declined because that was long-standing government policy.\textsuperscript{33} In 1945, the Labour Government restated its commitment to publicly provided and funded services\textsuperscript{34} following problems with a private hostel suspected of treating mental defectives from the ‘best’ residential areas of Auckland.\textsuperscript{35}

Non-institutional settings for private care and treatment were permitted, but they were strictly regulated\textsuperscript{36} and very limited. Private houses could rarely provide the necessary care and treatment.\textsuperscript{37} If mental hospital authorities were alerted that a home was operating in possible breach of licensing requirements, the premises were formally inspected. Prosecution sometimes followed.\textsuperscript{38} Small profit-making nursing homes or hospitals met a need for discreet private care and psychiatric treatment of persons who were not committed. Sunnyside and Seacliff Asylum records contain tantalising glimpses of the way well to do families used private hospitals to care for insane relatives in 1901-2. In his medical superintendent’s report on Christchurch Asylum for 1901, E.G. Levinge complained of this ‘obnoxious habit’ which he thought could only be broken by allowing voluntary admission or by subjecting private hospitals to government inspection.\textsuperscript{39} Levinge and Truby King, Medical Superintendent, Seacliff (1889-1921), also noted that private hospitals looked after the insane members of wealthy families until the prospect of recovery was hopeless, then they were committed.\textsuperscript{40} Private hospitals were first licensed in 1903 - long after licensed institutions (1868) - probably because of concerns about standards of maternity or surgical care,\textsuperscript{41} in a move that parallels the state registration of nurses

\textsuperscript{33} Lyttelton Times, 28 June 1909. Cf. Inspector-General to Dr A.G. Harvey, 14 April 1910, HMH 1910/304.
\textsuperscript{34} Minister to Minister of Internal Affairs, 28 March 1945, HMH 4/6.
\textsuperscript{35} E.K. Hughes [Psychologist, Auckland Child Guidance Clinic] to Acting Director-General, 18 March 1942, Minister to Minister of Internal Affairs, 4 May 1944, Medical Superintendent, Auckland to Director-General, 6 November 1944, HMH 4/6. Gray was sceptical about the foreign qualifications and background of a medical practitioner associated with the hostel. Director-General to Under-Secretary for Justice, 24 April 1946, HMH 4/6.
\textsuperscript{36} Lunatics Act 1868, ss. 48-51; Lunatics Act 1882, ss. 113-22; Mental Defectives Act 1911, ss. 19-23.
\textsuperscript{37} Medical Superintendent’s reports, Seacliff and Sunnyside, AJHR, 1900, H-7, pp. 6, 8.
\textsuperscript{38} Lunatics Act 1868, s. 38; Lunatics Act 1882, ss. 91-2; Mental Defectives Act 1911, ss. 70(3), 122-3; AJHR, 1907, H-7, pp. 16-17, 1915, H-7, p. 4, and 1935, H-7, p. 3.
\textsuperscript{39} Medical Superintendent’s report, Sunnyside, AJHR, 1902, H-7, p. 7.
\textsuperscript{40} Medical Superintendent, Seacliff to Minister, 28 May 1902, Seacliff Hospital Outwards Letterbook, Healthcare Otago Ltd Archives, National Archives, Dunedin, DAHI D 264/24; Medical Superintendent’s report, Sunnyside, AJHR, 1902, H-7, pp. 6-7.
\textsuperscript{41} The Private Hospitals Act 1903 provided for state regulation of private hospitals through licensing and inspection. From the extant records, it seems as if most private hospitals were maternity
(1901) and midwives (1904). Some private hospitals continued to care for uncertified mentally defective relatives.\textsuperscript{42}

Private arrangements were also made very occasionally for well-known individuals who became mentally infirm. For example, in 1932 or 1933, an application was received to commit Sir Truby King, whose mental powers were declining. The head office clerk who processed these papers recognized the sensitivity of this case, and referred the matter to the Director-General, who took personal charge. King was not committed but an order was made under the Aged and Infirm Persons Protection Act 1912. Until he died in 1937, a nurse seconded from Porirua Mental Hospital cared for King at his residence in Wellington.\textsuperscript{43} A similar arrangement was proposed for an 85 year old Member of the Legislative Council when he became senile. He was cared for at Lewisham Private Hospital, Christchurch, but he became unmanageable. The family was prepared to have him admitted to Clifton House at Seaciff. Gray, however, thought that he could possibly be nursed at home as that arrangement had worked so well for Sir Truby King.\textsuperscript{44}

\textbf{INSTITUTIONS AS COMMUNITIES}

Officials liked small institutions that could engender a sense of community and homeliness. Skae first found these qualities at Hokitika Asylum, and he praised the place as 'an exceptionally healthy community'.\textsuperscript{45} He found:

\begin{footnotesize}
\textsuperscript{42} In a divorce case in 1921, the husband opposed his wife's committal, even though the doctors involved would have certified her. The woman was first kept at home, and then sent to a Christchurch nursing home. When her condition deteriorated she was committed. Director-General to Secretary for Justice, 18 March 1935, Department of Health Archives, National Archives, Wellington, File H 30/28/21 (34252).

\textsuperscript{43} Personal communications to author, the late M.S. Moss, 16 May 1971 and Maureen Hickey; Director-General to Minister, 19 April 1937, HMH 7/5i4.

\textsuperscript{44} Director-General to Medical Superintendent, Sunnyside, 26 July 1937, MH 8/1460.

\textsuperscript{45} Inspector-General's report, Hokitika, 18-20 December 1876, AJHR, 1877, H-8, p. 18.
\end{footnotesize}
There is something quite exceptional and exceedingly pleasing in the peaceful quietness and cheerful activity which characterize this little community, and make one doubt for a moment if they can really be insane. Much of this may be due to the fact that the community is a small one, and that the patients have the appearance of being drawn from a better class, both as regards mental and physical qualities, than those of any other Asylum in the colony. But the chief cause undoubtedly lies in the manner in which they are kept continually occupied in healthful and varied employments, in which they appear to take as much interest as though they were working for themselves.⁴⁶

Years later, MacGregor also admired those features at Hokitika.⁴⁷ He sought them elsewhere, and found them at Mount View and Waitati. Despite its patchwork nature, Mount View Asylum always seemed to have a look of 'homely comfort'.⁴⁸ The Retreat at Waitati was 'particularly homely, and unsuggestive of an "institution".⁴⁹ The cultivation of institutional or ward communities showed a quest for esprit or, in the words of a later Director, that 'intangible but critically important "atmosphere" of the hospital [which] is its most valuable therapeutic agent.'⁵⁰

Characteristically, the hall was an impressive feature and central gathering point in Victorian era asylums. Concerts, entertainments, dances, movie screenings and religious worship were all held there. The asylum hall served a wider social role in some remote settlements, among which hospital balls ranked as highlights.⁵¹ Talented staff came to the fore with amateur musical and theatrical events.⁵² New institutions were not so fortunate and halls were a low priority. Meantime, the dayrooms of villas were used for organized recreation and worship. Other recreational amenities helped reinforce the notion of hospitals as community.⁵³ Some hospitals had their own small libraries, whose services were augmented when

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⁴⁶ AJHR, 1878, H-10, p. 4.
⁵⁰ R.G.T. Lewis, AJHR, 1958, H-31, p. 43. The words are very similar to World Health Organization, Expert Committee on Mental Health: Third Report, Technical Report Series No. 73, Geneva, 1953, p. 17, from whence they were probably drawn.
⁵² E.g., Williams, p. 195; Tod, pp. 62-63.
The hall was the venue of most important mental hospital gatherings, for entertainment, worship, and sometimes, dining. The hall at Sunnyside Asylum was typical of Victorian era asylums. (Author’s collection, Shirley Brunton photograph.)
Porirua Asylum dining hall, c. 1900. The hall is decorated for some festive occasion, possibly Christmas dinner. (Wendy Hunter Williams, 'Out of Mind Out of Sight: The Story of Porirua Hospital', Porirua, 1987, p. 75.)
The weekly movie screening, Auckland Mental Hospital, c. 1960. Female patients are seated in the front rows and men at the back. Movies became a regular form of entertainment in most mental hospitals in the 1920s. (Author’s collection.)
The Auckland Asylum patients' picnic at Ellerslie Race Course, 1892, photographed for lantern slides by the Medical Superintendent, Dr G. Hassell. This was the first time in several years that the picnic was held outside the asylum grounds. (Author's collection.)
Sports day was an annual event eagerly anticipated by patients. These photographs of contestants in the high jump, sack race and tug-of-war were taken at the Seaview Hospital sports day, held at the Hokitika Race Course, in 1947. (Seaview Hospital collection.)
A highly successful sports team, Chatham Cup winner and First Division champion, Portirua Mental Hospital Football Club, proudly show their trophies in 1935. The Director-General, Dr T.G. Gray, as Patron of the Club, holds the shield. The Medical Superintendent, Dr H.M. Buchanan, as Club President, is seated third from the left in the front row. (Wendy Hunter Williams, 'Out of Mind, Out of Sight: The Story of Portirua Hospital', Portirua, 1987, p. 143.)
the Country Library Service had included mental hospitals in its circuits by 1947.⁵⁴

Every institution had a canteen by 1947.⁵⁵

The patients' sports day, like Christmas festivities and the annual picnic, was an important event in the institutional community's calendar.⁵⁶ Sports fields, like recreation halls, helped strengthen institutional communities. In 1906, for example, a bowling green and croquet lawn were laid in a corner of the Sunnyside cricket field. These amenities provided neutral territory where 'occasional tea-parties' could be held for male patients who played bowls and female patients who played croquet. These grounds helped to 'soften the institutional feeling' in a 'community of misfortune'.⁵⁷ Sports or playing fields were intrinsic to villa style mental hospitals. Staff made their own fun. Sunnyside and Porirua fielded their own cricket teams.⁵⁸ Hospital bowls, tennis and ladies' hockey clubs were formed at Porirua.⁵⁹ Sport was always an important part in the life of Kingseat Hospital.⁶⁰ Seacliff and Porirua Mental Hospitals achieved national renown when their soccer teams won the Chatham Cup in 1923 and 1935 respectively.⁶¹

ACCOMMODATION PROBLEMS

The institutional development of psychiatry in New Zealand owes much to Skae's advice to the post-provincial governments on how to handle the major

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⁵⁴ Evening Post, Wellington, 15 November 1947; AJHR, 1948, H-32A, p. 8; Williams, p. 105; Janet Frame, Faces in the Water, Christchurch, 1961, pp. 205-9; Medical Superintendent's report, Nelson, AJHR, 1947, H-7, p. 10; Medical Superintendent's report, Seaview, AJHR, 1948, H-7, p. 13.⁵⁵ AJHR, 1948, H-7, p. 3.⁵⁶ E.g., Frank Tod, 'Outside Looking In' in Anon., The End of an Era, Dunedin, 1972, p. 16; Warwick Brunton, Sitivation 125: A History of Seaview Hospital, Hokitika, and West Coast Mental Health Services, 1872-1997, Hokitika, 1997, pp. 43, 57; Frame, pp. 169-73.⁵⁷ [Deputy?] Inspector-General's report, Sunnyside, 31 July 1906, AJHR, 1907, H-7, p. 20. The suggestion may have come from the Stipendiary Magistrate who guaranteed that local bowling clubs would donate the bowls if the Medical Superintendent developed a green. Medical Superintendent's report, Sunnyside, AJHR, 1907, H-7, p. 34.⁵⁸ Medical Superintendent's report, Sunnyside, AJHR, 1906, H-7, p. 9. The Porirua Hospital Cricket Club was formed in 1913. Williams, p. 144.⁵⁹ Williams, pp. 147-51.⁶⁰ B.J. Ryan, 'Sport at Kingseat' in Anon., Kingseat Hospital 50 Years 1932-1982, Papakura, 1982, p. 10.⁶¹ Tod, p. 64; Williams, p. 142. Seacliff won the first contest for the Cup in 1923. The Porirua Hospital Association Football Club won the Cup in 1935. The trophy is named after H.M.S. Chatham, which donated the Cup as the premier soccer award in New Zealand in appreciation of hospitality received during the ship's courtesy visit to this country in 1922.
accommodation crisis inherited from the provinces. Skae’s first report, for 1876, pointed out that the 783 patients resident in the country’s asylums exceeded the available accommodation by 513. The Whau, Auckland, was only half finished. Asylums at Dunedin and Christchurch had grown like Topsy to meet the needs of fast growing populations. Skae’s first report, for 1876, pointed out that the 783 patients resident in the country’s asylums exceeded the available accommodation by 513. The Whau, Auckland, was only half finished. Asylums at Dunedin and Christchurch had grown like Topsy to meet the needs of fast growing populations.62 Sunnyside Asylum was so overcrowded that caged birds died in the stuffy atmosphere.63 Of sheer necessity, beds were even made up in lavatories in 1879, after every male dayroom had been turned into a dormitory. Excited, discontented, and violent patients were ‘strewn about in all directions as thick as they can lie, on the floors, on the tops of tables, and underneath the tables’.64 There could not be ‘any special excellence in these overcrowded institutions’, Skae claimed.65

Skae was left with no option but to meet the accommodation shortfall and to anticipate the need to make space for an annual accumulation of chronic cases. Expanding institutions like india-rubber balloons, as a Dunedin newspaper called it, seemed the most feasible solution. Skae proposed that the provincial asylum network be consolidated and rationalized at the Whau, Mount View (Wellington), Nelson, Sunnyside (Christchurch), Hokitika, and Dunedin.66 Most of these asylums were deemed to have sufficient land or adjacent property for farming and outdoor work and to protect patients from the eyes of curious passers-by.67

Skae and all of his successors were constantly challenged by the general lack of a capital programme that took account of increased population and the accumulation of chronic patients.68 Hay could have spoken for any departmental head between 1876-1947:

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62 AJHR, 1877, H-8, p. 4. At the Whau, 163 inmates were crammed into space intended for 50 beds. Mount View had 32 patients more than the 40 it was built for. Sunnyside had room for only 80 beds, but it housed 191 patients. Hokitika had 57 patients but had space only for 40.
63 Sunnyside Hospital Inspection Book, 7 July 1876, p. 106, Sunnyside Hospital Archives, National Archives, Christchurch, CH 383/39.
64 AJHR, 1879, H-4, pp. 3, 7.
65 AJHR, 1878, H-10, p. 2.
66 Southern Mercury, 14 April 1877.
67 New Plymouth and Napier Asylums were destined for closure in 1879 and 1886 respectively.
68 AJHR, 1877, H-8, pp. 2-3, 1879, H-4, p. 4, and 1880, H-6, p. 11.
69 AJHR, 1914, H-7, pp. 6-7; Division of Mental Hygiene, History of the Mental Hygiene Division, Wellington, 1948, p. 3.
... Building must never cease. Each year will provide its increments to the [institutional] population, and, experience having shown how irregular these increments are, something will need to be done in advance of estimates.\footnote{70}

Failure to implement a long-term building plan put more or less unrelenting pressure on the available accommodation. Overcrowding varied in intensity by region and fluctuated over time, but the lack of bed-space clouded all other considerations.\footnote{71} Pressure was probably greatest during Skae’s inspectorate and in the years following 1942. The wartime situation was exacerbated by the effects of deferred capital works and the necessity to evacuate part or all of the main buildings at Porirua\footnote{72} and Seacliff Mental Hospitals.\footnote{73} Numerical details of overcrowding were probably an understatement.\footnote{74} Sir Truby King thought that the overcrowding was double or treble the official figures, and something like 10 per cent over the accommodation available.\footnote{75} Looking back upon his 37 years in the Department in 1925, King recalled that upon entering the service, all asylums were characterized by serious overcrowding. Despite superintendents’ urgent pleas, these primary shortcomings had never been rectified. King mentioned that overcrowding was usually worst in the poorly designed Victorian-era facilities that served the main population centres.\footnote{76}

Overcrowding struck hard at the therapeutic aims of institutional community building and classification. At worst, overcrowding reduced effort to the ‘bed rock’\footnote{77} of simply trying to find sufficient sleeping and feeding space for everyone, with minimum classification. In 1898, MacGregor reported in exasperation that:

\begin{itemize}
\item AJHR, 1912, H-7, p. 14.
\item AJHR, 1920, H-7, p. 2.
\item This followed major structural damage during the earthquakes of July-August 1942. See Williams, pp. 184-93.
\item AJHR, 1876, H-4, pp. 10, 12, and 1877, H-8, p.4.
\item Inspector-General to Minister, 7 August 1926, HMH 8/954.
\item Inspector-General to Minister, 29 July 1925, HMH 8/897.
\item Inspector-General to Minister, 2 March 1914, HMH 1913/372.
\end{itemize}
By far the hardest and most unpleasant part of my duty is to induce the Government to give the means to meet the spasmodic demands of the people for rational treatment of those terrible nervous diseases that afflict so many of our fellow-creatures. As things are now in New Zealand, the lack of accommodation makes it impossible for me in nearly all of our asylums even to pretend to a rational classification, which is the indispensable condition to the scientific treatment of mental disease.  

His successors were equally frustrated. In 1913, Hay pleaded that

Nothing is wanted in the way of extravagance, but we do want sufficient floor-space per individual, and sufficient sunlight and fresh air - given these, comfort can be added at a negligible cost. ... We should aim at being a year ahead of requirements, or at the very least six months, plus a margin for classification.  

'We want more than bare accommodation', he wrote seven years later. Gray used the same expression in 1936, when he complained that the need to deal with arrears of accommodation prevented the Department from providing modern and very necessary kitchens, stores, recreation halls and other offices. Faced by the post-World War II public works priorities and shortages of building materials, J. Russell, the acting Director-General (1947), said that 'bed-space will be quite enough for me to overcome in my time, and I will see to that before I ever recommend expenditure on a Church or Recreational Hall, etc. 

When available space in dormitories and single rooms was full, the standard procedure was to use day rooms, corridors, or attics. At the Auckland Mental Hospital, in 1945, the dayroom of one female ward was converted into a dormitory. The patients spent all day in the dining room, the tables being cleared only after meals. At Porirua, beds were stacked during the day to make room for chairs and

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78 AJHR, 1898, H-7, p. 3.
80 AJHR, 1920, H-7, p.2.
81 Director-General to Minister, 17 January 1936, HMH 26/8.
82 Acting Director-General to Medical Superintendent, Seacliff, 22 October 1947, HMH 26/61.
83 E.g., Medical Superintendent, Sunnyside to Inspector-General, 22 November 1915 and 3 May 1918, HMH 8/112; Porirua Official Visitor's report, 5 June 1929, HMH 7/5/5.
tables. The procedure was reversed at night. 'Shake-downs' (or palliasses) were made up on the floors and sandwiched between rows of beds in the dormitories. Gray claimed that he never saw shakedowns till he arrived in New Zealand. They were still in use here in 1930.

The effects of overcrowding were all too obvious to the asylum officials who reported them. In 1903, Truby King refused to be held responsible for casualties, deaths or disease that arose from overcrowded conditions at Seacliff. He maintained that his representations had been persistently ignored, and that the responsibility rested with those whose direct duty it was to see that fitting accommodation was provided and who had the power and means to make such provision.

Overcrowding baffled attempts at proper management, prevented the proper segregation of violent or agitated patients, led to the risk of serious accidents or even murder, and to 'abominable vices', to quote Skae. Overcrowding magnified the risk of infectious disease. The 'attendant evils of enforced idleness and loss of individual treatment' jeopardized patients' mental well-being. Overcrowding diverted staff from treatment to the more immediate alleviation of discomfort and danger. Only 'untiring vigilance and most rigid discipline' could avert public scandal. Ward congestion reduced 'moral suasion' and more mechanical restraint was used. Overcrowding also heightened the risk of fire which swept through the Whau main building (1877), Sunnyside female wing (1888), and the Auckland

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84 Acting Director-General to Minister, 5 September 1945, H 30/3 (33030).
85 Medical Superintendent, Sunnyside to Inspector-General, 22 November 1915 and 6 May 1918, HMH 8/112; Porirua Official Visitor's report, 5 June 1929, HMH 7/5/5.
86 Director-General, Circular, 12 May 1930, HMH 4/4/1.
87 Medical Superintendent, Seacliff to Inspector-General, 14 February 1903, DAHI D264/25.
88 E.g., AJHR, 1882, H-9, p. 13, 1883, H-3, p. 5, and 1888, H-8, p. 6; Medical Superintendent to Inspector-General, 23 October 1897, DAHI D264/20; Medical Superintendent's report, Auckland, AJHR, 1903, H-7, p. 7; Acting Director-General to Minister, 5 September 1945, H 30/3 (33030).
89 Cf., the reference to the 'pernicious idleness' of male patients at Dunedin simply because there was nowhere to put them. AJHR, 1878, H-10, p. 9, and 1879, H-4, p. 7.
90 Sunnyside Asylum Inspector's Book, 19 November 1877, CH 388/39; AJHR, 1879, H-4, p. 3.
91 AJHR, 1888, H-8, p. 3.
Auxiliary Asylum (1894/5), fortunately with very few casualties. A fire in female Ward 5 at Seaciff on 8 December 1942 was, at that time, New Zealand’s worst such tragedy, with the loss of 39 lives.

Overcrowding forced compromises between the ideal and the practical. Policies on location, institutional size, expansion and design were all affected by the attempt to reclaim, a sense of institutional community, a rational and manageable system of classification, and the preservation of patients’ individuality. These policies will each be discussed in turn.

LOCATION

Plans to move Dunedin and Mount View Asylums from the ‘extreme publicity’ of city sprawl were the start of a policy to develop new institutions in rural areas. Skae disapproved of patients working outside the asylum grounds, as happened at Dunedin when the ‘temporary’ asylum outgrew its original site. In Wellington, the hilly land, rocky soil, and strong winds limited agricultural work so that too many patients were confined or restrained. By the early 1880s, the Evening Post urged the government to adopt Skae’s advice on a policy of ‘rural lunatic asylums’.

External pressures precipitated the relocation of these two asylums. The asylum reserve at Brin’s Point (Seaciff), in Otago, became accessible when the northern railway line reached Waikouaiti in 1878. A decision was made to start a branch asylum there that year and the Dunedin site was reserved for the Otago Boys’

93 Auckland New Zealand Herald, 21 September 1877; Star, Christchurch, 17 October and 15 November 1888; Medical Superintendent, Seaciff to Inspector-General, 13 July 1890, Plunket Society Archives, Hocken Library, 89-098-25; Inspector-General’s report, Auckland, 8 January 1895, AJHR, 1895, H-7, p. 3. On fire safety, see also Inspector-General’s report, Sunnyside, 30 August 1892 and 10 January 1893, and Inspector-General’s reports, Seaciff, 25 August 1892, AJHR, 1893, H-4, pp. 4-5. Government buildings were not insured against fire damage, a ‘penny-wise and pound foolish’ policy as the Christchurch District Inspector termed it. Editorial, Evening Herald, Dunedin, 18 October 1888.

94 AJHR, 1943, H-7A.

95 AJHR, 1878, H-10, p. 3.

96 E.g., AJHR, 1877, H-8, p. 13, and 1881, H-13, p. 9.

97 Editorial, Evening Post, 11 July 1882.

98 Tod, Seaciff, pp. 1, 18, 58-59. Land for an asylum and industrial school was reserved by the Otago Provincial Government, Otago Provincial Gazette, 22 September 1875, p. 460.

99 Morning Herald, Dunedin, 24 April 1878.
High School. Construction of the new school buildings between 1882-4 greatly inconvenienced the asylum. It continued to function on a shrinking scale as the place was slowly demolished. The town site was vacated in October 1884.\textsuperscript{100}

Skae must have concurred with the decision of a government deputation to build a new and permanent asylum at Upper Hutt to serve the southern North Island.\textsuperscript{101} Grabham, however, steered the authorities towards Porirua where a 'colony' of working male lunatics could be established as an outpost of the Mount View Asylum. The government already owned superior land there. Porirua land was very suitable for grazing, and it had abundant water, brick-earth, shingle and firewood. Rail and road access was possible to and from Taranaki and Hawke's Bay. The buildings could be well sited and protected from the main road.\textsuperscript{102} Grabham and MacGregor both believed that Porirua offered a better long-term prospect than Mount View,\textsuperscript{103} but political dithering\textsuperscript{104} and accommodation pressures elsewhere reprieved the Wellington Asylum until the Mount View site was chosen for a new Government House.\textsuperscript{105} Although the Minister hoped that some land might be retained for mental hospital purposes, the Government decided not to. Mount View closed in June 1910.\textsuperscript{106}

\textsuperscript{100} G.J. Griffiths and E.J. McCoy, \textit{Otago Boys' High and its Historic Neighbourhood}, Dunedin, 1983, pp. 36-37; Inspector-General's report, Dunedin, 30 January 1883, AJHR, 1883, H-3, p. 8; Medical Superintendent, Dunedin to Colonial Secretary, 20 January 1882, Medical Superintendent, Dunedin to Secretary, [Otago] Education Board, 18 April 1883, Medical Superintendent, Dunedin to Inspector-General, 25 June and 23 November 1883, Medical Superintendent, Dunedin to Colonial Secretary, [n.d.] 1883, Medical Superintendent, Dunedin to R.A. Lawson, 13 April 1883, DAH D 264/10.

\textsuperscript{101} \textit{Evening Chronicle}, Wellington, 25 May 1878.

\textsuperscript{102} AJHR, 1885, H-6, pp. 2-3. The search began in 1883 when Grabham said that Mount View was unsuitable for permanent occupation. AJHR, 1883, H-3, p. 14. Land was reserved at Porirua in 1884. Williams, p. 42.

\textsuperscript{103} AJHR, 1885, H-6, pp. 2-3, and 1900, H-7, p. 3.

\textsuperscript{104} J. Duthie (City of Wellington) and Minister, NZPD, 20 September 1905, 135, p. 25; J.G.W. Aitken (City of Wellington), NZPD, 26 October 1906, 138, p. 657; C.H. Izard (Wellington North), NZPD, 28 August 1907, 140, p. 512; W.H. Field (Otaki), NZPD, 5 September 1907, 140, p. 730; F.M.B. Fisher (Wellington Central) and Minister, 15 November 1907, 142, p. 948. This drew little debate, although Hall-Jones, Minister of Public Works (1896-1906) was not necessarily convinced. He kept open the options of either rebuilding the asylum in brick on the same Wellington site, or of moving it to the country. NZPD, 26 September 1900, 94, p. 187.

\textsuperscript{105} The Governor allowed his official residence to be used for Parliamentary purposes after a fire swept through Parliament Buildings on 11 December 1907. Government House was then adjacent to Parliament.

The first asylums were gradually crowded out by suburban expansion, as shown in this photograph of Dunedin Asylum taken about 1883. The asylum continued to function with increasing difficulty as the buildings were demolished to make way for Otago Boys' High School. (*Author's collection.*)
Until the 1920s, public opinion or prejudice influenced the policy of rural institutions. Institutional planning was attended by public outcry. The popular expression 'out of sight, out of mind' was used for asylums as early as the 1880s. Similarly, neighbours and newspapers lobbied to have lunatics removed from the Albert Barracks, in the middle of Auckland, where they were given shelter after the Whau Asylum fire of 1877. Skae reacted by wanting to bundle the lunatics off to Motuihi Island. Plans to use the Addington Immigration Barracks, Christchurch (1889), The Camp, near Dunedin (1906), the Wolfe Home, Auckland (1909), the Reef site at Western Springs, Auckland (1912), and Hornby Lodge, near Christchurch (1919), all encountered strong public opposition. Objections had to be settled before Tokanui (1912) and the second stage of development of Stoke Farm (Ngawhatu Hospital), near Nelson (1927) could proceed. Local hostility to the proposed conversion of The Camp, or Larnach's Castle on the Otago Peninsula, into a mental hospital in 1906 raised typical arguments. Women and children had to be protected from danger. Property values would likely depreciate. The area would be ruined for public recreation.

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107 E.g., editorials, *Auckland Evening Bell*, 18 February 1887, and *Auckland Star*, 11 November 1891.
108 *New Zealand Herald*, 24 and 28 September 1877.
110 Inspector-General to Medical Superintendent, Auckland, 8 October 1907, YCAA 1079/3g, File 4/14/6. The purchase of additional land was considered to forestall local objections to the development.
111 AJHR, 1912, H-7, p. 7.
112 Secretary, Canterbury Education Board to Inspector-General, 19 August 1919 and reply, 2 September 1919, HMH 19/1/1a.
113 AJHR, 1910, H-7, p. 7.
114 H. Atmore, M.P. to Minister, 31 December 1926 and 10 February 1927 (telegrams), Minister's minute, 14 February 1927, HMH 16/1/1a; *Nelson Evening Mail*, 1-2 March 1927, HMH 16/1/1a; Minister to T. Neale (telegram), 25 March 1927, and reply, 29 March 1927, Minister to Minister of Public Works, 4 February 1927, HMH 16/1/1a. Gray claimed that the takeover of Stoke Farm for a 'large mental hospital' in 1921 was not attended by public outcry. Medical Superintendent’s report, Nelson, AJHR, 1922, H-7, p. 9; Inspector-General to Minister, 17 February 1928, HMH 16/1/1a.
115 Town Clerk, Dunedin to Minister of Justice, 20 June 1907, HMH 21/1/11; *Evening Star*, Dunedin, 20 June 1907; editorial, *Otago Daily Times*, 20 June 1907; Clerk, Portobello Road Board to E.G. Allen, M.H.R., 1 July 1907, M. Sinclair to Hon. J.A. Millar, 22 July 1907; Secretary, Broad Bay School Committee to Minister, 2 July 1907, E.G. Allen, M.H.R., to Minister, 5 August and 28 October 1907 (containing protests from the St Kilda Borough Council, Otago Peninsula Agricultural and Pastoral Association, Portobello School Committee, a public meeting at North East Harbour, the Portobello Road Board, and Hooper's Inlet School Committee), HMH 21/1/11; Petition of 300 Portobello residents in Clerk, House of Representatives to Colonial Secretary, 20 November 1907, HMH 21/1/11; E.G. Allen (Chalmers), NZPD, 5 September 1907, 140, p. 729.
A mix of population growth, the spread of transport systems, public apprehension, and accommodation pressures in the older institutions, also helped determine where new institutions should be situated. Departmental dreams and schemes tried to make new institutions accessible to regions of population growth. Areas suggested for new institutions included Hawke's Bay, the Manawatu, South Canterbury and Southland. None of these materialized. Tokanui, near Te Awamutu in the Waikato, was the first new mental hospital built after provincial times (1912). It was planned as a safety valve for overcrowding elsewhere. Six thousand acres of potential farmland anticipated ample space for 'other institutions or colonies which might be placed under the control of this Department'. Tokanui was planned to service the central North Island. Land was bought at Lake Alice in 1937 for the mental hospital that bore that name. Lake Alice, near the rural service town of Bulls, was equidistant between the cities of Wanganui and Palmerston North. These new North Island institutions gradually defined regional catchments rather than provincial catchment areas, whereas South Island institutions preserved a provincial connection.

Between the wars, the Department planned to close Auckland, Sunnyside and Nelson Mental Hospitals and replace them with new institutions at Papakura, Templeton and Stoke respectively. These rural sites were all several miles away from the cities they were intended to serve, and the land was more spacious than the outgrown original sites. By the 1920s, suburban sprawl made the Auckland site of dubious future value. As Inspector-General, Sir Truby King looked to develop a new mental hospital within easy distance of the city so that the Auckland Mental

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AJHR, 1860, H-6, p. 5, and 1881, H-13, p. 3.
AJHR, 1899, H-7, p. 3.
Inspector-General's report, Sunnyside, 20 January 1900, AJHR, 1900, H-7, p. 9; Deputy Inspector-General's report, Seaford, 10 January 1903, DAHI D 264/6.
AJHR, 1908, H-7, p. 5.
Inspector-General to Minister, 31 March 1913, HMH 13/1/6; Medical Superintendent, Auckland to Inspector-General, 29 June 1926, YCAA 1079/5J, File 5/6/0. The North Island main trunk railway was completed in 1908. Taranaki was linked by rail in 1891. The East Coast line reached the Bay of Plenty in 1928 but the connection to Gisborne was never completed. The rail link between Gisborne and Wellington was opened in 1942, which made Porirua more accessible for East Coast patients than Tokanui.
Conversation between E.C. Blomfield and Medical Superintendent Auckland, August 1923 [?], HMH 7/1/3; Minister to Prime Minister, 30 July 1925, HMH 8/897; Minister, NZPD, 11 September 1925, 208, p. 263.
Hospital could close by 1935. Suitable land was purchased near Papakura, in South Auckland, in October 1926, upon which Kingseat Mental Hospital was to rise. Sunnyside, like Auckland, also became cramped in suburbia. Nearby roads passed so close that people could hear the female patients swearing. 'Larrikins sometimes stop to amuse themselves,' Hay reported in 1920. The replacement institution may have been intended for Templeton, where the Department acquired land for a dairy farm in 1918. From 1931, Gray urged that the very deteriorated buildings at Nelson should be closed in favour of an institution for mentally defective children in some roomier and 'sparsely populated district'. Gray thought that a country environment would allow plenty of room for exercise 'without offending the eyes of those who are not accustomed to going there'. Dreams of vacating all of these city sites were abandoned by the degree of institutional overcrowding that followed the deferral of public works during the great depression and Second World War.

Later plans for new hospitals were spared the furore of earlier ventures. Gray attributed this to growing public tolerance of mental hospitals. The site of Lake Alice was not controversial. Little or no fuss seems to have followed the decisions to commandeer the Chateau Tongariro and Wairakei tourist hotels to evacuate patients from Porirua, and two decommissioned military facilities in country areas, near

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123 AJHR, 1925, H-7, p. 8.
124 Cabinet decisions, 22 July and 20 October 1926, H 39/6 (41885).
125 Superintendent of Experimental Farms, Agriculture Department to Inspector-General, 12 November 1923, HMH 19/1/1.
126 Inspector-General to Minister, 21 February 1920, HMH 19/1/1.
127 Superintendent of Experimental Farms, Agriculture Department to Inspector-General, 12 November 1923, HMH 19/1/1.
128 AJHR, 1931, H-7; p. 4; Director-General to Director of Education, 12 February 1942, HMH 16/1/1; Director-General to Medical Superintendent, Nelson (confidential), 27 November 1944; H 30/24/15 (34425).
129 Director-General to Minister, 18 April 1935, HMH 16/1/1a.
130 Director-General reported in Auckland Star, 14 October 1935, HMH 26/39; AJHR, 1936, H-7, p.2. The original Auckland site continued to be used as a psychiatric hospital until 1992. The Sunnyside campus (now known as Hillmorton) still provides mental health services. The Nelson Mental Hospital site provides intellectual disability services at Braemar.
132 These facilities ran as adjuncts to Tokanui Mental Hospital and accommodated many of the 532 evacuated patients. Wairakei Hotel was used from September 1942 to March 1946, and The Chateau Tongariro, from October 1942 to December 1945. Mental Defectives Amendment Act 1950, Second Schedule.
Levin (Kimberley Farm Colony)\textsuperscript{133} and Drury (Raventhorpe Mental Hospital)\textsuperscript{134} When Gray’s plan to eventually relocate the Seaciff Mental Hospital several miles away, on farm land owned by the Department at Cherry Farm, near Waikouaiti, was announced in November 1943, the \textit{Otago Daily Times} challenged the decision on the grounds that further retreat from the city would exacerbate the shortage of staff.\textsuperscript{135}

By 1947, New Zealand was served by a mental hospital system that was predominantly rural. Institutions like Auckland, Sunnyside and Nelson were originally provincial lunatic asylums that stayed like rustic enclaves in suburbia. Plans to close them in favour of more rural settings never materialized. Second and third generation mental hospitals were located in isolated rural areas, where there was abundant land for agriculture and where mental hospitals would be free from public curiosity or suspicion. Policies of rural relocation and staff accommodation reinforced the notion of social self-containment. Having overseen Kingseat from its beginnings, H.M. Buchanan, Auckland’s Medical Superintendent (1929-52), envisaged that it would eventually become ‘quite a community’ which would need its own school, church and village.\textsuperscript{136} The same could be said of the small towns of Seaciff, Porirua, Kihikihi, Te Awamutu, Waikouaiti or even Hokitika, where the local mental hospital provided the economic base, sustained employment for generations, and facilitated social life in the local community.

\section*{MAXIMUM SIZE}

Skæ set the first limits on institutional size to safeguard a sense of ‘asylum communities’\textsuperscript{137} and to respect patients’ individuality. He used overseas authorities

\begin{itemize}
\item \textsuperscript{133} The protest of a deputation from the Levin Borough Council got short shrift from the Prime Minister when they met him on the steps of Parliament Buildings. Anne Hunt, \textit{The Lost Years: From Levin Farm Mental Deficiency Colony to Kimberley Centre}, Foxton, 2000, p. 1.
\item \textsuperscript{134} The rationale for transferring some rural and not urban military facilities as mental hospitals is not clear. It may be surmised that the Department had some choice in the matter as other military facilities, such as Cornwall Park or Silverstream Hospitals, were transferred to hospital board control.
\item \textsuperscript{135} Editorial, \textit{Otago Daily Times}, 17 November 1943, HMH 26/39. Forward thinking staff at Seaciff who favoured a move to Wakari Hospital in Dunedin City, opposed the decision, which they blamed upon Gray’s stubbornness. Personal communication, J.O. Mackie, 1 February 2000.
\item \textsuperscript{136} Medical Superintendent, Auckland to Director-General, 10 September 1937, H 39/6 (41885). AJHR, 1879, H-4, p. 8.
\end{itemize}
to support his view that an asylum should not exceed 400-500 patients. In an emergency, 600-700 beds might be tolerated. These were English guidelines, not Scottish, where the accepted limit was 350 beds.

The desirable limit was extended as administrators had to accept the pragmatic realities of accommodation pressures, and frustrating delays with public works. In 1899, MacGregor adopted a maximum of 500 patients for the asylum he planned in the Manawatu. In 1900, he referred to a 600-bed ceiling, and a year later, to an institution for 1,000-1,100 patients. Porirua was said to have reached its limit at 738 resident patients in 1910 and at 1,603, in 1936. Gray regarded an ideal maximum as 500 and the practical maximum as 1,000 beds. This latter figure was used to set the size of Kingseat and Lake Alice. On 31 December 1947, the smallest mixed mental hospital, at Hokitika, had about 550 beds but Sunnyside and Auckland probably had in excess of 1,400 residents.

Maxima were also applied to ward accommodation. Soon after taking office, MacGregor measured the air capacity in wards at Auckland and found that most of them fell woefully short of the standard set by the English Lunacy Commissioners. By imposing similar statutory standards for air space in dormitories, the Inspector-General hoped the country would be forced to frankly face the whole question of

138 AJHR, 1881, H-13, p.3, and 1878, H-8, p.3.
139 AJHR, 1877, H-8, pp. 5-7, and 1878, H-10, p. 10. In his 1877 report, Skae gave F.N. Manning, Inspector of the Insane in New South Wales, and the English Lunacy Commissioners, as his authorities.
140 AJHR, 1899, H-7, p. 3.
141 This figure matched MacGregor's conclusion that Seaciff (599 patients), Sunnyside (507), and Auckland (500) had reached their maximum. Inspector-General's report, Sunnyside, 20 January 1900, AJHR, 1900, H-7, p. 9.
142 AJHR, 1901, H-7, p. 3.
144 T.G. Gray, [unpublished] Second Report to the Minister on an Overseas Study Tour, 17 October 1929, HMH 8/1041; AJHR, 1928, H-7, p.4 and 1931, H-7, p.2; Director-General to Acting Director of Mental Hygiene, Brisbane Mental Hospital, 25 November 1941, H 30/3 (33030); Director-General to Minister, 2 May 1944, HMH 8/0/1.
145 Director-General to Minister, 17 January 1936, HMH 28/8.
146 AJHR, 1948, H-7, p. 16. Voluntary boarders have been estimated on a pro rata basis of the average number of patients and boarders resident.
147 Inspector-General's report, Auckland, 28 April 1886, AJHR, 1887, H-9, p. 11. The English standard required single rooms to have 693 cubic feet of air space, equivalent to measurements of 9' x 7' x 11', and dormitory space of 50 superficial feet and 11 feet high for each patient.
asylum overcrowding.  The standard prescribed in New Zealand legislation of 1891 was 600 cubic feet per patient.  MacGregor tried to use this requirement to hasten the completion of Porirua’s main building, but he found that the regulatory imperative was unenforceable. State asylums could not meet the standard until 1905.  Meanwhile, E.G. Levinge, Medical Superintendent at Sunnyside, found the standard of limited value. It applied only to designated dormitories, not to corridors or day rooms, which had been turned into temporary accommodation. The standard ceased to apply to state institutions after 1911, although it was still cited as a measure of overcrowding 20 years later.

ARCHITECTURAL DESIGN

In the late nineteenth century, professional opinion overseas was divided over the functional, architectural and economic merits of variants of the pavilion style and the villa or village type of asylum. A third, ‘irregular or conglomerate’ style exhibited little or no architectural unity of style, and revealed the ad hoc development of institutions.

Design features were also debated in the antipodes. Skae liked the cottage style for private patients and for quiet, industrious patients who generally preferred the

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148 AJHR, 1890, H-12, p. 1.
149 AJHR, 1890, H-12, p. 1; Lunatics Amendment Act 1891, s. 3.
151 Medical Superintendent's report, Sunnyside, AJHR, 1899, H-7, pp. 5-6.
152 Mental Defectives Act 1911, s. 129; Minister, NZPD, 27 October 1931, 230, p. 538.
155 In Australia, F.N. Manning, Inspector-General of the Insane in New South Wales (1878-97), established that state's reputation for the most enlightened policy in Australia. Manning was a recognized authority on lunacy matters. He thought that cottages had a place, but 'the psychopathic hospital of the future' should integrate cottages with a central hospital for sick and acute cases, surrounded by pavilions or blocks of varying form and style for different classes. Cottages should be left for convalescent, quiet and certain chronic cases. Only Victoria wanted a scheme to house 1,500 patients in cottages in a "City of the Simple" at some distance from the metropolis. F.N. Manning,
'more natural and homely life' of a cottage to living in a 'vast Asylum'.

Building design during Skae's inspectorate, however, was more institutional in style and reflected, no doubt, the opinion of Colonel G.S. Whitmore, Colonial Secretary (1877-9) that buildings should be permanent in character. The Whau was completed according to the original plan, as urged by Skae. A male wing to complement the recently built brick and plaster female wing replaced the original Sunnyside buildings. R.A. Lawson's design for Seaciff Asylum was evidently modelled on Norwich County Asylum. When he was Medical Superintendent, (1882-7), W.E. Hacon favoured the block or pavilion style over the existing corridor design of Sunnyside Asylum. In 1882, J. Mackay, Deputy Inspector at Wellington, claimed that 'experts at Home' unanimously opposed large asylums and favoured a central asylum of moderate size for acute cases, with a number of small cottage asylums in the same grounds. Cottage asylums would allow an attendant to live with several patients and enable them to enjoy 'something like home life.'

No doubt remembering the sprawling Royal Earlswood Asylum which he ran for some years before emigrating to New Zealand, Grabham thought that Seaciff Asylum was 'palatial-looking but [a] cold and ill-planned structure below.' He thought that the design was out of date, like Sunnyside. Sunnyside was 'simply a copy of "older" English asylums.' In Grabham's eyes, the 'poverty-stricken appearance' of the Auckland Asylum resembled 'a bad English workhouse in olden times', rather than a 'modern hospital for the insane'. MacGregor was also unimpressed by the gloomy and depressing effect of these major institutions. In 1886, he likened Sunnyside Asylum to 'the leasehold of a bankrupt farmer than the
He considered Seacliff 'a dismal prison'.

Extending and altering these vast buildings was difficult, costly, and time consuming. If economic conditions were right, Skae said, it might take two years to finish a building. If not, construction proceeded exasperatingly slowly. Completing the Whau Asylum's original design took from 1867-81. The main building of Sunnyside Asylum proceeded in four stages, with slightly different designs, and took 19 years to complete.

Many things apart from architectural design problems contributed to construction delays in the late nineteenth century. The merger of provincial public works into a national programme was unsustainable as the country headed into the long depression. As Premier or Colonial Treasurer for much of the period 1874-91, H.A. (later Sir Harry) Atkinson adopted a cautious approach to public works as a remedy for prolonged depression. An 'atmosphere of political auctioneering surrounding public works' in the nineteenth century, as the Public Works Department's official history describes it, sacrificed priorities to the political pork-barrel. Apart from the political and economic problems, there were also practical difficulties. The Architectural Branch of the Public Works Department was greatly understaffed and poorly organized.

Government policy of accepting the lowest tender irrespective of experience, capital or ability, increased the risk of poor quality work. This was most apparent in the

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168 AJHR, 1887, H-6, p. 5.
169 AJHR, 1879, H-4, p. 10.
170 AJHR, 1882, H-9, p. 3.
171 Star, 18 October 1888. The original female wards of the present (but disused) main building were built according a design of S.H. Seager and H.W. Mountfort in 1872, with an addition by Connor and Mountfort in 1875. The eastern (male) wing and water towers were not built until 1880 according to a Cane plan, and the central or linking, block until 1887. The admitting office finalized the building in 1891.
174 Ibid., pp. 50-51, 63, 93.
175 Noonan, pp. 71-72.
defects of the Seacliff and Porirua main buildings. After site works had begun, Skae had well warranted second thoughts about the suitability of the ground at Seacliff. Land instability posed dangerous structural stresses from the outset. The Medical Superintendent protested that the Public Works Department was a source of 'unmitigated expense and annoyance' throughout construction of the main building, which may never have been finished according to the artist's drawings. According to Truby King, only the 'mere naked unfurnished shell' of the building was handed over. Fourteen years after it was first occupied, bad workmanship and design faults were still being rectified. The plumbing was 'utterly scamped'. The original plans made little provision for ventilation, drains or heating. Construction delays and defective workmanship also affected the main building at Porirua Asylum. This was designed as a single block in permanent materials, to be 'as plainly constructed and fitted as possible'. Slow progress immediately destroyed any capacity for the new asylum to be a national repository for the anticipated annual accumulation of chronic cases. By 1894, MacGregor bluntly admitted that he could not persuade the government to complete the project. Two years later, he was absolutely speechless. 'Nothing more can be done or said by me,' he wrote, as he portended some untoward calamity or scandal.

The annual cycle of public works was the worst problem. Departmental heads grumbled that one year was simply not long enough for works to be planned,

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176 AJHR, 1880, H-6, p. 8; W.B.D. Mantell (Wallace), NZPD, 17 August 1880, 37, p. 390; Appendices to the Journals of the Legislative Council, 1880, No. 17, p. 645; Report on Seacliff Lunatic Asylum by the Assistant Engineer-in-Chief, 31 August 1885, AJHR, 1885, H-25; M.S. Grace and Capt. Fraser, NZPD, 31 July 1885, 52, pp. 358-9; H.S. Fish, M.H.R., letter to Evening Herald, 13 February 1888; AJHR, 1888, H-7, pp. 2-6; Medical Superintendent to Inspector-General, 14 July 1888, DAHI D 264/10. Shifting ground at the rear of the northern wing of the building created dangerous stresses in the building, which were noticeable soon after it was completed. 
177 Medical Superintendent to Inspector-General, 22 September 1888, DAHI D 264/11. 
179 The builders used green timber for door lintels and the surrounding brickwork cracked. Seawater was used to mix mortar. Inspector-General's report, Porirua, 19 May 1898, AJHR, 1899, H-7, p. 11. 
180 AJHR, 1894, H-7, p. 2. The building was supposed to be ready in September 1893. NZPD, 30 June 1893, 79, p. 141. 
approved, and the appropriation spent.\textsuperscript{182} Gray stated publicly that an annual cycle meant that ‘no effective long-range building programme has ever been evolved [sic] to meet the inevitable increase in our population’.\textsuperscript{183} Of the £1,032,150 appropriated for mental hospital works between the financial years 1910-1927, only £682,411 (or 66 per cent) was spent.\textsuperscript{184} Table 7 highlights the recurring difficulty. The spending problem was compounded in 1921 when the Public Works Department was made a control department and other departments lost their capacity to become ‘miniature Public Works branches of their own’, to quote the Minister of Public Works.\textsuperscript{185}

MacGregor was so frustrated by delays in finishing Porirua Asylum that he felt certain the country could no longer continue to erect grand and expensive buildings.\textsuperscript{186} Bottlenecks in the Public Works Department had to be circumvented,\textsuperscript{187} so using their ingenuity, departmental administrators recycled wooden buildings. In 1884, Hokitika Asylum took over the old immigration barracks.\textsuperscript{188} In the late 1900s, the prison next door was incorporated into that mental hospital to accommodate a class of persons whose presence, in Hay’s opinion, was undesirable in mental hospitals.\textsuperscript{189} The old Toi Toi School was shifted to the Nelson Mental Hospital for dormitories.\textsuperscript{190} A ‘home built’ female refractory ward was tacked on to the main building at Seaccliff in 1907. The addition was neither architecturally designed nor safe as the appalling fire of 1942 was to prove.\textsuperscript{191} Other buildings were recycled for farm buildings or workshops.\textsuperscript{192}

\textsuperscript{182} AJHR, 1885, H-10, p. 2, and 1890, H-12, p. 2; Director-General to Minister, 20 October 1932, HMH 8/1285; Director-General to Minister, 17 January 1936, HMH 26/8.
\textsuperscript{183} AJHR, 1936, H-7, p. 1.
\textsuperscript{184} Director-General to Under-Secretary of Public Works, and covering memorandum to Minister, 26 April 1928, HMH 8/1046. Cf. Director-General to Minister, 20 October 1932, HMH 8/1285.
\textsuperscript{185} Minister of Public Works to Minister, 29 November 1921, YCAA 1079/21, File 4/1/0.
\textsuperscript{186} AJHR, 1891, H-2, p. 1.
\textsuperscript{187} Inspector-General’s report, Wellington, 21 December 1888, AJHR, 1889, H-22, p. 4.
\textsuperscript{188} Superintendent to Inspector-General, 31 May 1883, Westland Hospital Board Archives, National Archives, Christchurch, CAHW CH 22/10, p. 55; Inspector-General’s report, Hokitika, 19-20 December 1884, AJHR, 1885, H-10, p. 9.
\textsuperscript{189} Inspector-General’s report, Seaview, 13 May 1909, AJHR, 1909, H-7, p. 12.
\textsuperscript{190} AJHR, 1909, H-7, p. 6.
\textsuperscript{191} AJHR, 1943, H-7a. Being a ‘lesser building’, as likely as not, the building was not designed by a foreman-carpenter.
\textsuperscript{192} Inspector-General to Secretary, Public Service Commissioner, 7 March 1919, HMH 12/95.
\textsuperscript{193} For example, usable parts of the Taranaki Buildings were salvaged for workshops and outhouses at Nelson. (Inspector-General’s reports, Nelson, 31 August 1886, AJHR, 1887, H-9, p. 13, and 16 June 1887, AJHR, 1888, H-9, p. 7). The Dunedin Exhibition Buildings were used as farm buildings at Seaccliff. Inspector-General’s report, Seaccliff, 9 August 1890, AJHR, 1891, H-2, p. 5.
### TABLE 7
FINANCIAL ALLOCATIONS AND EXPENDITURE ON PUBLIC WORKS IN MENTAL HOSPITALS, 1877-1936

<table>
<thead>
<tr>
<th>Year</th>
<th>Appropriated</th>
<th>Net Expenditure</th>
<th>% Spent</th>
<th>Year</th>
<th>Appropriated</th>
<th>Net Expenditure</th>
<th>% Spent</th>
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Notes:
1. Figures for financial years.
2. Net expenditure rounded to nearest £.

Sources: AJHR, B-1 (1898-83), B-5 (1884), B-3 (1885-6), B-2 (1887-1904), B-1, Part 1 (1905-37).
Royal Earlswood Asylum for Idiots, Redhill, Surrey (1857). Working in this style of building convinced G.W. Grabham, the Medical Superintendent (1868-82) that New Zealand should not adopt such a grand style of architecture. (Richard Hunter and Ida MacAlpine, 'Three Hundred Years of Psychiatry', London, 1963, p. 967.)
Alt Scherbitz Asylum, Saxony, Germany, c.1890. Details of this colony-type institution were obtained by Dr Truby King. The idea inspired the Asylums Department to switch from large buildings to the villa system.

(Top) General view of the Alt Scherbitz Asylum.

(Lower) One of the asylum villas.

R. A. Lawson's grand building at Seacliff (1879–1884). This panoramic photograph of the main building was taken about 1900. Because the asylum was constructed on unstable ground, the tower and hanging turrets of the main block had to be demolished as a safety precaution in 1945. The building was demolished in 1959.

(Author's collection)
(Top) Sunnyside Hospital, c. 1892.
(Below) Porirua Hospital, c. 1900.

(Author's collection)
General views of the former Hokitika Prison, which was incorporated into the mental hospital in 1910. These photographs were taken during demolition in 1923.

(Seaview Hospital collection)
INSTITUTIONAL ARCHITECTURE: PROTOTYPES OF THE VILLA

(Top) Architect’s drawing of the cottage, Hokitika, built for 12 patients (1879).  
(National Archives, Christchurch, Reference: Public Works Department, Hokitika CH86, Item GR790)

(Centre) D Ward, Seacliff (1879) built for the 60 worker patients sent to prepare the site.  
(Author’s collection)

(Bottom) Pavilion-style ward, Auckland (1896). The ward was later known as M7. It was much larger (150 beds) than the earlier examples of separate accommodation blocks.  
(Author’s collection)
The Cottage (1898), Seacliff Asylum, built as a female admission/convalescent ward. It is shown in the centre right of the lower photograph, at some distance from the main building.

(Author's collection)
Rauta Block, Porirua Hospital (1916).

This 100-bed unit was intended to provide four wards for acute cases and for those who were physically sick. The block had a male and a female wing. The same plan was used for the reception house/infirmary at Sunnyside a year later.

Later style reception houses.

(Top) Clifton House, Seacliff, for men (1917).
(Lower) Braemar Lodge, Nelson (1923).

(Author's collection)
Open villa, Male Valley, Stoke Farm (Ngawhatu Hospital) in 1923. Dr T.G. Gray was responsible for the early work on this institution, which was intended to replace the old Nelson buildings. This standard two-storeyed villa bears some resemblance to the villas at Kingseat Hospital, near Aberdeen, Scotland, where Gray worked before emigrating to New Zealand. (Author's collection.)

Te Maire villa, Hokitika Mental Hospital, soon after construction in 1925. Note the staff rooms in the attic. (Author’s collection.)
Art deco style villa at Porirua Mental Hospital, built after the main building was demolished because of earthquake damage in 1942. The same design was used for villas at Lake Alice Hospital later in the 1940s. (Author's collection, Shirley Brunton photograph.)
An aerial view of Kingseat Mental Hospital under construction. The campus layout was characteristic of villa hospitals, built around playing fields. The Kingseat-style villa was also unique.

(Auckland Star, 6 March 1937)
Cottage style architecture was an alternative to recycled buildings or improvisation. The first cottage was built for 12 patients at Hokitika Asylum in 1879. Skae immediately saw the wide potential of the idea:

What will be wanted is accommodation of a simple, homely, and inexpensive kind, for quiet, harmless patients of a chronic class who will employ themselves in the fields; and this can best be provided by means of detached houses of various sizes, which, like a great part of the Hokitika Asylum, can be built by the patients with wood got from the Asylum grounds.\textsuperscript{193}

The 'comfortable little building' erected for the initial working party at Seacliff, and 60 bed wooden auxiliary buildings at Seacliff (1879) and Auckland (1883) were other prototypes.\textsuperscript{194} Cottages came into vogue for worker patients\textsuperscript{195} and for convalescent patients\textsuperscript{196} as the 'main building' era of asylum development drew to a close in the 1890s. MacGregor and G. Hassell, Medical Superintendent of Porirua (1899-1920) had some misgivings about timber construction but these surfaced too late to reverse what was, by then, already a trend.\textsuperscript{197}

The next step was to apply the concept systematically to new institutions. In 1897, Truby King wrote to Alt Scherblitz Asylum, Saxony and asked for details of the 'complete Colony system' adopted there. He thought the whole system, which had

\textsuperscript{193} AJHR, 1880, H-6, pp. 4-5.

\textsuperscript{194} For Seacliff, see AJHR, 1879, H-4, p. 5 and 1887, H-6, p. 5. For Auckland, see Inspector-General’s report, Auckland, 21-4 May 1882, AJHR, 1883, H-3, p. 5. This building was destroyed by fire several years later and was replaced, in November 1896, by the pavilion-style building later known as M-7 ward. Medical Superintendent’s report, Auckland, AJHR, 1897, H-7, p. 2.

\textsuperscript{195} E.g., for Sunnyside, AJHR, 1890, H-12, p. 3, and Inspector-General’s report, Sunnyside, 20 January 1900, AJHR, 1900, H-7, p. 9; for Seacliff, Medical Superintendent’s report, Seaciff, AJHR, 1900, H-7, p. 8, E.G. Allen (Waikouaiti), NZPD, 23 September 1902, 122, p. 557.

\textsuperscript{196} E.g., for Seacliff, 1 April 1893, and Official Visitor’s report, 22 April 1895, DAHI D 234/6. The building for female convalescent patients, known simply as ‘The Cottage’, was opened in 1898. AJHR, 1899, H-7, p. 3. Almost immediately, MacGregor suggested that a similar though larger building was needed for male convalescent patients. Inspector-General’s report, Seacliff, 2 March 1903, AJHR, 1903, H-7, p. 6. By the end of the century, there were cottages at Ashburn Hall (for inebriates), Nelson and Seaciff. Inspector-General’s report, Nelson, 23 January 1896, AJHR, 1896, H-7, p.9; Inspector-General’s report, Ashburn Hall, 20 August 1897, AJHR, 1898, H-7, p. 14; AJHR, 1899, H-7, p.3. Porirua converted the old auxiliary cottage building into a ward for 24 convalescent female patients in 1906. The doors were not locked during daylight hours so that patients had free access to the garden at any time. The patients led lives approximating that of a private home. Medical Superintendent’s report, Porirua, AJHR, 1906, H-7, p. 11.

\textsuperscript{197} E.g., Inspector-General’s reports, Sunnyside, 25 February 1903, Porirua, 7 February 1903, AJHR, 1903, H-7, pp. 5, 7; Medical Superintendent’s report, Porirua, AJHR, 1908, H-7, p. 17. The major fire at Colney Hatch Asylum (1903) was salutary to the New Zealand system with its many wooden buildings. Medical Superintendent’s report, Wellington, AJHR, 1904, H-7, p. 12.
been publicized in a review of A. Paetz's *Die Kolonisierung der Geisteskranken* (1893) in the *Journal of Mental Science*, would be applicable at Seacliff. King shared the international interest in the colony system at Alt Scherbitz that was stimulated by Paetz's publication. King was excited by the colony system:

One cannot live and work constantly among the insane without feeling keenly the wrong and cruelty of our present system. If this state of matters were inevitable, it could be endured, but the galling irony of the position lies in the fact of feeling oneself hopeless where so easy and cheap a remedy would be effective.

The colony system was consistent with trends in hospital and asylum architecture overseas. In late nineteenth century British asylum architecture, corridors became covered arcades and then became redundant as separate blocks became a design feature of Bexley (1898), Kingseat (1904) and elsewhere. A comparable trend towards villas can be noticed in the size and design of cottage hospitals.

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199 Medical Superintendent, Seacliff to Dr A. Paetz, Alt Scherbitz, 28 October 1897, DAHI D 264/20. I am very grateful to Mr Holger Steinberg of the Archiv für Leipziger Psychiatriegeschichte, Universität Leipzig Klinik und Poliklinik für Psychiatrie, for attempting to trace the correspondence between King and Paetz and for kindly providing details on Alt Scherbitz.


202 Medical Superintendent to Inspector-General, 3 September 1898, DAHI D264/20.

convalescent hospitals, infectious disease and isolation hospitals, and tuberculosis sanatoria.\textsuperscript{204}

By 1899, MacGregor was clearly impressed by this 'new system'. He thought it should be adopted in all future asylums. He had Paetz's work translated by Mrs Neill, the Assistant Inspector. The Inspector-General had obtained information about a similar system at Kankakee, Illinois.\textsuperscript{205} MacGregor believed that a new institution had to be built with 'separate blocks' for hospital cases, idiots, imbeciles, epileptics, (if possible) tuberculosis cases, and a nurses' home.\textsuperscript{206}

Experience revealed the benefits of the new system to medical superintendents and departmental heads alike. An asylum-colony would need a large increase in attendant numbers. Single rooms for staff would have to be added to the cottages or villas because New Zealand attendants would never sleep in a patients' dormitory like German attendants. But there would be cost-savings. Experience at Seacliff showed that the construction cost was about £20 per bed compared with £200 per bed in the main building.\textsuperscript{207} Detached buildings would allow the principles of graduated restraint and differentiation to be applied to the needs of patient groups, thereby reducing pressure and friction among the inmates. Each patient could enjoy an appropriate degree of personal liberty, including open parole, without the need to confine many under lock and key behind grated windows. More individual attention and treatment were possible. Separate buildings reduced the fire risk and improved sanitary conditions. Staff, too, were said to benefit because of an increased sense of responsibility.\textsuperscript{208} Arguments for cottage and colony development were politically attractive. In the Estimates debate of 1902, H.G. Ell (City of

\textsuperscript{204} Ibid., pp. 9-10, 44-45, 737-4, 77, 92, 109-11, 119, 122, 142-3.
\textsuperscript{205} AJHR, 1899, H-7, p. 3. King may have obtained his own copy of the original work or the Department may have procured one for its departmental library. Neither copy can be traced.
\textsuperscript{206} AJHR, 1901, H-7, p. 3.
\textsuperscript{207} Medical Superintendent's report, Seacliff, AJHR, 1899, H-7, p. 7. King also said that the Simla block had more light and space, better air and more cheerful quarters so that as with other 'more home-like detached buildings', it was much preferred to the main building. King said that the Simla block for 99 patients cost £1,850. Medical Superintendent to Inspector-General, 29 October 1902, DAIH D284/24. By comparison, a 50-bed addition at Hokitika was constructed using virtually only asylum labour in 1903 - an 'extraordinary triumph of skill and economy'. It cost about £750. Inspector-General's report, Hokitika, 11 December 1903, AJHR, 1904, H-7, p. 6.
\textsuperscript{208} AJHR, 1899, H-7, p. 3; Director-General to Minister, 17 October 1929, HMH 8/1041; Medical Superintendent's report, Nelson, AJHR, 1922, H-7, p. 9; Medical Superintendent's report, Seaview, AJHR, 1925, H-7, p. 11; Theodore G. Gray, The Very Error of the Moon, Ilfracombe, 1958, pp. 64-65.
Christchurch) and E.G. Allen (Waikouaiti) hoped that no more ‘huge blocks of buildings’ or ‘palatial structures’ would be built. Wooden buildings were much better.\textsuperscript{209} W. Hall-Jones, Minister of Public Works (1896-1908), warmed to the idea, and gave the notion political nurture at a critical time.\textsuperscript{210} His successor, G. Fowlds (1906-11), opposed building any more ‘large piles of buildings’.\textsuperscript{211}

The “villa system” (so named because it was based on villas rather than small, domestic cottages) was intrinsic to the planning of all new mental hospitals in the twentieth century. Hay envisaged that each 25-100 bed ward block at Tokanui would be ‘a separate house in a garden city’ linked by a light rail system.\textsuperscript{212} The planning of Tokanui was also informed by a visit to Kingseat Hospital, Newmachar, Scotland, by A.H. Crosby, a departmental medical superintendent, in 1910.\textsuperscript{213} Kingseat, Scotland’s first villa style mental hospital was inspired by the Alt Scherbitz colony system. Kingseat Mental Hospital was destined to have further significance in New Zealand. Working there as an assistant medical officer (1906-1911) made a profound impact upon T.G. Gray.\textsuperscript{214} He never forgot the conceptual debt he owed to his training ground and he used the same name for the showpiece mental hospital at Papakura.\textsuperscript{215} Using that model, Gray advised his counterpart in Queensland to develop a 1,000-bed hospital on 1,000 acres of land. The hospital should have 12 parole villas, each of 50 beds; two 60 bed villas for mentally infirm patients, two 40 bed villas for farm workers, 1 hospital unit of 60 beds for males and females, two 20 bed neuropathic\textsuperscript{216} villas, and two closed villas of 50 beds each. The villas should be spaced about 30-50 yards apart. Gray’s model institution was to be planned as a community with its own library, canteen, occupational therapy block, and swimming pool. In a further innovation, Lake Alice Mental Hospital was supposed to provide a

\textsuperscript{209} NZPD, 23 September 1902, 122, p. 557.
\textsuperscript{210} NZPD, 3 and 17 July 1903, 123, pp. 163-4, 548, and 18 September 1903, 125, p. 605.
\textsuperscript{211} NZPD, 28 August 1908, 144, p. 508.
\textsuperscript{212} Inspector-General to Minister, 11 April 1910, HMH 1910/345. The railway was never built.
\textsuperscript{213} New Zealand Times, 14 April 1910. Crosby was Medical Superintendent at Mount View (1905-10) and undertook the study tour when that hospital closed.
\textsuperscript{214} Gray, pp. 64, 88.
\textsuperscript{215} Director-General to Minister, 7 September 1935, HMH 26/8. The bond between the two Kingseats was affirmed when a slab of Aberdeen granite from Kingseat Hospital, Scotland was used as the foundation stone of the chapel of its antipodean namesake. Anon., Kingseat, p. 1.
\textsuperscript{216} A contemporary term for the venue of acute treatment of mental and nervous disorders in a mental hospital. The term should not be confused with the American term “psychopathic hospital”, which was sometimes used to refer to similar arrangements in a general hospital.
street of houses, each of 12 beds, for the best parole patients. Gray took advantage of natural calamities to promote villa style hospital development at Cherry Farm and Porirua.

Trial and error gradually improved a standard design for villas. As Minister of Public Works, W. Hall-Jones hinted at the value of using common building plans throughout the Department as early as 1903. This idea took some time to be applied, judging from surviving records and buildings. The plan for the reception home at Auckland (Wolfe Home) was supposed to have been copied elsewhere but it bears little likeness to those designed for Porirua (1915) and Sunnyside (1916). They did, however, resemble each other. Hokitika Mental Hospital was redeveloped entirely along villa lines, using modified plans of Porirua-style villas. Plans for two-storeyed villas to replace the main building demolished at Porirua were copied at Lake Alice. Standard plans for the Templeton, Kingseat and Porirua style villas, were modified in the light of experience.

CONCLUSION

A strongly institutional system of psychiatric care and treatment prevailed in New Zealand between 1876-1947. Institutional care developed because it embodied three key ideals. Patients could be classified into manageable groups based upon gender, diagnosis, prognosis, behaviour, and level of dependency. In a system where the prognosis for the great majority of resident patients was never good, cottages or villas and various recreational amenities in institutions could help foster a sense of community. Policies on the location, space, size, expansion, and

217 Director-General to Director of Mental Hygiene, Brisbane Mental Hospital, 25 November 1941, H 30/3 (33030).
218 Older staff at Porirua recalled that after the severe earthquake of 1942, the Director-General instructed workmen to exaggerate the cracks by painting lines on the plaster and brick walls. Gray successfully used the ruse to strengthen his arguments for total demolition of the building. Personal communication, the late Or R.G.T. Lewis.
219 NZPD, 3 July 1903, 123, p. 163.
221 AJHR, 1915, H-7, p. 4.
222 Medical Superintendent, Seaview to Inspector-General, 9 April 1924, MH 18/4/1(1). The accommodation of each villa was increased from 34 to 38.
223 Acting Director-General, Circular, 20 June 1947, H 30/3 (33030).
architectural design of institutions attempted to realize those therapeutic ideals. The ideal institution, colony, villa or cottage had to be small enough to engender both a sense of individual welfare and a sense of community. The rural villa hospital with a regional catchment was the ultimate expression of these ideals. Second and third generation mental hospitals were removed from urban areas and placed amid abundant land for agriculture, where there was no alternative to institutional self-containment and community building.

Attainment of the therapeutic ideals that underpinned long-term planning was repeatedly bedevilled by fiscal priorities and the structure of annual public works programmes. Progress was conditional upon the right mix of ingredients - sufficient resources, political will, fiscal flexibility, administrative pressure, public acceptance, public works priorities, and structural defects in older buildings. Nevertheless, capital development was constantly frustrated by an accommodation supply-demand spiral that invariably left mental hospitals to cope with far more patients than they reportedly had room for. In such circumstances, the provision of recreation halls, libraries, hairdressing salons, canteens, sports areas or other community amenities were secondary concerns to the necessary preoccupation with providing adequate bed space for everyone. New Zealand’s growing tradition of state-run social services and the lack of a wealthy upper class limited opportunities for the development of more than one licensed institution. Non-institutional settings for private care and treatment were permitted, but avenues were very limited.
8.

‘MARKED OUT FOR SPECIAL TREATMENT’¹
CLASSIFYING THE PATIENTS

Classification, or the allocation of patients to a particular ward according to clinical judgment and common sense, was vital to care and treatment policies. Institutions looked after two kinds of patient - the recoverable and the chronic. Recoverable patients consisted mainly of persons of unsound mind, as defined by the Mental Defectives Act 1911. This group comprised mental disorders known nowadays as neuroses, alcohol dependence, acute reactions to stress, depressive disorders, some affective psychoses, or puerperal conditions. The mental condition of some of these patients could be treated or stabilized in a relatively short time. Table 8 shows that on average about two-thirds of committed patients who were discharged recovered spent less than one year in a mental hospital.² The high level achieved initially can be explained in part by the practice of remanding suspected cases of insanity, and cases of ‘transient mental derangement’ or delirium tremens to asylums.³ The renewed high level in the 1940s shows the impact and expectations of somatic treatments that were introduced about that time.

Chronic patients greatly outnumbered the recoverable patients. Chronic or long-term conditions included senile and other dementias, schizophrenic psychoses, paranoid states, personality disorders, and mental retardation. In 1938, schizophrenia accounted for about 16 per cent of mental hospital admissions and about 60 per cent of chronic patients.⁴ A distinction was made among patients on the basis of a well-recognized administrative rule of thumb that someone who had not been discharged

¹ Appendices to the Journals of the House of Representatives (AJHR), 1910, H-7, p. 4.
² No figures are available for voluntary boarders.
⁴ AJHR, 1938, H-7, p. 3.
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<td>55.9</td>
<td>82.9</td>
<td>88.8</td>
<td>94.1</td>
<td>97.6</td>
<td>98.8</td>
<td>99.7</td>
<td>100.0</td>
<td>100.0</td>
</tr>
<tr>
<td>1947</td>
<td>14</td>
<td>89</td>
<td>95</td>
<td>124</td>
<td>77</td>
<td>85</td>
<td>32</td>
<td>16</td>
<td>15</td>
<td>6</td>
<td>5</td>
<td>3</td>
<td>561</td>
</tr>
<tr>
<td>%</td>
<td>2.5</td>
<td>18.4</td>
<td>35.3</td>
<td>57.4</td>
<td>71.1</td>
<td>86.3</td>
<td>92.0</td>
<td>94.9</td>
<td>97.5</td>
<td>98.6</td>
<td>99.5</td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Source: Departmental reports, AJHR, 1877-1948.
after six months was a ‘lifer’. The presence of great numbers of chronic patients in mental hospitals created an air of pessimism. In 1882, W.E. Hacon, Medical Superintendent at Sunnyside, reckoned that of every 10 patients attacked by insanity, five would recover, though only two of those would remain well during the rest of their lives. The remaining three would experience subsequent attacks during which two of them would die. An asylum, therefore, could anticipate the return of nearly 60 per cent of all so-called recoveries. A career in the Department’s service taught Sir Truby King that only 25-30 per cent of insane persons remained permanently outside or died outside a mental hospital. Three sets of statistics convey the impact of chronic patients upon the mental hospital system. Table 9 shows that the proportion of patients deemed to be “curable” (a term that was not defined) shrank from one-quarter in the 1870s to a mere 7 per cent at the turn of the twentieth century. The nadir was reached in 1905, but mental hospital doctors continued to regard the great majority of patients as incurable. This was particularly so for mental infirmity and mental subnormality. Between 1920-45, mental hospitals experienced an exponential growth in the legal classes of mental defect III-V, or the former category of idiocy (Table 6). The cumulative total of mental hospital deregistrations between 1876-1947 (Table 10) provides a third indicator of incurability. Deaths rose from 22 per cent to 37 per cent of all deregistrations. During that time, there was a corresponding decrease in the proportion of recoveries from 64 per cent to 49 per cent. This arose from the large proportion of mentally infirm patients and from the natural aging of the “lifers” with chronic conditions.

5 F. Truby King evidence, Regina v. W.F. Kitchen, Mental Hospitals Department File MH 1891/2511, transcript of evidence, p. 312, formerly held at the Health Department head office, but current whereabouts unknown. See also Director-General to Attorney-General, 2 September 1931, Health Department Archives, National Archives, Wellington, File H 30/28/21 (34252); Director-General to Dr A.H. Carbery, 29 September 1933, H 30/19/11 (28449); W.D. Lysnar, New Zealand Parliamentary Debates (NZPD), 1 November 1921, 191, pp. 990-1, J. A. Young (Reform, Hamilton), 6 August 1926, p. 279 and 2 October 1929, 223, p. 272.

6 Medical Superintendent’s report, Sunnyside, in AJHR, 1882, H-9, p. 11.

7 AJHR, 1926, H-7, p. 7.

8 In 1936, the Medical Superintendent at Hokitika explained that the typist was told the percentage chance of recovery of a newly admitted patient so that it could be included in the weekly report. No record was kept of the assessment and it was never checked. The numbers were therefore ‘hopelessly wrong’. Medical Superintendent, Hokitika to Director-General, 3 March 1936, Seaview Hospital Archives, Hokitika, pending transit to National Archives, Christchurch, CAHCH 706, File (48). Lacking clear guidelines, the hospital interpreted recovery as the prospect of the likelihood of a discharged patient being able to resume his or her living or, in the case of a married woman, to resume domestic duties.

9 I.e., discharges, escapes, probation (leave) and deaths. The information was derived from a national system of registrations (first admissions, readmissions, and transfers) established in 1876. The framework of epidemiological, social and human accounting statistics was developed by Skae and based upon British precedents.
TABLE 9
‘CURABLE’ AND ‘INCURABLE’ PATIENTS IN MENTAL HOSPITALS, 1876-1945

<table>
<thead>
<tr>
<th>Years</th>
<th>&quot;Curable&quot; Patients</th>
<th>&quot;Incurable&quot; No.</th>
<th>Total Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>1875</td>
<td>730</td>
<td>554</td>
<td>730</td>
</tr>
<tr>
<td>1880</td>
<td>1116</td>
<td>940</td>
<td>1116</td>
</tr>
<tr>
<td>1885</td>
<td>1524</td>
<td>1284</td>
<td>1524</td>
</tr>
<tr>
<td>1890</td>
<td>1797</td>
<td>1498</td>
<td>1797</td>
</tr>
<tr>
<td>1895</td>
<td>1987</td>
<td>1795</td>
<td>1987</td>
</tr>
<tr>
<td>1900</td>
<td>2672</td>
<td>2489</td>
<td>2672</td>
</tr>
<tr>
<td>1905</td>
<td>3112</td>
<td>2907</td>
<td>3112</td>
</tr>
<tr>
<td>1910</td>
<td>3670</td>
<td>3273</td>
<td>3670</td>
</tr>
<tr>
<td>1922</td>
<td>5199</td>
<td>4163</td>
<td>5199</td>
</tr>
<tr>
<td>1925</td>
<td>5138</td>
<td>4229</td>
<td>5138</td>
</tr>
<tr>
<td>1930</td>
<td>6532</td>
<td>4970</td>
<td>6532</td>
</tr>
<tr>
<td>1935</td>
<td>7919</td>
<td>5326</td>
<td>7919</td>
</tr>
<tr>
<td>1940</td>
<td>8388</td>
<td>6485</td>
<td>8388</td>
</tr>
<tr>
<td>1945</td>
<td>8829</td>
<td>5290</td>
<td>8829</td>
</tr>
</tbody>
</table>

Notes:
1. No information is available for the years 1911-21. Figures for 1873-1905 are based on the number of patients remaining on 31 December / 1 January.
2. Numbers for 1922-45 are based on the patient population resident on or about the week ended 30 June.
3. No record can be found of the criteria used for "curability" and "incurability" so that these statistics should be regarded as clinically impressionistic than conclusive.

Sources: Statistics for the Colony of New Zealand, 1873-1909; AJHR, 1911, H-7, p. 4; Unpublished institutional weekly reports, 1922-45, Health Department Archives, National Archives, Wellington, ABQU, W 4415, Boxes 614-617.
### TABLE 10
**CUMULATIVE TOTAL OF MENTAL HOSPITAL DEREGRATIONS, 1876-1947**

<table>
<thead>
<tr>
<th>Year</th>
<th>Cumulative Total Deregistrations</th>
<th>Discharged Recovered</th>
<th>%</th>
<th>Other Discharges</th>
<th>Discharges Subtotal</th>
<th>Cumulative % Discharges</th>
<th>Deaths</th>
<th>Cumulative % Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>1880</td>
<td>1466</td>
<td>932</td>
<td>63.6</td>
<td>210</td>
<td>1142</td>
<td>77.9</td>
<td>324</td>
<td>22.1</td>
</tr>
<tr>
<td>1885</td>
<td>3037</td>
<td>1761</td>
<td>58.0</td>
<td>540</td>
<td>2301</td>
<td>75.8</td>
<td>736</td>
<td>24.2</td>
</tr>
<tr>
<td>1890</td>
<td>4693</td>
<td>2641</td>
<td>56.3</td>
<td>824</td>
<td>3465</td>
<td>73.8</td>
<td>1228</td>
<td>26.2</td>
</tr>
<tr>
<td>1895</td>
<td>6393</td>
<td>3523</td>
<td>55.1</td>
<td>247</td>
<td>4594</td>
<td>71.9</td>
<td>1799</td>
<td>28.1</td>
</tr>
<tr>
<td>1900</td>
<td>8355</td>
<td>4482</td>
<td>53.6</td>
<td>287</td>
<td>5840</td>
<td>69.9</td>
<td>2515</td>
<td>30.1</td>
</tr>
<tr>
<td>1905</td>
<td>10762</td>
<td>5723</td>
<td>53.2</td>
<td>240</td>
<td>7321</td>
<td>68.0</td>
<td>3441</td>
<td>32.0</td>
</tr>
<tr>
<td>1910</td>
<td>13711</td>
<td>7307</td>
<td>53.3</td>
<td>193</td>
<td>9098</td>
<td>66.4</td>
<td>4613</td>
<td>33.6</td>
</tr>
<tr>
<td>1915</td>
<td>17331</td>
<td>9107</td>
<td>52.5</td>
<td>361</td>
<td>11259</td>
<td>65.0</td>
<td>6072</td>
<td>35.0</td>
</tr>
<tr>
<td>1920</td>
<td>21386</td>
<td>10931</td>
<td>51.1</td>
<td>445</td>
<td>13528</td>
<td>63.3</td>
<td>7858</td>
<td>36.7</td>
</tr>
<tr>
<td>1925</td>
<td>25641</td>
<td>13004</td>
<td>50.7</td>
<td>466</td>
<td>16067</td>
<td>62.7</td>
<td>9574</td>
<td>37.3</td>
</tr>
<tr>
<td>1930</td>
<td>30471</td>
<td>15264</td>
<td>50.1</td>
<td>620</td>
<td>18947</td>
<td>62.2</td>
<td>11524</td>
<td>37.8</td>
</tr>
<tr>
<td>1935</td>
<td>36028</td>
<td>17891</td>
<td>49.7</td>
<td>815</td>
<td>22389</td>
<td>62.1</td>
<td>13639</td>
<td>37.9</td>
</tr>
<tr>
<td>1940</td>
<td>43069</td>
<td>21001</td>
<td>48.8</td>
<td>1361</td>
<td>26860</td>
<td>62.3</td>
<td>16209</td>
<td>37.6</td>
</tr>
<tr>
<td>1945</td>
<td>51081</td>
<td>24614</td>
<td>48.2</td>
<td>1297</td>
<td>31770</td>
<td>62.2</td>
<td>19311</td>
<td>37.8</td>
</tr>
<tr>
<td>1947</td>
<td>55123</td>
<td>26983</td>
<td>48.9</td>
<td>532</td>
<td>34651</td>
<td>62.9</td>
<td>20472</td>
<td>37.1</td>
</tr>
</tbody>
</table>

**Notes:**
1. Excludes institutional transfers.
2. Other discharges include voluntary boarders who were committed and committed patients discharged as relieved or unimproved. Persons on probation were counted as unrecovered unless evidence of recovery was produced at the end of the probationary period. AJHR, 1919, H-7, p. 2.
3. Deaths include committed patients and voluntary boarders.
4. Criteria for the discharge categories of recovered, relieved and unimproved were not defined. AJHR, 1927, H-7, p. 1 and 1929, H-7, p.1. Recovery could mean the abeyance of symptoms that prompted admission, or it could mean fitness for rehabilitation into ordinary civil life, with the person's mental constitution still below par. AJHR, 1931, H-7, p. 1.

**Sources:** [For committed patients] Departmental reports, AJHR, 1877-1948, tables 'Showing the Admissions, Discharges, and Deaths from 1st January, 1876, to 31st December...'; and 'Summary of Total Admissions: Percentage of Cases since the Year 1876'; [for voluntary boarders], summary table in AJHR, 1948, H-7, p. 2.
Deaths accounted for 44 per cent of all deregistrations among committed patients; slightly more than the proportion discharged recovered.

Medical staff took into account a range of considerations in classifying patients. Mercier’s textbook on asylum management of 1894 listed the date of admission, the duration of the malady, and the existence and nature of any bodily disease. A tendency to suicide or violence was important. Feebleness or vigour, noisiness, offensiveness of habits, and ‘sexual tendency’ also had to be considered. ‘Industry or the reverse, and occupation’ were other factors, as was the amount of liberty that could be safely allowed. Mercier’s ideal asylum was therefore expected to provide gender-based accommodation and a proportion of single rooms to total beds that was determined according to the needs of different classes.

Mercier suggested that an asylum should accommodate recent cases and new admissions in small wards. Patients there needed individual observation, maximum attention, and to be spared the shock of contact with patients of more repulsive or terrifying habits. Separate wards with observation dormitories were needed for ‘sturdy and irascible’ epileptics to manage fits. Mercier urged that ‘suicides, general paralytics, &c.’ could share some facilities but that general paralytics should be kept apart from epileptics, because of their proneness to injury and aggression-provoking habits. At night, the restless and dirty habits of patients with general paralysis of the insane meant they could share wards with feeble and quieter patients. Suicidal patients should be kept far enough away from epileptics to avoid further aggravation of their mental depression, but close enough to general paralytics to be cheered by their geniality and high spirits. An infirmary should be provided for physically sick patients, but separate from the detached hospital to care for cases of contagious disease. Turbulent (refractory or disturbed) patients needed their own wards. Other wards should accommodate ‘chronic demented and feeble patients mainly’ provided that those wards also housed patients who could scrub and clean the ward. Then there should be wards for ‘the industrious and for convalescents' who could be given extra liberty. Noisy patients warranted separate accommodation at a distance from other patients and staff. Sexually repulsive patients or those with repulsive behaviour should be suitably segregated from sensitive or sensible patients.¹⁰

The large wards in Victorian era institutions, accommodation pressures, and building delays thwarted attempts to impose a thorough system of classification in New Zealand asylums along Mercier's lines. Once started, the best had to be made of major buildings like Seacliff or Porirua. Hay likened them to a band marked out at intervals into wards like a foot rule in inches. In time the wards filled up and the buildings could not be conveniently added to.\textsuperscript{11} Large wards impeded classification and individual care and treatment. With one exception, wards in the main building at Sunnyside in 1934 contained between 65-106 patients.\textsuperscript{12} The Porirua main building was much the same. Ward M4 had four rows with 77 beds. The beds were only 18 inches apart so there was little privacy or comfort. Each patient had only 400 cubic feet of air space.\textsuperscript{13} A former head attendant at Seacliff remembered D Ward, with 146 male patients, as the largest in the country.\textsuperscript{14} Many of these large wards mixed the most physically dependent patients. In 1934, Sunnyside's D Ward had 36 sick, aged and infirm males and pre-adolescent mental defectives. Ward 1 contained 82 idiot children; senile and demented women whose mental and physical deterioration left them dirty in their habits. Annexe Ward housed 78 sick or senile patients or others who required special nursing care.\textsuperscript{15} These conditions were typical of other main-building style buildings.\textsuperscript{16} Sir Truby King said that 'unduly large dormitories' of 60-80 beds continued to be built until c. 1910, so improvements in classification proceeded slowly in older buildings. He instituted a policy of subdividing these wards into four smaller dormitories in 1925.\textsuperscript{17}

Keeping recoverable and sensitive patients apart from chronic patients was the bottom line of patient classification. During accommodation crises of the late nineteenth and early twentieth centuries, classification was limited to 'two lots - the quiet and moderately tidy, and the noisy, destructive, and dirty'.\textsuperscript{18} All had to be treated the same.\textsuperscript{19} In 1898, Truby King, then Medical Superintendent at Seacliff

\textsuperscript{11} AJHR, 1913, H-7, pp. 7-8.
\textsuperscript{12} B.E.P. McCullough, 'A Study of Endemic Typhoid Fever at the Sunnyside Mental Hospital, Christchurch', Preventive Medicine Dissertation, University of Otago, 1934, pp. 70-73.
\textsuperscript{13} M. and R. Christie, 'A Study of Porirua Mental Hospital', Preventive Medicine Dissertation, University of Otago, 1936, [no pages given].
\textsuperscript{14} E.C. Treweek, 'Memories of the Hospital' in Anon., The End of an Era, Dunedin, 1972, p. 11.
\textsuperscript{15} McCullough, pp. 70-73.
\textsuperscript{17} AJHR, 1925, H-7, p. 7.
\textsuperscript{19} AJHR, 1889, H-22, p. 2, and 1890, H-12, p.2.
(1889-1921), condemned the way the 'most violent or repulsive and degraded of patients' were kept alongside the 'sensitive':

The huddling together of some insane women of all classes in three wards is a crime which nothing can excuse or even extenuate and as long as such a state of things is permitted to exist, a Superintendent who endures it without protest makes himself particularly criminis [sic]. I call again for immediate relief.

King went on to graphically describe the results:

These small numbers [of extremely degraded or violent patients] mixed with the rest are the curse and evil leaven of our institutions. The sum of actual pain, physical and mental, which a single bad case can directly inflict during the course of a bad life, one shrinks from admitting, and yet this is perhaps not half the evil for the degradation and violence of one person will contaminate and corrupt a whole ward .... I leave it to your imagination to picture the number of smashed windows, black eyes, kicked and punched bodies that J.C. has alone brought about, and to sicken at the vile stenches, the filthy oaths, and the abominable personnel which timid gentlewomen like Mrs H. have to endure from daily association with such a creature. Nothing can overdraw this picture. Nothing can excuse its continuance.20

Press comment of the time picked up these themes:

For a sensitive, well-bred woman to be forced to associate with the all sorts and conditions necessarily met with in a mixed asylum, is a terrible hardship. She may be mad enough to render confinement essential, but may still retain sufficient sense to suffer exquisite torture from contact with the rougher female lunatics.21

It is disgusting that a man of sensitive feeling should have to herd with some of these poor demented and unfortunately very low specimens of humanity.22

Early classification policy was simple – collecting the country’s chronic patients in one large institution and leaving other asylums free to deal with acute cases. In the rest

20 Medical Superintendent, Seacliff to Inspector-General, 3 September 1898, Healthcare Otago Ltd Archives, National Archives, Dunedin, DAHI D 264/20.
21 Auckland Evening Star, 6 March 1891.
22 Lyttelton Times, 24 September 1904.
of this chapter, I will outline how classification policy evolved from simple schemes for a national asylum for chronic patients, into a more sophisticated system. The complicated policies of separating incipient, acute, recoverable and convalescent patients will next be examined. Finally, I will follow efforts to classify different groups of chronic patient – mentally infirm persons, mentally subnormal children and adults, epileptics, highly dangerous or criminally insane patients, and habitual inebriates.

**SIMPLE CLASSIFICATION**

The debate over the concept of a central asylum was still a live policy issue when F.W.A. Skae took office as Inspector-General in 1876. He was averse to a central asylum because it would only become ‘a mere receptacle for chronic and hopeless patients, on whom the specially qualified Medical Officers and Asylum staff would exercise their skill to little purpose’.  

Skae’s three successors did not share these reservations. G.W. Grabham, Inspector-General (1882-6), regarded a special asylum for harmless patients as a substitute for boarding out. D. MacGregor, Inspector-General (1886-1906), wanted Porirua as the national asylum for chronic and incurable patients, though the frustrating delays in completing the project put paid to that idea. F. Hay, Inspector-General (1907-1924), had the same hopes for his brainchild of Tokanui as MacGregor had held for Porirua.  

A central institution for chronic patients was central to the scheme envisaged by the Minister in the Mental Defectives Bill 1911. Such segregation would have left other mental hospitals free to treat persons of unsound mind. According to Sir Truby King, who was never enamoured of Hay’s scheme, Tokanui was supposed to serve for all time as a ‘great farm colony’ for all those chronic patients from throughout New Zealand who could work outside and whose relatives did not object to the transfer. Plenty of cheap, second-class land was acquired, but the scale was grandiose; only one-third was needed.

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23 AJHR, 1877, H-8, p. 7.
24 AJHR, 1885, H-10, p. 2.
25 AJHR, 1892, H-4, p.1; Inspector-General’s report, Nelson, 16 June 1887, AJHR, 1888, H-8, p. 7. Macgregor argued that an experienced lay manager should run Porirua because patients would not need much medical attention. This did not happen.
27 NZPD, 4 August 1911, 154, p. 193.
28 Inspector-General to Minister (confidential), 4 March 1926, H 39/6 (41885). King declined to help select the land so Hay and the North Island medical superintendents made the choice.
There was no further talk of a central chronic institution when King succeeded Hay (1924-7). Most mental hospitals continued to provide both acute and long-term care for a mix of patients. Because the Department's network of institutions was looked upon as one vast mental hospital, chronic patients with no known relatives or friends were likely to be transferred en masse from overcrowded metropolitan institutions transferred to new or secondary institutions with spare room. Mass transfers to Hokitika Asylum began in 1898 and became the raison d'être of that institution. Mass transfers enabled hospitals to off-load dependent or refractory patients and to retain their worker patients.

After the hospital model and villa system were adopted as policies in the first decade of the twentieth century, instead of a national asylum for chronic patients, special but different facilities were sought for different classes of patient. The Department explored the establishment of such national facilities or colonies for habitual inebriates, demented elderly persons, mental defectives, epileptics, and the criminally insane. Classification of acute or recoverable patients became more stylish also as distinctions were drawn between the management of neuroses and other forms of mental disorder. Classifying acute and convalescent cases first took place in mental hospitals. Institutional outreach and the separate management of functional nervous disorders later saw the makings of psychiatric services within the wider hospital system.

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29 Inspector-General to Minister, 11 April 1910, HMH 1910/345.
30 The balance was disposed of to the Prisons Department, which wanted the land for a vagrants' home, or subsidiary prison to Mt Eden. Controller-General of Prisons to Minister of Justice, 10 April 1930, HMH 13/1/1.
31 E.g., AJHR, 1885, H-10, p. 2, and 1886, H-6, p. 1.
32 Warwick Brunton, *Situation 125: A History of Seaview Hospital and West Coast mental health Services, 1872-1997*, Hokitika, 1997, pp. 30-31. The imposition and accommodation needed to transfer in so many patients, such as the shipment from Sunnyside at short notice in 1903, was greatly disruptive. Official Visitor's report, 22 June 1903, Westland Hospital Board Archives, National Archives, Christchurch, CAHW CH 22/63; Superintendent to Inspector-General (telegram), c. 25 June 1903 and c. 13 July 1903, CAHW CH 22/15, pp. 448-9, 481.
33 Inspector-General to Medical Superintendent, Wellington, 13 May 1895, Inspector-General's Letter Book 6, p. 103, formerly held in the Department of Health head office but current whereabouts unknown; Medical Superintendent, Seaciff to Inspector-General, 22 February 1899, Medical Superintendent's Confidential Letter book, Plunket Society Archives, Hocken Library 89-098-16; Superintendent, The Camp to Inspector-General, 29 July 1906, HMH 21/1/11; Medical Superintendent, Tokanui to Inspector-General, 12 October 1922, MH 2/15/3; Superintendent, Hokitika to Chief Clerk, 2 November 1911, CAHW CH 22/18; Medical Superintendent, Auckland to Inspector-General, 17 September 1918, MH 8/433; Medical Superintendent, Auckland to Inspector-General, 6 May 1925, MH 2/15/3; Director-General to Medical Superintendents, Seaciff and Sunnyside, 11 January 1946, H 30/28/24 (36137).
34 AJHR, 1899, H-7, p. 3.
CLASSIFYING NEWLY ADMITTED AND RECOVERABLE PATIENTS

The hospital model provided the conceptual basis for improving the classification of new and recoverable or convalescent patients. Hay's phrase the 'hospitalization of the institutions',\(^\text{35}\) encapsulated many of these improvements because hospitalization was a key component of wider efforts to counteract the stigma of lunacy, asylums and committal. The process must therefore be linked to simplified admission procedures and practices, less obvious involvement by police and courts, and transforming specialist mental health staff into professionals.

Departmental officials were first attracted to the hospital model in the 1880s. During Hacon's superintendence (1881-7), locally printed stationery was headed 'Sunnyside Hospital for the Insane'.\(^\text{36}\) As early as May 1882, he claimed to have prophesied that the present generation would make use of asylums as 'hospitals for the treatment of diseased brains'. Hacon said that the hospital model was consistent with up to date thinking throughout Australasia.\(^\text{37}\) MacGregor thought that hospitals evoked a sense of greater therapeutic intervention through scientific medicine than did asylums, with their custodial image. In 1887 he wrote:

> Our increasing knowledge of the physiology and pathology of mind is rapidly widening the professional and popular conceptions of mental disease. It is being steadily recognized that insanity must be treated like any other disease, and that therefore to deal with it successfully we must counteract it in its earliest stages. Under the influence of the same ideas asylums for the safe-keeping of lunatics are being transformed into hospitals, whose main object must be by early treatment to prevent mental diseases from becoming chronic and inveterate. [Thus must follow] the improvement of asylums and the consequent lessening of the horror which they formerly inspired, thus inducing the friends of patients to have recourse to timely treatment.\(^\text{38}\)

\(^{35}\) AJHR, 1923, H-7, p. 5.

\(^{36}\) E.g., letter pasted inside Case Book 3, Sunnyside Hospital Archives, National Archives, Christchurch, CH 388/17.


\(^{38}\) AJHR, 1887, H-9, pp. 1-2.
Later that century, when MacGregor's thinking made little headway with the Liberal government, forward-looking medical superintendents, Truby King at Seacliff (1889-1921) and E.G. Levinge at Sunnyside (1887-1904), espoused the specialist hospital model.\textsuperscript{39} To Levinge, mental hospital sounded 'more scientific, euphonious, and less compromising' than 'lunatic hospital'.\textsuperscript{40} MacGregor picked up the theme again, using terms like hospitals for nervous diseases, special hospitals, hospitals for mental diseases, or just mental hospitals.\textsuperscript{41} The term mental hospital crept into official correspondence after July 1905,\textsuperscript{42} and was incorporated in the Mental Defectives Act 1911. The 1911 Act also swept away the nomenclature of lunatics, asylums and idiots. Institutions officially retained the name of mental hospital until 1946.\textsuperscript{43}

Classification of newly admitted and recoverable cases was intended to counter the 'irrational, though kindly meant delay' in sending people for care.\textsuperscript{44} Truby King and Levinge suggested alternative policies to break down the barriers to care. King's initiatives at Seacliff in the 1890s initially steered policy towards the establishment of separate admission and convalescent facilities situated at the periphery of asylum estates. Levinge enunciated care based upon 'some intermediate place of early treatment between the [patient's] home and the asylum'. This would be best attached to general hospital, in line with English trends.\textsuperscript{45} Levinge favoured the development of services in general hospitals. Each approach was duly adopted. During the first phase of classification, mental hospitals separated newly admitted and recoverable patients from other patient groups and drafted them into self-contained new facilities situated some distance from the main buildings and other

\textsuperscript{39} Medical Superintendent's reports, Sunnyside, AJHR, 1898, H-7, p. 8, and 1900, H-7, p. 6; Medical Superintendent, Seacliff to Minister, 28 May 1902, DAHI D 264/24.
\textsuperscript{40} Medical Superintendent's report, Sunnyside, AJHR, 1898, H-7, p. 8.
\textsuperscript{41} Inspector-General's report, Wellington, 17 November 1903, AJHR, 1904, H-7, p. 6; AJHR, 1905, H-7, pp. 1-2; Lunatics Bill 1906, Part II.
\textsuperscript{42} Macgregor signed his annual report, which was dated 1 July 1905, as Inspector-General of Mental Hospitals. AJHR, 1905, H-7, p. 1. Soon afterwards, the Superintendent, Nelson crossed out the printed title of Lunatic Asylum on a memorandum form and wrote in Mental Hospital. Superintendent, Nelson to Inspector-General, 30 August 1905, H 30/28/21 (35252). Macgregor's final report, dated 21 July 1906 reverted to the designation of Inspector-General of Asylums, though he referred to his visits of inspection to mental hospitals. AJHR, 1906, H-7, pp.1, 3.
\textsuperscript{43} Definition of 'institution', s. 2.
\textsuperscript{44} Medical Superintendent's report, Sunnyside, AJHR, 1900, H-7, p. 6.
\textsuperscript{45} Medical Superintendent's report, Sunnyside, AJHR, 1898, H-7, p. 8. Levinge drew upon the example of a psychiatric outpatient clinic at St Thomas's Hospital, London. He reckoned that outpatient services at his 'old school', West Riding Asylum, Wakefield, Yorkshire, were less successful, probably on account of its association with the asylum.
patients. The second phase, of institutional outreach into general hospitals, proceeded under agreement between local hospital boards and the Department.

An underlying theme of these developments should not be overlooked; that is the attempt to create a form of social as well as clinical classification that catered for refined or so-called sensitive patients in public mental hospitals. Moves to accommodate social classification had several origins; one being the growing expectation that public hospitals should be accessible to all classes of the community. Alienists had therapeutic motives for encouraging anyone to seek early treatment in public asylums. Ashburn Hall was underutilised during the long depression. The fee structure put this unique national institution beyond the reach of many people, like private medical care in general, as ‘Hopeful’ noted in 1887. All classes of the community then expected to access publicly funded services like hospitals. Special attendance in public asylums paid for at a higher rate of maintenance was tried in the early days at Seacliff but no distinction could be made in the treatment or surroundings in an overcrowded asylum. There were so many ‘indirect evil results to the organization of the staff that the scheme was abandoned. Despite the failure of the Seacliff experiment, attempts to find a social dimension to patient classification were revived in the development of services for early treatment and neuroses.

In 1900, the two directions for encouraging early treatment, as represented by the ideas of King and Levinge, were clear. The Minister of the day, W. Hall-Jones, opted for building detached villas for convalescent cases and admission wards because specialist professional expertise was concentrated almost exclusively in asylums. MacGregor agreed. A legal framework for general hospital psychiatry existed throughout the period, but MacGregor was anxious to avoid provoking a

47 ‘Hopeful’ [pseudonym], Taken In, London, 1887, [1974 reprint, Christchurch], pp. 84-85.
49 AJHR, 1888, H-8, p. 4; Medical Superintendent, Seacliff to Dr Cross, 14 March 1889, DAHI D 264/11.
50 NZPD, 17 August 1900, 113, p. 72.
51 AJHR, 1905, H-7, p. 4.
52 Lunatics Act 1868, S. 22; Lunatics Act 1882, ss. 67-70; Mental Defectives Act 1911, s. 135.
chronic struggle' between the local rates and general taxation.\textsuperscript{53} Relationships between central government and autonomous local hospital and charitable aid boards were a touchy political subject. Governments of the time were not prepared to antagonize these bodies. The 1911 Act granted the Minister authority to require boards to provide an observation ward, but provided no means of enforcing that authority.\textsuperscript{54} For some years budgetary provision was made for "examination rooms" in the public general hospitals in the main centres, but the money was not spent.\textsuperscript{55} The sensitivity of central-local government relationships and the mind-set of alienists favoured the building of detached villas for convalescent cases and admission wards on the periphery of mental hospital campuses. This became government policy in 1900.\textsuperscript{56} The 'beautiful' Cottage for women newly admitted to Seacliff (1898)\textsuperscript{57} and the reception-cottage at Waitati (1904) convinced MacGregor that these were 'a good beginning on proper lines'.\textsuperscript{58}

By 1905, these pioneering efforts had been successful enough to warrant application elsewhere.\textsuperscript{59} This was a task Hay tackled early in his inspectorate. Convinced that patients were best treated in mental hospitals, Hay pushed for the construction of "reception houses" which, he thought, combined with voluntary admission, would materially contribute to early and scientific treatment of insanity and boost the recovery rate.\textsuperscript{60} General hospital wards, he believed, would only acquire the same stigma as mental hospitals, Hay later told an inquiry into hospitals.\textsuperscript{61}

Financial provision was first made for reception homes at Auckland, Wellington and Christchurch in 1906 but the funds were not spent.\textsuperscript{62} The next facility, Auckland's Wolfe Bequest Hospital (1910),\textsuperscript{63} was expedited by a generous legacy. The Wolfe

\textsuperscript{53} AJHR, 1398, H-7, p. 4.
\textsuperscript{54} Mental Defectives Act 1911, s. 135; Lunatics Act 1882, s. 68. The Act repealed the penalty provision that allowed the Minister to withhold government subsidy from a board that did not comply with the Minister's request.
\textsuperscript{55} Inspector-General to Minister, 19 March 1921, and Inspector-General to Chairman, Hospitals Commission, 23 May 1921, HMH 4/4/2.
\textsuperscript{56} NZPD, 17 August 1900, 113, p. 72.
\textsuperscript{57} AJHR, 1899, H-7, p. 3, and Inspector-General's report, Seacliff, 3 March 1899, p. 10. King's annual reports made no reference to it.
\textsuperscript{58} AJHR, 1905, H-7, pp. 3-4.
\textsuperscript{59} NZPD, 12 July 1905, 132, pp. 490-2.
\textsuperscript{60} AJHR, 1907, H-7, p. 7.
\textsuperscript{61} Inspector-General to Minister, 19 March 1921, and Inspector-General to Chairman, Hospitals Commission, 23 May 1921, HMH 4/4/2.
\textsuperscript{62} C.M. Gray (Christchurch North), NZPD, 15 November 1907, 142, p. 948.
\textsuperscript{63} AJHR, 1911, H-7, p. 7.
Home (as it was popularly known) was grander than the Seacliff precedents. The 38-bed block made provision for men and women patients in separate wings. Hay intended that the place should develop 'general hospital ideals as far as desirable'. Hay intended to repeat the same design, with modifications as necessary, at Porirua and Sunnyside.\textsuperscript{64} The Rauta block at Porirua (1917), however, followed a different style and was larger than the Wolfe Home. One hundred beds were arranged in four pavilions to give separate care to early or convalescent cases and to the physically sick. The block also contained a 30 bed nurses' home.\textsuperscript{65} Sylvan Annexe, at Sunnyside (1919), whose construction was held up by the war and construction problems,\textsuperscript{66} was of comparable size and scale. Smaller units were built elsewhere. These were the 15-bed male reception unit, Clifton House (1916) at Seacliff,\textsuperscript{67} Braemar Lodge at Nelson (1923),\textsuperscript{68} the admission block at Hokitika (1924),\textsuperscript{69} and male and female reception units at Tokanui (1922 and 1926 respectively).\textsuperscript{70} Appearances were important in every case. All were situated some distance away from the main mental hospital buildings and were approached by a separate entranceway through well-tended grounds. A newly arrived 'saner and more self-respecting' patient should see only presentable worker patients and not 'untidy, obviously imbecile or demented patients'.\textsuperscript{71}

The 1920s equivalent of the reception home was the "neuropathic hospital" of the sort envisaged by Mrs Coleridge Farr\textsuperscript{72} in 1915. She thought that people from superior paying classes who were used to 'delicate surroundings' should be able to enter one of these 'real hospitals' and be spared the humiliation of having to be treated among ordinary mental hospital patients.\textsuperscript{73} She convinced Christchurch doctors, H.G. Ell (Liberal, Christchurch South) and the Christchurch based Minister,

\begin{itemize}
\item \textsuperscript{64} AJHR, 1909, H-7, p. 6.
\item \textsuperscript{65} The block has the same Maori name as the hill on which it stands. Medical Superintendent's report, Porirua, AJHR, 1918, H-7, p. 8.
\item \textsuperscript{66} AJHR, 1918, H-7, p. 5, and 1920, H-7, p. 6.
\item \textsuperscript{67} AJHR, 1917, H-7, p. 3.
\item \textsuperscript{68} AJHR, 1924, H-7, p. 5.
\item \textsuperscript{69} AJHR, 1925, H-7, p. 7.
\item \textsuperscript{70} AJHR, 1923, H-7, p. 6; Medical Superintendent's report, Tokanui, AJHR, 1927, H-7, p. 10.
\item \textsuperscript{71} The reception ward was named Hay in honour of the late Inspector-General.
\item \textsuperscript{72} Mrs Farr was the wife of the Professor of Physics at Canterbury University College. She had a history of mental illness. J. Campbell, 'Farr, Clinton Coleridge', DNZB, Vol. 4, Auckland, 1998, p. 168; M. Lewis, \textit{Managing Madness}, Canberra, 1988, p. 124; Petition 1935/160, HMH 26/24; AJHR, 1935, I-1, p. 3.
\item \textsuperscript{73} Mrs C. Farr to Minister, 24 October 1915, HMH 19/1/10.
\end{itemize}
G.W. Russell, of the merits of the scheme.\textsuperscript{74} The next Minister, Sir Francis Bell (1919-20) praised the idea because it would save wealthy families from sending insane relatives abroad.\textsuperscript{75}

Farr’s idea materialized as The Lodge, near at Hornby, near Christchurch in 1922.\textsuperscript{76} Suitable premises amid spacious surroundings were bought for a 10-13 bed home for ‘well conducted ladies’ in 1919. The home was placed under the oversight of Sunnyside Mental Hospital, but Hornby Lodge was intended to have its own resident doctor, matron, nursing staff, domestics and farm staff. Patient labour was not to be utilized.\textsuperscript{77} Arrangements could be made for a private sitting room or special private nurses.\textsuperscript{78} To ensure that Hornby Lodge was a paying proposition, legislation was amended to authorize higher fees.\textsuperscript{79} The minimum fee was £7.7s.0d. with special arrangements possible for extended stay, or extra care.\textsuperscript{80} This fee can be contrasted with Ashburn Hall's fee structure in 1939, when the standard weekly rate was £5.5s.0d. Extra care or attendance for homicidal or suicidal patients cost a further guinea or two. Constant individual care for patients who were actively homicidal or suicidal cost between £9.9s.0d. to £15.15s.0d.\textsuperscript{81}

The boundary between clinical and socio-economic considerations in the establishment of Hornby Lodge was blurred. Hay was sympathetic to the establishment of other lodges for men at Christchurch,\textsuperscript{82} and at Auckland,\textsuperscript{83} but

\textsuperscript{75} NZPD, 14 October 1919, 185, p. 326.
\textsuperscript{76} Hay had trouble choosing the name. “Hornby House, Hornby” was too alliterative. “The Lodge, Hornby” would look good on note paper but the size of the premises did not fit the dictionary meaning of the term. The choice was made after discussion with the Minister. Inspector-General to Medical Superintendent, Sunnyside, 28 March 1922, Sunnyside Administration File 1921/43, formerly held at the Hospital, but current whereabouts unknown. To distinguish this from similarly named facilities, I have used the name Hornby Lodge.
\textsuperscript{77} Medical Superintendent Sunnyside to Inspector-General, 14 April 1919, Inspector-General to Minister, 26 May 1919, HMH 19/1/1a; Inspector-General to Medical Superintendent, Sunnyside, 2 June 1919, Sunnyside Hospital Administration File 182; Inspector-General Circular, 16 February 1922, Sunnyside Hospital Administration File 1921/43.
\textsuperscript{78} Inspector-General, Circular, 13 July 1922, Sunnyside Administration File 1921/43.
\textsuperscript{79} AJHR, 1918, H-7, p. 3, and 1919, H-7, pp. 4-5; Appropriation Act 1918, s. 36.
\textsuperscript{80} Inspector-General Circular, 16 February 1922, Sunnyside File 1921/43.
\textsuperscript{81} Medical Superintendent, Ashburn Hall to Director-General of Health, 23 November 1939, H 209/2/8 (30407); Director-General of Health to Medical Superintendent, Ashburn Hall, 19 December 1939, HMH 3/71. The basic fee was reduced a little for clergymen, religious or persons in strained circumstances and for two very long-term patients. The fees were raised in 1946 to a level comparable with a private hospital. Solicitors for Ashburn Hall to Director-General of Health, 20 June 1946, HMH 3/71/1.
\textsuperscript{82} Minister, NZPD, 6 October 1922, 197, p. 668.
\textsuperscript{83} Inspector-General to Minister, 22 March 1919, HMH 8/490.
neither proposal came to anything.\textsuperscript{64} By 1926, Gray, writing as Deputy-Inspector-General, referred to Hornby Lodge as a ‘hospital for nervous affections’.\textsuperscript{65} ‘Naturally’, he claimed later, the possession of wealth was not a sound or workable basis for classifying mental patients.\textsuperscript{66} Those who wanted to pay more were directed to Ashburn Hall or to Sunnyside Mental Hospital,\textsuperscript{67} and Hornby Lodge turned into a neuropathic hospital for men (1926).\textsuperscript{68} Small neuropathic hospitals were opened at Puketeraki, Otago (1928),\textsuperscript{69} and The Lodge, at Auckland (1931).\textsuperscript{70} Advertising them in 1928, Gray described neuropathic hospitals as ‘entirely detached curative sanatoria’ designed to promote individual treatment. Their attractive grounds and amenities left ‘little to be desired’ and avoided ‘the appearance of an “institution”’.\textsuperscript{91} Apart from Auckland, these buildings were located several miles from their parent institutions.

Separate admission and convalescent units associated with mental hospitals did not placate those sections of the community that wanted acute care and treatment to be provided independently. Gray bluntly blamed the demand upon

Parents and kinsmen [who] are unable to accept the suggestion that the patient is “a mental patient” or in popular language a “lunatic”. They are quite willing to admit to a “nervous breakdown” and to agree to his admission to a “half-way house”, but it is almost impossible to convince them that most of the cases which fill our mental hospitals began as nervous breakdowns or in other words had an incipient stage.\textsuperscript{92}
The first moves towards the formation of separate services for neuroses in the wider hospital system began in December 1915. Initial arrangements for managing soldiers with war neuroses assumed correctly that public opinion would not countenance committal or treatment in the main buildings of mental hospitals except in extreme circumstances. Representatives from key government departments and the organized medical profession decided, therefore, that shock patients who were not physically incapacitated should be looked after by committees of patriotic ladies according to the '[social] class of people' from which the soldiers came. More serious cases that needed some restraint or specialist treatment were to be handled in special facilities away from mental hospitals as much as possible. Truby King loaned his seaside house at Karitane, but it could not cope with the number sent there. Premises later known as Anzac House Hospital were then made available at Puketeraki, three miles north of Seacliff. If soldiers needed something akin to mental hospital treatment, they were sent to the male reception ward at Seacliff. Seacliff's national role was complemented in 1917, when the Wolfe Home was taken over as an 'intermediate institution' for North Island soldier patients with 'neurasthenia, shell-shock, and other nervous disorders'. Defence authorities marked mental disorder behind euphemisms. "Shock cases" ... might mean anything or nothing. Patriotic, veterans and women's organizations and backbench Members of Parliament were upset at any hint that soldiers were not segregated from other mental patients.

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93 Director of Military Hospitals to Director-General of Medical Services, 21 April 1916, Army Department Archives, National Archives, Wellington, File AD 49/301; AJHR, 1916, H-7, p. 3.
94 According to Clarke, this may have been meant for officers. R. Clarke, "Not Mad but Very Ill": The Treatment of New Zealand's Shellshocked Soldiers, 1914 to 1939, MA Thesis, University of Auckland, 1991, p. 52.
95 Notes of conference between Minister, Chief Health Officer, the Inspector-General and New Zealand Branch, British Medical Association, 20 December 1915, HMM 8/114; AJHR, 1917, H-7, p. 4. Clifton House and the Library Ward were back-ups at Seacliff. AJHR, 1918, H-7, p. 27.
96 Deputy Inspector-General to Director of Military Hospitals, 15 May 1917, AD 49/301.
97 Dominion, 26 March 1917.
98 Inspector-General to Director of Military Hospitals, 11 May 1916, HMM 8/163. See also Director-General of Medical Services, Circular, 19 May 1916, and Director-General of Medical Services to Principal Medical Officer, Featherston, 2 August 1917, AD 49/301.
99 E.g., Observer, 27 January 1917; Minister of Defence to Minister, 23 February 1917, HMM 8/284; Returned Servicemen's Association reported in New Zealand Herald, 22 March 1917; H.T.J. Thacker (Liberal, Christchurch East), J. Payne (Labour, Grey Lynn), C.H. Poole (Liberal, Auckland West), J.A. Young (Reform, Waikato), T.M. Wilford (Liberal, Hutt), and W.T. Jennings (Liberal, Taumarunui), NZPD, 19 July 1919, 185, pp. 171 and 327-8; C.H. Poole (Liberal, Auckland West), NZPD, 14 October 1919, 185, p. 321; Secretary, Auckland Branch, Victoria League to Minister of Internal Affairs, 23 January 1919, AD 49/301; Secretary, Waipawa Branch, Women's Christian Temperance Union to Minister, 19 May 1919, HMM 44/2; Minister of Defence to Secretary, Gisborne Citizen's Defence Committee, 28 August 1919, Secretary, Auckland R.S.A. to Minister of Defence, 26 September 1919, Secretary, Dunedin R.S.A. to Minister of Defence, 20 November 1919, AD 49/301; Secretary,
Put another way, the special consideration given to soldier patients implicitly meant providing different services for treating neuroses. Reversion to peacetime administration accelerated the separation. 'Borderland' cases were transferred to Queen Mary Hospital, Hanmer Springs when Wolfe Home and Anzac House stopped being used for soldiers. That hospital began as a special military convalescent hospital in 1916, but soon acquired a specialist role with war neuroses. Between 1916 and 1920, some 700 cases of a 'light mental nature' passed through the hospital, sufficient for the hospital to be accepted as a specialized 'neurological centre' after June 1919.

Public vigilance is the most likely explanation why, in January 1922, Queen Mary Hospital was decommissioned to civilian control under the Department of Health and not the Mental Hospitals Department. The following year the Minister caused embarrassment when he suggested that Queen Mary Hospital dealt with borderline mental cases. Hospital authorities reacted sharply: the hospital treated nervous diseases and not minor mental states. Patients were admitted for hysteria, 'true neurasthenia', psychasthenia, very early borderland cases and later, alcoholism and the drug habit. Patients received 'special psychological treatment' from the first designated psychiatrists employed in the Public Service. In the 1920s, patients

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Christchurch R.S.A. to Prime Minister, 14 January 1920, HMH 8/569; Secretary, Taranaki Provincial War Relief Association to Minister of Defence, 16 June 1920, AD 49/301/1; New Zealand Medical Journal, 20, 1921, pp. 152-3.

Inspector-General to Director-General of Medical Services, 13 August 1919, HMH 8/521; Director-General of Medical Services to Assistant Director of Medical Services, Canterbury, 29 May 1920, AD 49/261/1.

D.E. Fenwick, 'The Neuroses and their Treatment', New Zealand Medical Journal, 19 (1920), p. 213. This figure may be contrasted with the 334 military patients who were admitted to mental hospitals during the five years ended 4 August 1919. Two-thirds of these were voluntary boarders or informal cases who went home 'recovered'. Committals numbered 168 and by 1919, 35 per cent of these had also been discharged recovered. AJHR, 1919, H-7, pp. 27-28.

Director-General of Medical Services to Officer in Charge, Hanmer Springs, 21 September 1920, AD 49/261/1.

Instruction from General Headquarters, 18 January 1922, AD 49/261/1.

Minister reported in Press, 14 May 1923.

Medical Superintendent Queen Mary to Director-General of Health, 16 May 1923 and Director-General of Medical Services to Minister of Defence, 23 May 1923, H 54/79.

P. Chisholm and R. Baxter, 'The Value of Hanmer to the General Practitioner: Suitable and Unsuitable Cases', New Zealand Medical Journal, 21, 1922, pp. 140-4; Fenwick, pp. 215-21; Director-General of Health, Circular to General Practitioners, 12 November 1925, YCAA 1079/1i, File 2/6/1A.

'Vanquisher', London to 'Defender', Wellington [coded telegram], 20 February 1919, and Director of Medical Services, New Zealand Expeditionary Force to Director-General of Medical Services, 24 (?) July 1919, AD 49/922; Chisholm and Baxter, pp. 140-4; Fenwick, pp. 215-21; Director-General of Health, Circular to General Practitioners, 12 November 1925, YCAA 1079/1i, File 2/6/1A.

The first doctors were trained in psychotherapy at the Maudsley Hospital, London, and recruited when Queen Mary Hospital was still under military control.
were charged £3.3s.0d per week. A certain number developed mental disorders and had to be committed to mental hospitals.

The stories of early treatment facilities for all forms of mental disorder, classification of newly admitted and convalescent patients in mental hospitals, special services for functional nervous disorders, and attempts to accommodate well-to-do and sensitive patients are very difficult to untangle. Confusion was compounded when vague names were bandied about as euphemisms for acute psychiatric services. For example, in 1946 the medical superintendent called Queen Mary Hospital a half way house, but Hay also called reception houses or Hornby Lodge halfway houses. Borderland or borderline homes, ‘mid-way institutions’, mental rest homes and special mental hospitals were other terms, but halfway houses were the most common. The common thread in all these names was separate treatment outside mental hospitals for a muddled range of symptoms and mental disorders.

Mental hospital administrators and those they advised tried to explain how existing facilities met certain needs. Hay thought no useful purpose would be served by setting up borerland homes when reception houses were available. The Minister, J.A. Young, declared in 1926, but defined halfway house as a ‘place where

108 Department of Health, Appendix to the Annual Report (Hospitals and Charitable Institutions Statistics), Wellington, 1924, p. 19. A single room cost £5. 5s.0d. per week. Director-General of Health, Circular to General Practitioners, 12 November 1925, OK 2/6/1a.
109 Director-General to Minister, 2 June 1933, H 30/25/5 (59635).
110 Medical Superintendent, Queen Mary to Director-General of Health, 19 March 1946, H 11/19/4 (45604).
111 Inspector-General to Minister, 2 October 1919, AD 49/301; NZPD, 1 November 1921, 191, p. 997; Inspector-General to Minister, 9 April 1923, HMH 4/4/2; Press, 16 April 1923.
112 Minister to Corresponding Secretary Christchurch Branch, Women’s Christian Temperance Union, 31 August 1918, HMH 4/4/2.
113 Minister to Secretary, Hospital Boards’ Association, 22 June 1937, HMH 4/4/2.
114 Otago Witness, 27 March 1923.
115 Secretary, Christchurch Branch, National Council of Women to Minister, 8 June 1920, HMH 44/4/2.
116 E.g., ‘Deeply Interested’ letter to Lyttelton Times, 20 April 1921; E.J. Howard (Labour, Christchurch South), NZPD, 1 November 1921, 191, p. 994, Minister of Defence to Minister, 3 July 1923, H 54/79 (11305); T.K. Sidey (Liberal, Caversham), NZPD, 30 July 1923, 201, p. 365; Tauranga Returned Services Association reported in Bay of Plenty Times, 8 April 1924; Secretary, New Zealand Returned Services Association to Minister, 12 August 1924, HMH 4/4/2; W.H. Field (Reform, Otaki), and J. O’Brien (Labour, Westland), NZPD, 19 August 1924, 204, pp. 174-5; H. E. Holland, (Labour, Buller), A. Harris (Reform, Waitemata), H.G.R. Mason (Labour, Eden), H.L. Tapley (Reform, Dunedin North), and J. Horn, (National, Wakatipu), NZPD, 6 August 1926, 210, pp. 270-1, 277, 279; Notes of meeting of a Deputation of the New Zealand Justices of the Peace Association and the Minister, 12 June 1930, HMH 4/4/2; Secretary, Canterbury Women’s Club to Minister, 2 September 1930, HMH 4/4/2; Mother Machree to Minister, 19 December 1935, HMH 4/4/3; Secretary, Women’s Christian Temperance Union to Minister, 30 April 1937, HMH 4/4/2; Secretary, Women’s Service Guild to Minister, 21 October 1937, HMH 4/4/8.
people who are not badly afflicted with mental disease, or who are in an incipient stage, can be lodged among happy and suitable surroundings so that they may enjoy every inducement to forget the cause of their being there or, rather, the cause of their breakdown in health.' He noted that 'experts and heads of the mental departments' disliked that expression. Hay, for instance, thought that halfway houses would need their own trained specialists and beautiful grounds. They would acquire the same stigma as mental hospitals. Their only benefit would be 'largely a matter of sentiment for the relatives' King dismissed halfway houses because they would only become 'half a dozen small struggling independent colonies under new queen bees.' They would be too isolated and their patients would become depressed and self-centred. Halfway houses would deprive patients of the company of chronic patients who could entertain them with card games or singing. The large staff needed in a halfway house would isolate the expertise of mental hospital doctors. King agreed with Hay that halfway houses would acquire the same stigma as mental hospitals.

Official explanations and comparisons did not satisfy a steady call from various pressure groups for psychiatric care to be provided outside mental hospitals. While the ailing Hay stayed doggedly in office, he probably saw the need for major change but lacked the energy to bring it about. Psychiatrists, however, recognized that existing services were grossly out of date.

With Hay abroad on extended sick leave in 1924, the time was ripe for overdue reform. By 1925, some hospital boards were prepared to play a part. By-laws may technically have excluded the insane from treatment, but hospital statistics show a changing picture. Table 11 shows a notable growth in the transit care provided

\[\text{Table 11 shows a notable growth in the transit care provided}\]

\[\text{Minister in NZPD, 6 August 1926, 210, p. 280.}\]
\[\text{Inspector-General to Minister, 24 October 1918, HMH 4/4/2.}\]
\[\text{AJHR, 1925, H-7, pp. 5-6.}\]
\[\text{E.g., Medical Superintendent, Sunnyside to Inspector-General, 3 August 1923, Sunnyside Administration File 1922/138; J. Macpherson, Tokanui Hospital, letter to \textit{Lyttelton Times}, 18 May 1921; M. Barkas to Hon. W.H. Triggs [and confidentially circulated to medical superintendents], 1 July 1923, HMH 4/4/2; AJHR, 1925, H-7, p. 1.}\]
### TABLE 11

CASES OF MENTAL DISORDER DISCHARGED FROM GENERAL HOSPITALS, SELECTED YEARS 1876-1920

<table>
<thead>
<tr>
<th>Year</th>
<th>Close</th>
<th>Distant</th>
<th>Total</th>
<th>% Distant</th>
</tr>
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<tr>
<td>1876</td>
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<td>12</td>
<td>24</td>
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<td>1880</td>
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</tr>
<tr>
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<td>504</td>
<td>85</td>
<td>589</td>
<td>47.0</td>
</tr>
</tbody>
</table>

**Notes:**

1. No information was published for 1910.
2. "Close" hospitals were those in the main centres or accessible to a mental hospital by road or rail travel within two hours.

**Source:** *Statistics of the Colony of New Zealand (1876-1910), Vital Statistics (1920).*
for mental patients by individual hospitals until 1920, when the information was no longer collected in that form. This was particularly so for general hospitals far away from mental hospitals and gradually became normal practice.\(^{122}\) Table 12 is also interesting because it shows a steady rise in the admission of mental cases of all forms to general hospitals. The majority were discharged as unrelieved, which suggests that they were transferred to mental hospitals. This was almost certainly so for patients encompassed by the diagnostic groups 'Insanity &c.' or 'Insanity, General Paralysis of the Insane'. Yet the statistics show that hospitals actively treated alcoholism and the neuroses\(^{123}\) as gauged by the proportion of patients discharged ‘recovered’.

Where and how these patients were treated in general hospitals is not so readily ascertainable. Clues provided by public inquiries at Dunedin Hospital (1891) and Auckland Hospital (1905) showed that each had a padded room in the basement.\(^{124}\) The room at Dunedin Hospital was very different from the examination rooms proposed by Seacliff’s first medical superintendent in 1884\(^{125}\) and probably a far cry from the ward for psychiatric cases that A.R. Falconer, the hospital’s one time medical superintendent remembered being there about 1906.\(^{126}\) The Auckland Hospital Inquiry found that the hospital had great difficulty in dealing with people ‘just on the borderline of absolute insanity’. Doctors refused to certify most of them so they could not be sent to the asylum. Like people with delirium tremens, they were usually sent to the typhoid ward where they constantly disturbed the fever

\(^{122}\) Medical Superintendent Cook Hospital Board to Director-General of Health, 22 November 1945, H 53/97/7 (42463). My father, who worked as a porter at Cook Hospital, Gisborne about 1938, remembered that a padded room was used occasionally for violent mental patients until they could be sent to a mental hospital.

\(^{123}\) Queen Mary Hospital figures were not included. AJHR, 1891, H-1, Report (p. 5) and evidence of F.C. Batchelor (p.25); AJHR, 1905, H-22A, pp. 3-4.

\(^{124}\) Medical Superintendent, Seacliff to Clerk, Head Office, 22 August 1884, DAHI D264 10.

\(^{125}\) Lecture reported in Otago Daily Times, 8 November 1932. Falconer was the senior house surgeon at the hospital in 1905. As Resident Medical Officer (1907-10) and Medical Superintendent (1910-27), Falconer was very interested in mental health. In 1908, he claimed to have wanted a reception (observation) ward, but in 1923, he mooted plans for a ‘home’ to treat voluntary boarders at Wakari Hospital, Dunedin, for incipient and borderline mental states. Falconer said that Wakari Hospital was already taking in cases of nervous breakdown. Medical Superintendent, Dunedin Hospital to Secretary, Otago Hospital and Charitable Aid Board, 23 February 1923, H 54/79 (11305). The Dunedin Evening Star, 28 July 1925 gives a slightly different story, saying that plans for a ward at Dunedin in 1908 and at Wakari in 1913 failed because of a want of funds and because the Board could not convince the Department of Public Health, Hospitals and Charitable Institutions.
### TABLE 12
MENTAL DISORDERS TREATED IN GENERAL HOSPITALS,
SELECTED YEARS 1876-1940

<table>
<thead>
<tr>
<th>Year</th>
<th>Addictions (All Forms)</th>
<th>Mental Disorders</th>
<th>Epilepsy</th>
<th>Old Age / Senility</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1876</td>
<td>120</td>
<td>24</td>
<td>32</td>
<td>30</td>
<td>206</td>
</tr>
<tr>
<td>1880</td>
<td>129</td>
<td>46</td>
<td>69</td>
<td>84</td>
<td>328</td>
</tr>
<tr>
<td>1890</td>
<td>148</td>
<td>37</td>
<td>48</td>
<td>84</td>
<td>317</td>
</tr>
<tr>
<td>1900</td>
<td>184</td>
<td>57</td>
<td>60</td>
<td>60</td>
<td>361</td>
</tr>
<tr>
<td>1910</td>
<td>...</td>
<td>...</td>
<td>...</td>
<td>...</td>
<td>...</td>
</tr>
<tr>
<td>1920</td>
<td>346</td>
<td>699</td>
<td>185</td>
<td>431</td>
<td>1661</td>
</tr>
<tr>
<td>1930</td>
<td>364</td>
<td>1322</td>
<td>218</td>
<td>315</td>
<td>2219</td>
</tr>
<tr>
<td>1940</td>
<td>449</td>
<td>1472</td>
<td>351</td>
<td>381</td>
<td>2653</td>
</tr>
</tbody>
</table>

**Notes:**
1. Categories follow the prevailing international classification of disease (see appendix 6).
2. Mental disorders include all forms of psychoses and neuroses but exclude mental retardation.
3. Addictions include alcoholism and drug dependency of all forms.
4. Until 1900, the category "Old Age" is assumed to include senility.
5. Figures exclude attempted suicides.
6. Figures exclude Queen Mary Hospital.

**Sources:** *Statistics of the Colony of New Zealand* (1876-1910); *Vital Statistics* (1920-40).
patients.127 Both Dunedin and Auckland Hospitals did more than Christchurch Hospital in 1905. It simply would not touch lunacy cases.128

The limited or non-existent efforts of metropolitan general hospitals were a far cry from a ward for cases of incipient insanity expected of an ideal hospital and charitable aid board in 1910.129 Boards faced no political or fiscal pressure to meet this expectation; the government department that funded hospital boards preferred 'moral suasion' to direct intervention. Officers of the Department of Public Health, Hospitals and Charitable Aid, however, knew that seldom was there a question of any importance where the Department's requirements were not eventually acceded.130 It was to prove so for psychiatric services. In 1924, the Hospital Boards' Association, acting on the motion of the North Canterbury Hospital Board, passed a resolution that, among other things, called for wards in general hospitals to receive 'borderline cases'.131

The conference resolution paved the way next year for local initiatives by interested boards.132 Accompanied by the Director-General of Health, Sir Truby King met the Wellington Hospital Board in January 1925. The successful talks resulted in a national first. Doctors from Porirua started a weekly outpatient 'clinic for nervous affections' at Wellington Hospital without any implication of 'insanity, mental breakdown, or so-called "border-line" trouble'.133 Other mental hospitals started clinics as well, first in the main cities and then in other regional centres, as medical staffing allowed.134 Outpatient clinics handled a constant stream of referrals by relatives, general practitioners, honorary consultants and the Pensions Department.135 Clinics quickly proved their worth by obviating the need for

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127 AJHR, 1905, H-22A, pp. 3-4.
128 Ibid., p. 75.
129 AJHR, 1910, H-22, pp. 7-8.
130 Replies to questions asked by Mr Hanify for the information of the Hon. J. Huxham, Secretary for Public Instruction, Brisbane, 12 April 1920, H 170/3 (12345).
131 Director-General of Health to Inspector-General, 14 January 1925, HMH 21/28/1.
132 Acting Director-General of Health to Inspector-General, 19 June 1925, H 30/19/11 (28449).
133 Inspector-General to Head Office (telegram), 9 May 1925, H 30/19/11 (28449); D.M. McDonald to Inspector-General (personal), 27 June 1925, HMH 21/28/1; Chairman, Auckland Hospital and Charitable Aid Board reported in Auckland Star, 22 July 1925; Acting Director-General of Health to Inspector-General, 3 August 1925, H 30/19/11 (28449); Secretary, Southland Hospital Board to Minister, 7 August 1925 and reply, 30 September 1925, H 30/19/11 (28449).
134 E.g., Medical Superintendent's report, Porirua, AJHR, 1939, H-7, p. 8; Director-General to Medical Superintendent, Palmerston North Hospital, 14 December 1942, H 30/19/11 (28449).
135 Dominion, 3 January 1925; Secretary, Wellington Hospital Board to Acting Director-General of Health, 28 July 1925, H 30/19/11 (28449); AJHR, 1925, H-7, p. 2.
admission to a mental hospital,\textsuperscript{136} greater self-referral with better prospects of recovery,\textsuperscript{137} and sparing people the humiliation of a court appearance.\textsuperscript{138}

Outpatient clinics for nervous affections were followed by "child guidance clinics". Child guidance clinics, run by psychiatrists and social workers, began at Auckland and Wellington in 1929 and were the genesis of specialist child psychiatry services.\textsuperscript{139} Within a few years of inception, these clinics changed their focus from assessing children for mental retardation to providing specialist advice on child behaviour problems. J. Russell, Deputy Director-General, who ran the Wellington clinic, considered that the clinics could detect personality traits that foreshadowed future psychosis or psychoneuroses. He believed that if adjustment could be made in the most suitable environment, abnormal mental conditions might be arrested or moderated.\textsuperscript{140}

In 1925, King secured £2,000 to tempt large hospital boards to provide adequate transit care facilities.\textsuperscript{141} ‘Suitable rooms ... where mental patients can be suitably lodged and properly cared for pending medico-legal examination and up to the time of despatch to a mental hospital – if committed as insane’, King described them. Gray flatteringly called them ‘psychopathic wards’,\textsuperscript{142} but expected them to have the same modest function earlier suggested by Hay and King,\textsuperscript{143} as befitted a scale of 6-12 beds. With New Zealand's small and scattered population, Gray saw no sense in copying the residential treatment centres or psychopathic hospitals like those he saw overseas. His psychopathic wards were no more than 'observation blocks' where patients could be given a more exhaustive examination by a psychiatrist and other

\textsuperscript{136} AJHR, 1930, H-7, p. 1, 1931, H-7, pp. 3-4. Of the 580 new cases seen at outpatient clinics at Auckland and Wellington in 1933, only 147 were referred for admission to a mental hospital. AJHR, 1934, H-7, p. 2.

\textsuperscript{137} Medical Superintendent, Porirua to Inspector-General, 6 July 1926 in AJHR, 1926, H-7, p. 2, and AJHR, 1931 H-7, p. 4.

\textsuperscript{138} New Zealand Herald, 11 August 1927.

\textsuperscript{139} Early intervention services differed from outpatient psychiatric clinics in several respects. They were run by the Department, even though they had been set up by the Eugenics Board to assess children for mental deficiency who had been referred by families, social services, courts, and doctors.

\textsuperscript{140} AJHR, 1933, H-7, pp. 3-4.

\textsuperscript{141} Inspector-General to Head Office (telegram), 9 May 1925, H 30/19/11 (28449); D.M. McDonald to Inspector-General (personal), 27 June 1925, HMH 21/28/1; Chairman, Auckland Hospital and Charitable Aid Board reported in Auckland Star, 22 July 1925; Acting Director-General of Health to Inspector-General, 3 August 1925, H 30/19/11 (28449); Secretary, Southland Hospital Board to Minister, 7 August 1925 and reply, 30 September 1925, H 30/19/11 (28449).

\textsuperscript{142} AJHR, 1927, H-7, p. 3, and 1929, H-7, p. 2.

\textsuperscript{143} Inspector-General to Minister, 19 March 1921, HMH 4/4/2.
specialists. The Governor-General opened Wellington Hospital's male observation ward in March 1928. A women's ward was opened in June 1936 with nurses seconded from Porirua. A psychopathic ward was opened at Dunedin Hospital in 1936. Plans for Princess Margaret Hospital, Cashmere, Christchurch, envisaged three categories of mentally ill persons and male and female wards.

The Auckland Hospital Board was the most reluctant of the four major hospital boards, wary of a central government trick to dump on the Board. The ward used sometime after 1942 was hardly lavish.

By encouraging mental care in general hospitals the Department did not intend to relinquish an active role in acute psychiatric treatment. Gray made it known very early in his directorate that as a general policy he preferred not to treat acute mental illness in general hospitals. Gray's overseas study tour convinced him that 'psychopathic hospitals' built in general hospitals were too expensive to run, their therapeutic purpose clouded by a teaching role. He also thought that these facilities were prone to the same stigma as traditional institutions.

Gray was also concerned that if hospital boards appointed their own psychiatrists they might have the right of private practice. Departmental officers did not have that advantage so they might be tempted to switch employers. Reports from Porirua in 1937-8 hint that mental hospital administrators may have feared that general hospitals would "capture" the interesting acute work, which would have left mental hospitals with a residual and custodial role with chronic patients.

B.D. Hart, Medical Superintendent

AJHR, 1928, H-7, p. 2.

Dominion, 12 March 1928.


Director-General to Minister's Private Secretary, 31 March 1937, HMH 26/8.

Christchurch Star-Sun, 23 May 1946.

New Zealand Herald, 21 August and 16 October 1929; Minister, NZPD, 2 October 1929, 223, p. 275. The Chairman incorrectly said that the North Canterbury and Wellington Hospital Boards shared his suspicion, although the track record in Wellington suggests otherwise. Director-General of Health to Secretary, Auckland Hospital Board, 10 March 1943, H 53/977 (42463).

New Zealand Truth, 29 February 1945, HMH 28/39. I have been unable to ascertain clearly when this ward was opened. The gist of similar criticism by Mrs M.M. Dreaver (Labour, Waitemata) in NZPD, 20 August 1942, 261, p. 608 suggests that provision may have changed little beyond the padded room(s) mentioned at the 1905 Auckland Hospital Inquiry. That was certainly so in 1933. Gillian Boddy and Jacqueline Matthews, Disputed Ground: Robin Hyde, Journalist, Wellington, 1981, p. 45. In 1946, the Medical Superintendent of the Auckland Mental Hospital discussed with his counterpart at Auckland Hospital the need for a 'psychiatric ward' at Auckland Hospital. Although interested, the board's medical superintendent said that it was contingent upon buildings and would take time. AJHR, 1947, H-7, p. 5. J.S.B. Lindsay recalled that Dr Gordon Short was appointed as the Board's psychiatrist in 1942. J.S.B. Lindsay to P.P.E. Savage, 31 March 1966, original held by addressee.
of Porirua made it clear that a general hospital ward was not supposed to be a subsidiary mental hospital. The mental hospital 'alone' could provide the necessary specialized care and treatment for all well-defined cases of psychosis. In 1938, Hart reported that the 'psychiatric wards' of Wellington Hospital provided both observation and 'where possible, early treatment of cases exhibiting mental or nervous symptoms'. He stressed, however, that these services took place 'under our supervision'.

Gray did not envisage providing observation wards outside the major cities so plans of provincial hospital boards were toned down and clinics started instead. J. Russell, Acting Director-General (1947), had fewer qualms about general hospital psychiatry than Gray. His vision of psychiatric services in Otago was markedly different from Gray's. Convinced that a 'treatment hospital' should be located in Dunedin, Russell advised the Minister to develop a 50-bed unit for men and women at Wakari Hospital or Ashburn Hall (if it were nationalized). Cherry Farm should be restricted to 600 beds for chronic cases. Russell also envisaged a 25-30 bed mixed unit and outpatient service at the Nelson Mental Hospital site which was across the road from Nelson General Hospital.

By 1940, when policies were settled for handling military casualties, the availability of inpatient and outpatient psychiatric services in general hospitals, growing public acceptance of mental illness, and a crude system for screening recruits meant that arrangements were different from those adopted in the Great War. An interdepartmental report of November 1940 advised the Government not to hide behind euphemisms. 'There is no advantage to be gained in labelling a general paralytic, an epileptic, or a frankly insane man as a "neurasthenic" or "Shellshock" case,' the report said. All such cases were officially psychiatric. Invalided soldiers provisionally classified as mental, psychoneurotic or epileptic on a hospital ship were

\[155\] Medical Superintendent's report, Porirua, AJHR, 1938, H-7, p. 8.  
\[156\] AJHR, 1927, H-7, p. 3.  
\[157\] For Southland Hospital Board, see Medical Superintendent, Southland to Director-General, 12 March 1929 and reply, 19 March 1929, Medical Superintendent, Seacliff to Director-General, 30 July 1929, and Director-General of Health to Director-General (private), 26 September 1929, HMH 21/28. For Wanganui, see Director-General of Health to Director-General, 7 August and 21 October 1946, H 30/19/11 (28449); Wanganui Chronicle, 20 September 1946.  
\[158\] Director to Minister, 2 March 1948, H 44/1/33 (31344).  
\[159\] Director to Medical Superintendent, Nelson, 9 March 1948, MH 7/6/1.  
\[160\] Former patients were weeded out from the lists of recruits. AJHR, 1941, H-7, p. 3; Minister to High Commissioner, London, 13 December 1943, HMH 27/32.
to be examined by a board, which included a specialist psychiatrist, at one of the main centres upon their arrival in New Zealand. They would be treated at one of the 'psychiatric wards' or psychiatric outpatient clinics. They would then be returned home, committed or sent to Queen Mary Hospital as appropriate. In spite of continued support for special and separate treatment for soldiers by some women's and patriotic organizations, the Returned Services Association, and Members of Parliament, existing policy was not altered. New Zealand's official war history noted that psychiatric casualties were low. During World War II, 481 servicemen were admitted to a mental hospital. By March 1944, 568 returned servicemen had passed through Queen Mary Hospital.

Policies to classify patients with incipient or acute stages of mental disorders proceeded apace with ways of differentiating recoverable and convalescent patients. The conceptual model of hospitalization began with the building of reception houses and other facilities on the edge of institutional campuses. Then institutions reached out in general hospitals, as circumstances permitted, to provide outpatient clinics and observation wards. Progress was halting and dependent upon local initiatives, the state of medical staffing, and the philosophical stance of departmental heads on the place of general hospital psychiatry. Meanwhile, largely as a result of public pressure to manage war and other neuroses separately from the mental hospital system, as is most obvious in the case of Queen Mary Hospital, general hospitals

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161 Organization for National Security Paper 160 [report of interdepartmental conference], 24 October 1940, CAHW CH706, File 109 No. 1; Minister to High Commissioner, London, 13 December 1943, HMH 27/32. No special organization was set up in the field to deal with psychiatric casualties in the Second New Zealand Expeditionary Force. More serious cases were sent to British Army psychiatric units. T.D.M. Stout, War Surgery and Medicine, Wellington, 1954, p. 641.

162 E.g., J.A. Lee (Independent, Grey Lynn), W.E. Barnard (Labour, Napier), W.T. Anderton (Labour, Eden), NZPD, 20 August 1941, 260, pp. 155, 164, 166; Minister to J.J. Crawford, 1 July 1942, HMH 27/5; J.A. Lee (Democratic Labour, Grey Lynn), NZPD, 20 August 1942, 261, p. 604; C.M. Bowden (National candidate) in Dominion, 15 September 1942; R.S.A. conference resolution in Minister to Minister of Defence, 8 December 1943, Secretary, Miramar Branch, Labour Party to Minister of Rehabilitation, 3 March 1945, Secretary, Dunedin Women's Branch, Labour Party to Minister, 11 April 1945, and Secretary, Wakefield, Wai-iti and Northern Motupiko Patriotic Committee, 2 May 1945, H/VH 27/5; Minister of Defence to Minister, 8 December 1943, and Minister of Defence to General Secretary, Returned Services Association, 10 December 1943, HMH 27/5; President, Women's Service Guild in letter to Evening Post, 7 April 1945; President, Society for the Protection of Women and Children reported in Christchurch Star-Sun, 25 October 1944; W. Sullivan (National, Bay of Plenty), NZPD, 14 August 1946, 274, p. 197.

163 Stout, p. 637.


165 Medical Officer in Charge, Queen Mary Hospital to Director-General of Health, 30 March 1944, H 11/17 (22385).
slowly began to play an active rather than a passive role in treating milder forms of mental disorder.

CLASSIFYING CHRONIC PATIENTS

Mentally Infirm

Mental infirmity reached policy prominence because of the twin effects of demographic change and MacGregor’s failure to force hospital and charitable aid boards to accept a measure of responsibility for institutional welfare of this group of people. Thomson suggests that hospital or charitable aid boards and churches did not neglect the need for residential accommodation for old people. Nevertheless, a national institution for senile patients within the asylum network (or one in each island) was mooted in 1890, 1903, and 1917. None eventuated. In the 1920s, hospital boards pressed the government to open such an institution, although they were wary lest ratepayers should foot the bill. In 1928, when the Director-General contended that less than 40 per cent of the 462 elderly persons in mental hospitals required that care, Gray, with the support of the Director-General of Health, advised the government on a ‘definite policy’. That policy was enshrined in the Rest-homes Act 1929, and empowered the Crown, hospital boards or private individuals and organizations to run special rest homes. Inspired by features of the Mental Defectives Act 1911, the Rest-homes Act provided for committals or voluntary admission to a rest home. The Minister was empowered to transfer any mentally infirm patient from a mental hospital to a rest home.

The Rest-homes Act was not put into effect. The Labour Opposition criticized the lapse during the great depression, but in office (1935-49) it did not respond to

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167 NZPD, 15 September 1890, 69, p. 920.
168 NZPD, 15 September 1903, 125, p. 605.
169 NZPD, 21 September 1917, 180, p. 323.
170 Minutes of Conference of Representatives of the Auckland, Wellington North Canterbury and Otago Hospital Boards, 13-4 July 1922 [filed with copies of departmental reports once held by E. Killick, first Secretary to the Department of Health and retained in the Ministry of Health Library]; Auckland Hospital Board, reported in New Zealand Herald, 21 September 1927; Secretary, Hospital Boards’ Association to Director-General of Health, 6 October 1927, H 54/79.
171 Director-General to Minister, 17 October 1929, HMH 8/1041.
173 E.g., NZPD, 27 September 1932, 233, pp. 31-5; 1 September 1934, 239, p. 635. On the first occasion, Cabinet approved the recommendations of the National Expenditure Commission that
Gray’s bid to activate the legislation.\textsuperscript{174} The Act remained a dead letter. Mental hospitals never set up a national institution for mentally infirm persons. Post-war records hint that Raventhorpe may have been intended to receive a large number of mentally deteriorated elderly patients,\textsuperscript{175} but the notion was soon lost amid more urgent pressures. Individual hospitals continued to classify mentally infirm patients as circumstances permitted but catchall institutions inevitably continued to nurse many senile patients in wards whose basis was determined not by age but nursing dependency.

**Mentally Defective Children**

The development of special institutions for mentally defective children owes much to a series of petitions to Parliament, pressure from educational interests, the persistence of a radical Liberal, H.G. Ell, M.P. (Christchurch City), and practical difficulties encountered by lunatic asylums in the care and management of these patients. Ell forced the Government to consider the matter as part of a general review of industrial and reformatory schools in 1900. He suggested that the worst cases needed to be in a separate ward of an asylum.\textsuperscript{176} Ell and other Christchurch Members actively supported the series of petitions organized by Jessie McKenzie between 1899-1905 that called for homes for imbeciles.\textsuperscript{177} The Parliamentary Petitions Committee Government strongly rebuked the Government for failing to act upon its recommendations that favourable consideration be given to these petitions.\textsuperscript{178}

MacGregor had made a similar suggestion in 1897 and he added his voice to the lobbyists.\textsuperscript{179} In 1900, he urged that a ‘special institution’ be set up for epileptics,
imbeciles and idiots.\textsuperscript{180} By 1902, the government had said that it would consider setting up a special institution, but the ideal spot was hard to find.\textsuperscript{181} Meanwhile, information was collected about the likely numbers.\textsuperscript{182} Richmond, a few miles from Nelson, was eventually decided upon. The Richmond Home for Defectives, as the new institution was known, was placed under the control of the Mental Hospitals Department in September 1905.\textsuperscript{183} The Richmond Home received the ‘more promising of the boy imbeciles’ from mental hospitals throughout the country, but Hay thought the home too small to be the ‘ultimate institution.’ Girls were not admitted.\textsuperscript{184} The Richmond Home was an administrative anomaly\textsuperscript{185} that would have been superseded by Hay’s grand scheme for Tokanui Mental Hospital.\textsuperscript{186} He told the Committee of Inquiry into Mental Defectives and Sex Offenders (1924) that he foresaw there a male and female colony situated on a large estate. It would start with 400 beds and probably expand to 1,000 with an industrial colony for idiots, imbeciles and feebleminded.\textsuperscript{187}

After the Richmond Home was transferred to educational administration as a special school,\textsuperscript{188} the Department tried to develop its own institution for the growing number of hopeless mentally defective children in mental hospitals.\textsuperscript{189} The idea of using Nelson Mental Hospital for that purpose may have arisen because it was only a few

\textsuperscript{180} AJHR, 1900, H-7, p. 3.
\textsuperscript{181} NZPD, 11 July 1902, 120, p. 287. The Inspector of Schools looked through Nelson Asylum as part of an apparent site investigation. Official Visitor’s report, 27 November 1903, Nelson Inspector’s Book, Nelson-Marlborough Adult Mental Health Service, Records, Ngawhatu Hospital (NMAMHS).
\textsuperscript{182} NZPD, 18 September 1903, 125, p. 604; Superintendent to Inspector-General, 30 July 1903, CAHW CH 22/15, L. 77/03. Return showing persons under the age of 21 in [institutions] or ... dependent on local rates of Government funds, 8 July 1904, LE 1/1904/151. The return showed 92 persons under the age of 21 in New Zealand asylums.
\textsuperscript{183} AJHR, 1905, H-7, p. 4; NZPD, 12 July 1905, 132, p. 482; Official Visitor’s report, 23 October 1905, Nelson Inspector’s Book, Nelson-Marlborough Adult Mental Health Services, records, Ngawhatu Hospital; Superintendent, Hokitika to Inspector-General, 24 January 1906, CAHW CH 22/16, p. 428; Mental Defectives Act 1911, s. 30; Inspector of Special Schools to Inspector-General of Schools, 10 August 1911, CW 40/5/5.
\textsuperscript{184} AJHR, 1907, H-7, p. 12.
\textsuperscript{185} Deputy Inspector-General to Minister, 11 September 1906, HMH 1905/844.
\textsuperscript{186} Inspector-General to Minister, 10 February 1916, CW 40/5/-.; Inspector-General to Minister, 11 April 1922, HMH 4/8.
\textsuperscript{187} Inspector-General to Secretary, Committee of Inquiry into Mental Defectives and Sex Offenders, 14 June 1924, H 30/17/1 (55765).
\textsuperscript{188} The Government decided that the Richmond Home would be taken over by the Education Department as a home for epileptic boys in December 1914, but the transfer did not take place until 1916. File note, CW 40/5/5.
\textsuperscript{189} Principal, Otakeke Special School to Inspector-General of Schools, 11 September and 7 October 1912 and 24 May 1915, Inspector-General to Secretary for Education, 19 January 1914 and 10 February 1916, Secretary for Education to Minister of Education, 30 June 1916, CW 40/5/-. 
miles from Richmond Home. Climatic factors may also have played a part.\textsuperscript{190} Whatever the reasons, in 1922-3 the Nelson Mental Hospital was set apart as a national facility for mentally deficient boys under the age of 14.\textsuperscript{191} Sir Truby King preferred this modest scheme for about 200 boys and girls to Hay's grandiose scheme. Progress depended on completion of the new mental hospital at Stoke.\textsuperscript{192}

The Nelson initiative began under Gray's superintendence and duly became part of his long-term plan to remove mentally subnormal patients from mental hospitals altogether. Meanwhile, Gray thought, mental hospitals would remain 'largely custodial in function, to the detriment of both classes'.\textsuperscript{193} As chairman, Gray used the Eugenics Board\textsuperscript{194} to recommend to the Minister that Templeton be reserved exclusively for training feebleminded patients.\textsuperscript{195} He hoped that this would foreshadow a separate institutional system run by his department.\textsuperscript{196} Gray emphasized the distinction by calling the Templeton establishment a farm or farm colony.\textsuperscript{197} As the residents matured, provision was made for adults. Jenkin's Farm, next door, was therefore acquired.\textsuperscript{198}

The need for special provision in the North Island was obvious enough before the Second World War.\textsuperscript{199} Accommodation pressures and public works priorities meant that the issue might not have been tackled as early as 1945, save for the Department's fortuitous acquisition of the former Levin air force station.\textsuperscript{200} Nelson, Templeton and Levin helped separate mentally retarded children and adolescents from psychiatric patients, but there were no equivalent institutions for adults. A

\textsuperscript{190} Medical Superintendent, Sunnyside to Inspector-General, 24 January 1918, Sunnyside Administration File 8/389; AJHR, 1921, H-7, p. 2.
\textsuperscript{191} The first mass transfer of 52 patients took place in 1922. Medical Superintendent's report, Nelson, AJHR, 1923, H-7, p. 8; Inspector-General to Under-Secretary of Justice, 29 July 1924 and Director of Education, 6 August 1925, H 30/28/16 (59665).
\textsuperscript{192} AJHR, 1926, H-7, p. 5, and 1934, H-7, p. 1.
\textsuperscript{193} Director-General to Director of Education, 18 June 1929, CW 40/5/51.
\textsuperscript{194} This Board was set up to oversee the management of persons registered with it under the Mental Defectives Amendment Act 1928.
\textsuperscript{195} Eugenics Board minutes, 26 March 1929, CW 40/5/5; Director-General Circular, 2 April 1929, YCAA 1079/7G, File 5/64/-.
\textsuperscript{196} Director-General to Minister [Public Service Commissioner ?], 25 May 1929, H 50/1 (42536).
\textsuperscript{197} Director-General to Medical Superintendent, Sunnyside, 5 August 1929, H 50/1 (42506). He thought that the staff should be referred to as "institution officers". A medical superintendent would not be necessary at first.
\textsuperscript{198} AJHR, '34, H-7, p. 1.
\textsuperscript{199} Director-General to Hon. J. Alexander, 1 October 1936, H 30/24/15 (34225).
\textsuperscript{200} Anne Hunt, \textit{The Lost Years: From Levin Mental Deficiency Colony to Kimberley Centre}, Foxton, 2000, pp. 3-4, 16-17.
small number were retained in the farm colonies but many were transferred to "mixed" mental hospitals. This problem continued for many years.201

Epileptics

Reed's study of the management of epilepsy at Seacliff between 1880-1915 shows that asylums cared for patients whose epilepsy was associated with other forms of mental disorder and whose behaviour could be unpredictable and violent. There were also sane people who suffered from epilepsy, the sort of people Dunedin doctors saw as a superior type of patient.202 With the advantages of inside knowledge in Truby King's case, and academic independence in the case of D. Colquhoun, medical forums spearheaded pressure for better and separate provision for sane epileptics in asylums between 1903-5. These ideas drew upon overseas models of epileptic colonies.203

The Minister was supportive of the concept once 'hospitals for mental diseases' were put on a proper footing.204 Facilities for the 'Waitati Epileptic Colony'205 became available when the Orokonui Inebriates Home failed. In 1905, asylums were asked to identify suitable patients who were 'keenly sensitive' to their confinement in asylums and who were able to appreciate an improved environment.206 The colony was opened in 1907 amid doubts about the propriety of the association between the facility and an asylum.207 The colony remained small and consisted only of males. After a promising beginning, unmanageable patients

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201 For example, a 1974 national survey of patients in mental hospitals showed that only 47.6 per cent of persons in the diagnostic category of mental subnormality were patients in what were then called "psychopaedic hospitals". In the mixed mental hospitals, mentally subnormal patients comprised 33.5 per cent of the patient population. I.J. Jeffery and J.M. Booth, Survey of Patients in Psychiatric Hospitals, Wellington, Department of Health, Special Report No. 47, 1975, p. 15.
204 Minister NZPD, 17 August 1904, 129, p. 478.
206 Superintendent to Inspector-General, 25 April 1905, CAHW CH 22/16, L. 89/05; Medical Superintendent, Seacliff to Inspector-General, undated letter [early 1905], cit. Reed, pp. 84-86. According to that letter, the colony was opened in May 1905. Other asylums took advantage of the opportunity to transfer cases that were totally unsuitable.
207 Inspector-General to J. Ritchie, 7 May [?] 1907, HMH 1907/495; T. Wilford (Hutt), NZPD, 5 September 1907, 140, p. 728.
had to be transferred to a more secure environment at Seacliff.\textsuperscript{208} An increase was proposed in 1916.\textsuperscript{209} In 1909, Hay thought that women patients should be admitted to Waitati,\textsuperscript{210} but he soon favoured Tokanui.\textsuperscript{211} That proposal did not eventuate. King wanted to extend the Orokonui facility into a special colony as a capital priority in 1926. An announcement was made, but then the project lapsed.\textsuperscript{212}

**Highly Dangerous Patients**

Each institution had “refractory” or disturbed wards with tighter security where those with the worst behaviour were secluded and / or mechanically restrained for most of the time. Special precautions were taken to protect staff and others from the manic fury of some of these patients.\textsuperscript{213} A few patients, however, were extremely dangerous. Dangerousness is not necessarily synonymous with criminality, as Gray rightly noted in 1931,\textsuperscript{214} but consideration of a maximum-security facility was intended to cater for both groups. The criminally insane,\textsuperscript{215} constituted only about two or three per cent of the patient population.\textsuperscript{216} Gray said that there were no more than 100 patients throughout the country in 1931 whose ‘hallucinations, persecutory ideas, sexual, fire-raising, or other abnormal proclivities’ made them greatly dangerous.\textsuperscript{217}

Officials turned their attention to the special needs of the criminally insane in the 1900s. W.B. Gow, Medical Superintendent at Wellington, shared his thoughts on

\begin{itemize}
\item[208] Reed, pp. 66-67.
\item[209] AJHR, 1916, H-7, p. 2.
\item[210] Inspector-General to Minister, 20 December 1909, HMH 1910/290.
\item[211] Inspector-General to Minister, 22 February 1910, HMH 4/6.
\item[212] A.H. Crosby, Medical Superintendent of Sunnyside Mental Hospital, proposed that epileptic colonies be established within each mental hospital. Medical Superintendent’s report, Sunnyside, AJHR, 1925, H-7, p. 12; AJHR, 1926, H-7, pp. 5-6; NZPD, 6 August 1926, 210, p. 281; Director-General to Medical Superintendent, Seacliff, 22 March 1929, HMH 8/1183.
\item[213] Nurses’ reminiscences of F. Ward and the Lower Buildings, Porirua Hospital, in Williams, pp. 179, 208. Although these were memories of the early 1950s, the conditions described were characteristic of refractory wards.
\item[214] AJHR, 1931, H-7, p. 3.
\item[215] Hay used the term to refer to insane criminals, as well as persons whose insanity declared itself in some act or omission which, had they been in their right mind, would have constituted a crime. AJHR, 1907, H-7, p. 11.
\item[216] There were 60 (3.5 per cent) in 1889, 85 (2.8 per cent) in 1905, and two per cent in 1929. AJHR, 1889, H-22, p. 2, and 1905, H-7, p. 4; Director-General to Minister, 17 October 1929, HMH 8/1041. The authoritative Mercier thought that the proportion of violent patients among the inmates was invariably much smaller than was commonly supposed. Mercier, p. 133.
\item[217] AJHR, 1931, H-7, p. 3.
\end{itemize}
the matter with the Medical Association in 1904.218 MacGregor picked up the theme during an inspection of Sunnyside in February 1905.219 He returned to the question elsewhere in his annual report that year, when he noted that mental hospitals housed 85 criminal lunatics, 31 of them at Seacliff. The Inspector-General wanted to build a ‘special block’ for them at a mental hospital. Better still, part of a prison could be converted into a special asylum. Either solution would overcome the ‘serious disorders’ faced by all institutions in managing these patients.220 The Minister evidently accepted the Inspector-General’s advice.221 The Camp (Larnach’s Castle) on the Otago Peninsula was considered a suitable place for this ‘most embarrassing class of patients’, and unsuitable for the feeble-minded or for senile dementes.222 Hay checked out the buildings in February 1906 and the premises were bought for £3000.223

Policy was then shaped for a time by the antics of Edward Lionel Terry (1873-1952).224 Terry was convicted for murder in 1905 and later found to be suffering from paranoid delusions about racial purity. He was transferred from prison and placed under a variety of restrictions at Sunnyside and Seacliff Mental Hospitals.226 Hay called him a ‘sufficiently anxious’ charge226 because of Terry’s penchant for publicity and his capacity to arouse public sympathy. Terry’s escape from

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220 AJHR, 1905, H-7, p. 4. Prior to 1905, Macgregor thought there were too few criminal lunatics to warrant a central and special purpose criminal asylum. AJHR, 1889, H-22, p. 2, and 1890, H-12, p. 2.
221 NZPD, 15 September 1905, 134, p. 746.
222 AJHR, 1906, H-7, p. 3, and 1907, H-7, p. 11.
223 Editorials, Otago Daily Times, 9 January 1906 and Lyttelton Times, 9 January 1906; Deputy Inspector-General to Inspector-General, 20 February 1906, Minister of Public Works to Deputy Inspector-General, 8 March 1906, Superintendent, The Camp to Inspector-General, 13 June and 2 July 1906, HMH 21/1/11.
224 Edward Lionel Terry was arguably New Zealand’s best-known psychiatric patient. He was convicted of the murder of an elderly Chinese in Wellington in 1905. The sentence was subsequently commuted to life imprisonment on the grounds of insanity because of Terry’s delusions about racial purity. His escapes from various mental hospitals and noisy protestations between 1905-14 earned Terry an embarrassing reputation with the authorities. See Frank Tod, ‘Terry, Edward Lionel’, in DNZB, Vol. 3, Wellington, 1996, p. 525. He was a man of immense strength. Even at age 67, it took several attendants to hold him down after a scuffle. Medical Superintendent, Seacloff to Director-General, 17 June 1940, DAHI D 286/51, File 4281. Terry’s account of the incident is contained in a letter to H.W. Bundle, S.M., 24 June 1940, in the same file. See also W.A. Brunton, ‘Myth, Menace and Maximum Security’, unpublished paper presented to the New Zealand Branch Conference of the Royal Australian and New Zealand College of Psychiatrists, Palmerston North, 1986.
225 Clinical note, 2 May 1906, Sunnyside Patient File 3227; Christchurch Star, 24 and 28 September 1906; Medical Superintendent, Sunnyside to Inspector-General, 25 September 1906, Terry to Premier, 30 November 1906, Sunnyside Hospital Case Notes.
226 Inspector-General to Medical Superintendent, Sunnyside, 27 February 1907, Sunnyside Patient File 3227.
The Camp (Larnach Castle), Otago Peninsula, was bought by the government in 1906, with the intention of using it as a criminal lunatic asylum. Following strong public opposition, the plan was abandoned. The Camp continued to be used for mental hospital purposes until 1918, although it was never gazetted as a mental hospital. (Author’s collection.)
Edward Lionel Terry (1867-1952). A convicted murderer, Terry's constant testing of the security measures between 1906-1914 led to a reappraisal of what would nowadays be called forensic psychiatric facilities. Terry enjoyed a number of privileges between 1914-1940, including his own rose garden, where this photograph was taken, c. 1935. Terry is wearing his characteristic white suit that, with his flowing white hair and beard, served his prophetic self-image. (Author's collection.)
Reginald Matthews (1890-1980) had a history of sexual offending but was convicted for murder in 1921. He was one of the country's top security patients, along with Lionel Terry. After a celebrated escape from Seacliff Mental Hospital in 1921, Matthews was subjected to possibly the toughest security measures ever instigated for a psychiatric patient in New Zealand. (New Zealand Listener, 23 February 1980, p. 21.)
Sunnyside in 1906\(^{227}\) revealed the weakness of security measures and elicited embarrassing newspaper criticism.\(^{228}\) Determined to block 'mawkish sensationalism' at any cost, Hay whisked him under the strictest security to the hospital wing of Lyttelton Gaol, which was specially gazetted as a mental hospital.\(^{229}\) He was later transferred to Seacliff and destined for The Camp. Meanwhile, the Minister directed that he was to have a special day and night attendant.\(^{230}\)

Terry’s well publicized escapes from Seacliff\(^{231}\) helped spike plans to use The Camp as a criminal lunatic asylum. Official reassurances about the intended high security\(^{232}\) were unconvincing when people had been told earlier that only harmless patients would be kept there.\(^{233}\) After Terry’s escape in January 1908, there was some speculation that Terry might be sent to England.\(^{234}\) In the face of strong public pressure, the Prime Minister buckled and announced that the Camp would not be used as a criminal asylum.\(^{235}\) With its real purpose gone, The Camp was a white elephant. It was never gazetted as a mental hospital, but easily managed patients

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\(^{227}\) Medical Superintendent, Sunnyside to Inspector-General, 25 September 1906, Sunnyside Patient File 3227. See also F. Tod, The Making of a Madman, Dunedin, 1977, pp. 53-57.


\(^{229}\) Inspector-General to Medical Superintendent, Sunnyside, 13 December 1906, DAHI D 266/51, File 3227; case note, 24 December 1906, Sunnyside Patient File 3227.

\(^{230}\) Inspector-General to Medical Superintendent, Sunnyside, 5 October 1906, DAHI D 266/51, File 4281; Medical Superintendent, Sunnyside to Inspector-General, 10 October 1906 and case note, 7 June 1907, Sunnyside Patient File 3227.

\(^{231}\) Clinical note, 21 November 1907 and Medical Superintendent, Seacliff to Inspector-General, 14 January 1908, DAHI D 264/30; Tod, pp. 67-71, 77-82.

\(^{232}\) Inspector-General to Minister, 25 June 1907, HMH 21/1/11; Minister, NZPD, 10 July 1907, 139, pp. 235-6. A 15-foot high wall was planned along with prison-style security precautions. Work on the security fence was authorized on 22 July 1907.

\(^{233}\) A.C. Hanlon to E.G. Allen, M.H.R., 24 June 1907, and E.G. Allen to Minister, 19 July 1907, HMH 21/1/11; J.F. Arnold (Dunedin South) and E.G. Allen (Chalmers), NZPD, 31 July 1907, 139, pp. 788, 807 and 15 November 1907, 142, p. 947.

\(^{234}\) Medical Superintendent, Seacliff to Inspector-General, 18 January 1908, DAHI D 264/33. By then, the Inspector-General had determined to send Terry to Broadmoor, the criminal lunatic asylum in England. Medical Superintendent to Inspector-General, DAHI D 264/30.

\(^{235}\) Medical Superintendent, Seacliff to Inspector-General, 17 January 1908, DAHI D 254/30; Inspector-General to Minister, 19 March 1908, HMH 21/1/11.
were sent there on probation to give them a change of environment. The Camp was never economic and closed in 1918.

Terry's tricks quickly proved to Hay that he was a 'tremendous responsibility' and very dangerous. Unusual measures were devised to contain him at Lyttelton Gaol and Sunnyside. He was finally sent to Seacliff in 1914 where he was housed in a special part of M.B. Ward. This was the institution's most secure male ward. Terry was "specialled" by three or four handpicked strong attendants. Upon undertaking not to escape, however, Terry was given parole and opportunities to pursue his artistic and horticultural interests. Dressed messiah-like in white, Terry was a familiar sight to Seacliff villagers. True to his word, Terry never again tried to escape. His privileges were abruptly cancelled after an altercation with staff in 1940. He died at Seacliff Hospital in 1952.

Further work towards a criminal asylum / maximum security unit lapsed during the First World War but was revived in 1921 when Terry was joined by Reginald...
Matthews (1890-1980), a convicted murderer with a history of sexual offences. Matthews’s trial attracted considerable publicity, conflicting psychiatric evidence, and some public sympathy because of his appalling family background. The Government then ordered an independent psychiatric examination. Found insane, Matthews was transferred from Mount Eden Gaol to Seacliff to be held in ‘absolutely secure quarters and supervision’ among similar cases. Following Matthews’ conviction, the Lyttelton Times called for a special institution, an idea that coincided with departmental thinking. Hay’s grand plan envisaged such a place situated between Tokanui Mental Hospital and Waikeria Borstal. Keen to put the place on a ‘scientific footing’ and at the Controller-General of Prisons’ behest, Hay appointed H. St L. Gribben as Medical Superintendent at Tokanui.

Russell, letter to Lyttelton Times, 12 April 1921; Dunedin Evening Star, 5 August 1921; Inspector-General to Minister, 17 August 1921, MH 1/6650. Matthews was imprisoned for indecent exposure in 1919 but he escaped the next year. While he was at large he shot dead the brother of a woman in whose bedroom he was peering.

Police Gazette, 1919, p. 554, 1920, pp. 582, 566. Matthews’ sanity was questioned at his trial and afterwards. See editorial, Lyttelton Times, 14 and 26 February 1921; R C Pratt, letter to Lyttelton Times, 22 February 1921; New Zealand Truth, 26 February 1921; petitions from Christchurch and Invercargill in Prison Department Archives, National Archives, Wellington, J PR 1921/69. Cabinet sought an independent psychiatric assessment by Hay and Hassell. Matthews’ death sentence was commuted to imprisonment for life with hard labour, which meant an indeterminate sentence. Minister of Justice to Governor-General, 5 March 1921, J PR 1921/69; Press, 7 March 1921.


Petitions from Invercargill and Christchurch residents, c. February 1921, J PR 1921/69. Matthews’ family history was assembled in a confidential manuscript, The Case of Reginald Matthews by D.F. MacKenzie based on his study of Justice Department records. I am most grateful to the late Mr MacKenzie for allowing me to peruse this manuscript.

Minister of Justice to Inspector-General, 23 February 1921, Inspector-General and G. Hassell to Minister of Justice, 1 March 1921, J PR 1921/69.

Controller-General of Prisons to Stipendiary Magistrate, Christchurch, 12 March 1921, J PR 1921/69; Inspector-General to Controller General of Prisons, 10 March 1921, Minister of Justice’s order, 22 March 1921 and Inspector-General to Medical Superintendent, Seacliff, 23 March 1921 (telegram), MH 1/6850; Personal communication, the late Mr R. Matthews, 23 August 1970. The Matthews case also contributed to the idea of a specialist unit for sex offenders within the prison system that could provide medical and surgical “treatment”. AJHR, 1921, H-7, pp. 2-3; Inspector-General to Secretary, Committee of Inquiry into Mental Defectives and Sex Offenders, 14 June 1924, H 30/171 (55755).

B.E. Baughan, ‘To Reduce Crime’, Lyttelton Times, 2 April 1921; editorials, Lyttelton Times, 5-6 April 1921; Bishop Brodie reported in Lyttelton Times, 9 April 1921.

AJHR, 1919, H-7, p. 9.

AJHR, *920, H-7, p. 5.
Further impetus was provided by Matthews' ingenious escape on 5 August 1921. He was at large for three days before he was recaptured without incident. Matthews' escape, like Terry's earlier disruptions, once again thrust into policy prominence the complexity of considerations that surround the care of patients under conditions of maximum security. It also showed the fickleness of a press that now howled for tougher confinement or worse. Matthews' escape was a double political embarrassment because it coincided with the media furore over the conditions at Hokitika Mental Hospital. Matthews' menace to society then assumed mythical proportions. Disturbing information about from the prominent Dunedin merchant, D.E. Theomin, was laid before Cabinet and clear orders issued to send Matthews to prison if the Department had the slightest doubt about its ability to contain him. No chance was taken. The security precautions installed for Matthews were the most stringent in the country. ‘Humanity ... must be put aside altogether - we have the public to protect and out [sic] own reputation’, Hay decreed when listing the new procedures. These arrangements were never

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254 Medical Superintendent, Seaccliff to Inspector-General, 5 August 1921 (telegram), MH 1/6650; Medical Superintendent, Seaccliff to Inspector-General, 15 August 1921, Matthews' Clinical File, Lake Alice Hospital, current whereabouts uncertain; Otago Daily Times, 15 August 1921. Matthews claimed that he had gone to Oamaru to find evidence to prove his alibi for the murder. Personal communication, the late Mr R. Matthews, 23 August 1970.

255 E.g., editorial, Timaru Herald, 8 August 1921; Dunedin Evening Star, 5 August 1921; editorials, Christchurch Press, Wairarapa Age, Timaru Post, 6 August 1921; 'Indignant', letter to Press, 9 August 1921; editorials, Waikato Times and Waimate Times, 9 August 1921.

256 Minister to Inspector-General, 15 August 1921 (telegram), MH 1/6650.

257 In briefing the Minister on Matthews' bid for freedom, Hay cited press reports which claimed that upon his recapture, Matthews said he would have used a gun on his pursuers had he been armed. The Otago Daily Times, 8 August 1921, was the likely source of this claim that was repeated in the Dominion, 9 August 1921, where Hay probably saw it. This very important detail of Matthews' dangerousness was not checked against the Medical Superintendent's incident report that made no mention of it. Inspector-General to Minister, 17 August 1921, MH 1/6650; Medical Superintendent, Seaccliff to Inspector-General, 15 August 1921, Clinical File, Lake Alice Hospital.

258 D.E. Theomin to Minister of Justice, 11 October 1921, Minister of Justice to D.E. Theomin, 13 October 1921, Minister of Justice to Inspector-General (private.), 13 October 1921, and Minister to Inspector-General, 17 October 1921 [two memoranda], H 30/28/17 (45235).

259 Matthews' cell was strengthened and double reinforced windows installed. Like Terry, Matthews was provided with his own airing court, which was entirely enclosed by wire netting to prevent any contact from outside. Matthews was secured in a straitjacket and escorted by three attendants whenever he was taken from his cell to the pen or to the ablutions. At all times, he had to 'speciallys' (attendants assigned exclusively to watch him, in the pen. One special attendant remained in the corridor outside his room to constantly observe the patient. This attendant was to summon two other attendants if Matthews' cell had to be entered. At least in the early days, Matthews was kept in a restraint jacket at all times except during meals. District Inspector's report, 30 August 1921; Inspector-General to Medical Superintendent, Seaccliff, 17 and 29 August, 13 and 17 October 1921; Medical Superintendent, Seaccliff to Inspector-General, 24 August and 20 October 1921; Inspector-General to Minister, 17 August and 20 October 1921, MH 1/6650; Matthews and E. Treweek [retired Head Attendant Seaccliff] interviewed in TVNZ documentary, At His Majesty's Pleasure, 1980.

260 Inspector-General to Medical Superintendent, Seaccliff, 17 October 1921, MH 1/6650.
relaxed during the period covered by this thesis and long after Seacliff staff felt that Matthews' risk warranted such rigid conditions.  

'No stronger argument' was needed than the risk of another escape bid by Matthews to rekindle official interest in starting a special institution for the criminally insane at Tokanui. Twenty-six 'particularly dangerous or offensive' patients were listed as likely inmates. Plans foundered because of fiscal retrenchment, political backtracking, and other capital priorities. When Matthews complained about his harsh conditions in 1926, special arrangements in a gaol-asylum were contemplated, but the Department was told to await a general policy statement from the Government. No trace of any such policy can be found. King's bid for a maximum-security facility in 1926 got nowhere either. Despite pleas of urgency, Cabinet deferred a decision on the 75-bed institution. Matthews was listed for transfer to it, and Gray added Terry to the list.

The particular requirements of maximum-security patients were lost in the backlog of deferred capital works during the great depression and the Second World War. Gray's policy work on a custodial institution for about 100 patients in 1931-2 was

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261 Medical Superintendent, Seacliff to Director, 2 April 1952 and reply, 27 May 1952, MH 1/6650; the late Dr R.G.T. Lewis, personal communication; Transfer report, 7 April 1967, Lake Alice Hospital case notes.
262 Medical Superintendent, Seacliff to Inspector-General, 10 October 1921, Minister to Inspector-General, 17 October 1921, and Inspector-General to Minister, 20 October 1921, MH 1/6650; Otago Daily Times, 28 March 1924.
263 Minister of Justice to Minister, 13 October 1921, Minister to Inspector-General, 13 October 1921 and reply, 20 October 1921, and Inspector-General, Circular, 20 October 1921, H 30/28/17 (32778).
264 The matter was considered in Cabinet on 7 November 1921 but stood over. File note, H 30/28/17 (45235); Inspector-General to Minister, 9 July and 28 August 1924, H 30/28/17. The Minister took the matter to Cabinet on 10 and 19 July 1924 but it was not considered until 18 August 1924, when no action was to be taken. When at departmental insistence, the matter was again referred to Cabinet, with the hope of at least obtaining approval in principle and the authorization of plans being drawn, the matter was stood over for 12 months by Cabinet on 1 September 1924.
265 Matthews to Minister of Justice, 30 May 1926, Acting Medical Superintendent, Seacliff to Inspector-General, 2 June 1926, Inspector-General to Minister of Justice, 6 July 1926, Controller General of Prisons to Minister, 13 July 1926, Medical Superintendent, Seacliff to Inspector-General, 30 August 1926, 8 February and 4 April 1927, MH 1/6650.
266 AJHR, 1926, H-7, p. 6.
267 Inspector-General to Minister, 9 July and 28 August 1926, Deputy Inspector-General, Circular, 8 March 1926, Inspector-General to Lunatic Department, Perth Prison, 26 March 1926, Inspector-General to Medical Superintendent, Broadmoor Asylum, 26 March 1926, H 30/28/17 (32778); AJHR, 1926, H-7, p.8.
268 Medical Superintendent, Seacliff to Inspector-General, 11 March 1926, H 30/28/17 (32778).
269 Director-General to Under-Secretary for Justice, 1 May 1935, H 30/28/17 (45235).
wasted. He was told to wait for better times.\textsuperscript{270} Fresh proposals in 1935-6 also came to nothing.\textsuperscript{271} Only when M.B. ward had to be evacuated in 1957, because of the structural deterioration of Seacliff Mental Hospital, was attention once more given to a custom-built facility, and then only after several years occupation of M3 ward at Auckland Mental Hospital. The National Security Unit, Lake Alice Hospital, was opened in 1966.\textsuperscript{272}

### Habitual Inebriates

The disease model affected the management of habitual inebriates in the late nineteenth and early twentieth centuries. Asylums found it impossible to meet a statutory requirement that habitual inebriates be treated separately from lunatics. As part of a comprehensive solution, MacGregor thought that asylums should look after dipsomaniacs and persons found to be certifiable after remand. He hoped that Porirua would handle these cases nationally.\textsuperscript{273} Ashburn Hall, having seen a need, established a separate cottage for inebriates.\textsuperscript{274} The issue became important politically after the long depression.\textsuperscript{275} An Act was passed to set up a state-run inebriates home in 1898, but no funds were voted.\textsuperscript{276} The decision to develop the 900-acre Orokoune estate at Waitati, near Seacliff, for a 30-bed inebriates institution, then gave effect to the Act. Truby King was given responsibility. He sought advice overseas about an appropriate philosophy and management before finalizing arrangements.\textsuperscript{277} King’s doubts about the scheme and its potential for abuse as a

\textsuperscript{270} AJHR, 1931, H-7, p. 3; Prime Minister to High Commissioner, 23 November 1932, Director-General to Senior Medical Commissioner, Board of Control, London, 24 November 1932, H 30/28/17 (32778); Minister, NZPD, 9 November 1932, 234, p. 227.
\textsuperscript{271} AJHR, 1935, H-7, p. 2; Medical Superintendent’s report, Seacliff, AJHR, 1936, H-7, p. 10; Director-General to Under-Secretary, Department of Justice, 1 May 1935, Director-General to Minister, 19 June 1935, H 30/28/17 (45235).
\textsuperscript{272} The building was ready in 1965 when the Mt Eden Prison riot necessitated temporary use of the National Security Unit as “Rangitikei Prison”. AJHR, 1966, H-31, pp. 78-79.
\textsuperscript{273} AJHR, 1887, H-9, p. 3, and 1895, H-22, p. 2.
\textsuperscript{275} E.g., H.A. Levestam (City of Nelson) and R. Turnbull (Timaru), NZPD 5 August 1886, 56, p. 518, W.P. Reeves (Minister), NZPD, 18 August 1893, 81, p. 200; AJHR, 1894, H-7, p. 2. The Wellington Coroner called for special inebriates asylums following the death of an inebriate in gaol. See Star, 18 August 1899. Medical opinion also supported such a place, e.g. Dr W.A. Chapple, Evening Post, 7 August 1900; F.T. King, ‘Inebriety as a Disease’ and discussion, New Zealand Medical Journal, 3, 11 (1904), pp. 310-32. These developments are discussed more fully in C. Bayvel, Pressure arose from the death of an inebriate sent to gaol. “Not a Drop to Drink”: New Zealand’s Inebriate Homes, c. 1890s-1930s’, MA Thesis, Victoria University of Wellington, 1996.
\textsuperscript{276} AJHR, 1899, H-7, p. 3.
\textsuperscript{277} Medical Superintendent, Seacliff to Physician in Charge, Crenty Inebriates Reformatory, 12 June 1901, Medical Superintendent, Seacliff to A.W. McCarter, 3 October 1901, and to Inspector-General, 22 October 1901, DAHI D 264/23.
dumping ground for hopeless drunkards\textsuperscript{278} were accurate. Growing public recognition that the experiment had not worked\textsuperscript{279} led to the estate being gazetted as an auxiliary to Seacliff Asylum in 1904 when it was used for acute male patients and epileptics.\textsuperscript{280}

\textbf{CONCLUSION}

A system for separating mental patients into different groups according to their behaviour, risk, diagnostic category, and level of functioning, was a hallmark of policy on mental care and treatment. Many attempts were made after 1876 to classify patients within institutions and within the country’s mental hospital system as a whole. The needs and claims of particular groups of patients were identified from time to time through public pressure, numerical significance, and international trends in treatment. These needs were addressed as funds allowed, ministers determined, and capital priorities permitted. Cottages and villas let hospitals classify patients more sensitively and in a more specialized way. These smaller and manageable units were much better suited to classification than large, old fashioned and multi-purpose wards. Villa hospitals were an even greater boon because classification could be incorporated into the planning and design features.

Local classification was one thing, but systemic classification is another theme in the policy. The notion of a national asylum for chronic patients lingered from the 1870s until c. 1920 but was gradually overtaken by policies to create national colonies or special purpose institutions for various groups of patients. Colonies for congenital mental defective children and the country’s high security male ward at Seacliff were the most enduring sign of this policy. Special institutions for epileptics, inebriates, and mentally infirm persons failed to flourish or flowered only for a short time. Mental hospitals thus remained catchall institutions and continued to hold large numbers of congenitally mentally defective adults as well as patients with psychiatric diagnoses.

\textsuperscript{278} Medical Superintendent to Inspector-General, 21 July 1902, DAHI D 264/66. King’s doubts were shared by the Chief Health Officer, Dr J.M. Mason. See discussion, \textit{New Zealand Medical Journal}, 3, 11 (1904), p. 332. Medical Superintendent to Inspector-General, 30 January 1903, DAHI D 264/66, p. 218.

\textsuperscript{279} Editorials, Christchurch Press, 15 June 1904, and Wellington Evening Post, 16 June 1904.

\textsuperscript{280} AJHR, 1905, H-7, pp. 3-4.
Moves to segregate chronic patients were matched by the adoption of the hospital model for classifying people who sought early treatment for mental and nervous disorders and those well along the way to discharge as recovered. The first special facilities for acute and convalescent patients in asylums arose from local initiative in the late 1890s. The success of these schemes assured the adoption of a national policy to build reception houses and later neuropathic hospitals on the periphery of mental hospital estates. Departmental administrators were keen to reduce the social stigma of insanity and to increase patients' therapeutic chances. The Department responded, reluctantly at times, to provide refined quasi-private wards in mental hospitals.

Social pressure to treat neuroses, and especially war neuroses, away from mental hospitals steered the course of policy towards general hospitals and Queen Mary Hospital as a national hospital for the treatment of functional nervous disorders. The Pomare-King reforms of 1925 mandated institutional outreach into general hospitals. A network of specialist outpatient clinics and psychiatric wards slowly spread to a number of provincial towns and cities as well as the metropolitan centres of New Zealand. The spread was uneven and progress halted by staff pressures and the demands of overloaded institutions. Because extramural development was so dependent upon the capacity and attitudes of mental hospital specialist psychiatrists, by 1947 it can be said that the network of public mental hospitals was still the cornerstone of psychiatric care and treatment in New Zealand.
THE MAKINGS OF A PROFESSIONAL STAFF

'To raise their ideal of their duty, and remove the prejudice'.

In his overview of the evolution of the health workforce in New Zealand, Belgrave suggests that between 1860-1914, the 'volatile jumble of nineteenth-century work' was transformed into something resembling the modern health economy. Occupations were defined and stratified within hospital bureaucracies by responsibilities, skills, training and status, in a process that still continues. A clear hierarchy was established in relation to medical orthodoxy and medical dominance as various occupational groups in direct contact with patients modelled their work and their aspirations on those of medical practitioners. Belgrave claims that doctors remained on top largely because of their ability to control the technology of scientific medicine, and so they dictated the terms by which newer semi-professions could find their own niche. Workers in some occupations aspired to and emulated the medical practitioners' model of professionalism with its hallmarks of national state licensure and professional organization, even at the cost of subordination to doctors.

The professionalization of health care, which Belgrave outlined, affected some asylum staff too, and occurred in wider contexts, both international and national. Job specialization, the organization of labour, state intervention, and residential institutions of many kinds were all partly a product of the industrial revolution. New Zealand developments followed after the United Kingdom pattern, where practitioners aspired to be part of scientific medicine. The imperial "home" model was the prime cultural reference point for New Zealand initiatives in medicine and many other fields. Links were continuously nurtured through specialist training, study tours, immigration,

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1 Appendices to the Journals of the House of Representatives (AJHR), 1890, H-12, p. 3.
the spread of knowledge and ideas through learned journals, and membership of British (and later Australasian) professional associations and societies. Developments in mental health services mirrored these trends. This chapter will concentrate upon staffing and personnel policies that affected doctors, attendants and the paramedical occupations because they were the occupations primarily engaged for care and treatment.

In New Zealand, professionalization and bureaucracy went hand in hand. Each was a deliberate staffing strategy of the Department as much as it was a result of wider forces. Professionalization of those occupational groups in closest contact with patients led to their differentiation from other staff. Bureaucratization helps to explain the power structure and hierarchical organization of professions within state mental hospitals. The phenomenon of bureaucracy also helped shape the notion of a national career service for departmental staff and the wider public service that was formalized in 1913.4 By virtue of its specialized staff, the Department was a microcosm of this wider system. Institutional custom and traditions supported hierarchical and power relationships. At the obvious level, staff were distinguished from patients by possession of such symbols as the ubiquitous "service key",5 separately identifiable cups and saucers,6 and segregated dining facilities. Doctors dined separately from nurses, clerical staff dined on their own, and nurses dined according to rank.7 The place of doctors and medical superintendents at the head of an institutional hierarchy was firmly secured by practices such as saluting,8

4 This term refers to a system that selects and recruits outsiders and trains staff (according to their technical competence, personal attributes and efficiency) for competitive promotion to more senior positions within the organization. Then they retire from working life. Later entrants, whose careers have followed a similar path, succeed retired staff. A national career service inculcates its staff with particular values expressed as rules and enforced through acculturation, discipline and penalties.

5 Attendants and other staff who needed access to the wards were given a standard key for all doors in either the male or female division. Senior staff had a 'master key' that enabled those doors to be check-locked or double-locked. Principal officers possessed a 'grand master key' to lock and check-lock all doors in either division. Service keys are still used.

6 Janet Frame, Faces in the Water, Christchurch, 1961, p. 26; personal communication, the late Dr S.W.P. Mirams.


8 S. Maxwell, evidence in R. v. Maxwell, 31 August 1893, MH 1891/2511, p. 414. Saluting was not limited to medical superintendents. The lay Superintendent at Nelson in 1906 expected staff to salute him as a sign of respect for his office and as an example to patients. Superintendent, Nelson to Inspector-General 2 January 1906 and Inspector-General to Minister, 11 January 1907, Health
inspection parades of attendants by their head, or the matron's preliminary inspection in advance of the daily ward round.

Centrally determined salary relativities and reporting relationships cemented hierarchy into the formal organizational structure. Decisions about staff numbers and mix, or about pay and conditions of work needed in a government service reflected the inherent tensions between fiscal and social objectives of public policy. Decision-making was a melting pot of staff aspirations, industrial pressure, and concern about the level of public expenditure. Balancing the interests of patients, staff, and taxpayers was never easy and the ideal was inevitably compromised. Departmental staff sought to improve their pay and working conditions by participating in the organized labour movement that helped to shape the course of New Zealand politics since 1890.

Personnel costs steadily grew from 38.6 per cent of gross departmental expenditure in 1877 to 60.7 per cent in 1947. Departmental staffing and personnel policies were based upon a division of labour needed to maintain, develop and run institutions. More than four-fifths of the staff was employed to care for and treat patients. A small number were doctors; there were far more attendants. The remaining one-fifth maintained the offices, buildings and grounds. Staff needs were simple at first. Among the 99 positions budgeted for in the Lunatic Asylums Department in 1876 were medical officers, attendants or keepers, what would nowadays be called domestic or household staff, and keeper-clerks (in modern parlance, administrative staff). Based on the information contained in Table 13, there was approximately one active medical practitioner for every 214 patients, and a nominal ratio of one male or female attendant for every 9.8 patients. Patient numbers grew. Institutions proliferated. Institutional farms developed. Buildings had to be maintained. Administrative systems became more complex. New therapies

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Department, Mental Health Division Archives, National Archives, Wellington, File HMH 1910/53. The practice was very entrenched. An impressionable young assistant medical officer at Sunnyside in 1945 recalled how older attendants still raised their hand in a manner resembling a salute. Personal communication, the late Dr S.W.P. Mirams.

9 As late as 1952, Seacliff attendants were paraded daily before the Head Attendant. Personal communication, Mr J.J. Thompson.

10 AJHR, 1878, H-10, p. 19, Table XIII for financial / calendar year 1877, and 1948, H-7, p 25, Table XI for financial year ended 31 March 1948.

11 AJHR, 1878, B-28, pp. 34-36. A part-time music instructor at Auckland was not included.
### TABLE 13
DEPARTMENTAL EMPLOYEES BY FUNCTION, NUMBERS AND PERCENTAGES, 1876-1947

<table>
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<tr>
<th></th>
<th>Administration</th>
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Notes:
1. Figures expressed as full time equivalent positions.
2. Management /administration includes an estimated 50 per cent medical superintendent's time, all head office staff and all institutional clerical staff.
3. Early medical staffing includes a pro-rata allocation of medical superintendents' time.
4. Figures include Waitati Inebriates Home and Richmond Home for Defectives where applicable.
5. Attendant category includes institution officers at Templeton Farm Colony.
6. Between 1905-15 artisan attendants were identified separately. Time has been estimated at 50 per cent in each category.
7. Budgeted figures for 1940 and 1947 were 1907 and 2232 respectively. The difference is accounted for part-time and temporary staff.
8. No information is available for 1945.

Sources: AJHR, 1876-1948, Estimates of Expenditure; Public Service Classification Lists, Supplements to New Zealand Gazette 1940-1947.
were labour intensive. So more staff and more specialized staff were needed. Table 13 shows how staff numbers grew in relation to some of these factors. By 1947, the Department employed 2,232 permanent and temporary employees. Unfortunately there is insufficient information to estimate the staff-patient ratios in 1947 beyond a nominal 1:324 doctor- and 1:10.1 nurse / attendant-patient ratios. The ratios must be used with great caution as they do not take account of regional variations, day / night staffing levels, or the gender composition of overall patient numbers.

General medical staff and specialist psychiatrists provided treatment with some help from paramedical staff such as occupational therapists and psychiatric social workers. Patient care and custody remained the domain of attendants who, by 1947, were recognised as specialist psychiatric nurses. Institutions were managed by medical and not lay superintendents. The number and types of administrative, trades, and household / estate workers reflected the cumulative effect of policy decisions about farming, capital works, and the role of attendants as the functions of mental hospitals became more complex. Job clusters became more specialized, as is discussed further in appendix 6. Throughout the entire period the philosophy of work therapy utilized a large pool of largely chronic patients as unskilled and largely unpaid labour. Patient labour was indispensable to the functioning of institutions. In a Biblical allusion, Truby King (then Medical Superintendent, Seacombe (1889-1921) and later Inspector-General (1924-27)) rightly called his worker patients at Seacombe the ‘hewers of wood and drawers of water’, without which paid labour would have had to be employed.

MEDICAL STAFFING

The decision to appoint a psychiatrist to head the new Lunatic Asylums Department in 1876 set important policy precedents. Psychiatry was recognised as a specialized

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12 AJHR, 1947, B-7 [Part I], p. 230. The inclusion of temporary employees swells the number beyond the 1880 full-time funded positions cited in Table 14.

13 Medical Superintendent, Seacombe to Inspector-General, 8 September 1891, Healthcare Otago Ltd Archives, National Archives, Dunedin, DAHI D 264/13, and 3 September 1898, DAHI D 264/20. King borrowed the phrase from the authoritative nineteenth century alienist, G.H. Savage, who quoted it from Joshua 9:23.
field of medicine and psychiatrists were deemed to have the specialist expertise needed to manage a national system of asylums. F.W.A. Skae, Inspector-General (1876-1881) and his successors slowly but systematically applied these precedents throughout the Department. A qualified or experienced psychiatrist eventually managed every institution and a psychiatrist was considered to be the ideal departmental doctor.

Skae boldly argued that specialist clinical responsibilities extended to overall management authority. The 'real management of the patients' had to rest with the man on the spot, that is, the physician, Skae wrote in his first report. In his belief that medical management would mean better management, colonial practice was brought into line with Britain where the trend towards medical superintendence was so advanced as to be a very strong model. Skae advocated for a medical superintendent at Sunnyside and Dunedin because each had more than 200 patients. He thought that asylums between 40-90 could be left to a lay superintendent with visiting medical attendance if this worked well, as it did in Scotland and at Hokitika.

Under pressure from some of the lunacy reforming politicians, the Hall Ministry decided to engage resident medical superintendents at asylums with more than 100 patients.

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14 AJHR, 1877, H-8, pp. 4-5.
15 Skae in evidence to the Royal Commission of the Inquiry into Wellington Asylum, 21 March 1881, p. 63, Internal Affairs Department Archives, National Archives, Wellington, IA 101/3. The Department's sole medical superintendent, T. Aickin, at the Whau Asylum, was hardly an example of the 'energetic, intelligent, and enterprising management' Skae expected of a medical manager. Aickin and some of his staff resigned when their poor management record was exposed in an inspection report. New Zealand Herald, Auckland, 10 February 1877. A. Young, who showed much greater zeal and energy, replaced him. AJHR, 1879, H-4, p. 6, 1880, H-6, p. 11, and Inspector-General's report, Auckland, 27 July 1885, AJHR, 1885, H-10, p. 5.
17 AJHR, 1877, H-8, pp. 4-5, and 1878, H-10, pp. 10-11.
18 Gribben's management at Seaview was satisfactory in every respect, but at Nelson, the 'very slovenly' superintendent, T. Butler, was replaced by an 'intelligent and zealous' though inexperienced lay officer. See AJHR, 1877, H-8, p. 3, and 1877, H-34. Butler then availed himself of every opportunity for redress. He never succeeded because his first appeal disclosed that Butler had made improper advances to the Matron and had tried to oust her from the job in favour of his granddaughter. New Zealand Parliamentary Debates (NZPD), 7 August 1880, 36, pp. 54-55; Correspondence between the Government and Thomas Butler, 20 July 1883, Legislative Department Archives, National Archives, Wellington, LE 1/1883/108.
19 E.g., Capt. T. Fraser, M.L.C. (Otago), NZPD, 2 August 1877, 25, p. 169, and Dr M.S. Grace, M.L.C. (Wellington) NZPD, 30 October 1879, 32, pp. 644-51.
patients. Wellington Asylum first passed that threshold in 1878 but remained under lay management in spite of growing public suspicion about the standard of care. A medical superintendent was not appointed until 1881 when a royal commission substantiated allegations of maltreatment at the asylum. Only a medical superintendent, armed with 'practical experience and technical training' and ample discretionary power could put things right, the Royal Commission found. The principle of medical superintendence, once established, was never reversed. Medical superintendence was extended to Nelson in 1911, Hokitika in 1921, and to new institutions. The last legal vestige of lay superintendence was removed in 1950; long after all the administration was in medical hands. The work had a complete medical orientation that should necessarily prevail, according to R.G.T. Lewis, the then Director of Mental Hygiene.

Skae was rankled by the fact that doctors received inferior pay to lay superintendents. He argued that the superior responsibility and education of a medical practitioner had to be recognised and compensated. Thus the government paid the first medical superintendents of the large southern asylums an annual salary

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20 T. Dick (Colonial Secretary) in NZPD, 5 August 1881, 39, p. 297.
21 AJHR, 1879, H-4, p. 20.
22 Evening Post, Wellington, 19 June 1877, and editorials, 20 and 27 June 1877, 21 and 27 February 1880; 'Inquirer', letter to Evening Post, 25 September 1877; Evening Argus, Wellington, 17 October 1877; New Zealand Times, Wellington, 21 and 23 June 1877, 18 February 1880; Evening Chronicle, Wellington, 3 March 1879 and 9 April 1880; W. Hutchison, letter to Evening Chronicle, 10 March 1879 and 7-9 April 1880; AJHR, 1879, H-4, p. 9; Colonial Secretary to Inspector-General, 3 April 1880, IA 4/47, L. 80/674. Skae steadfastly stood by J. Whitelaw, the Superintendent. AJHR, 1880, H-6, p. 6.
23 New Zealand Times, 23 April and 18 May 1881. A.H. Neill, a Dunedin medical practitioner was appointed. Details are unavailable about his experience in psychiatry. Neill may have agreed to take the job with the prospect of promotion to Dunedin / Seacliff where he returned in November 1881. Evening Post, 29 November 1881.
24 Report of the Royal Commission of Inquiry into the Wellington Lunatic Asylum, 13 April 1881, IA 101/1, p. 17.
25 Inspector-General to Minister, 7 February 1911, HMH 1913/1322.
26 A.C. McKillop was appointed in 1919 but took charge of Nelson Mental Hospital instead. H.M. Buchanan then expressed interest in the position at Hokitika and was given the job. AJHR, 1920, H-7, p.5; H.M. Buchanan to Inspector-General, 11 October 1920, and Inspector-General to Secretary, Public Service Commission, 30 October 1920, HMH 7/39; Inspector-General's report, Hokitika, 4 March 1921, West Coast Hospital Board Archives, National Archives, Christchurch, CAHW 83 CH 22.
27 Director to Minister, 27 June 1950, Mental Hospitals Department File, MH 25/23, formerly held in Health Department head office records storage but current whereabouts unknown; Mental Defectives Amendment Act 1950, s. 3.
28 AJHR, 1951, H-31, p. 16.
29 AJHR, 1877, H-8, p. 5.
of £600. This gave them a marked pay advantage over the former lay superintendents that was generally preserved. Even with residual anomalies, the medical salary advantage was established over other occupational groups at an early stage.

Skae expected medical superintendents to have specialist professional standing through experience as an assistant physician at a 'first-rate' British county asylum. The equivalent standing and experience was not available in New Zealand, whose first completely trained medical students did not graduate until 1885. Even so, medical education in New Zealand provided rudimentary instruction in insanity although the subject was optional for some years, as appendix 5 notes. Nineteenth century New Zealand medical professional associations operated at the general and not the specialist level. In Britain, however, insanity became a compulsory subject of the medical undergraduate curriculum in the late nineteenth century. The Medico-Psychological Association (M.P.A.) was a specialist body for psychiatrists in the United Kingdom and Ireland, membership of which was obtained through clinical experience in British asylums. A number of early New Zealand medical superintendents like W.E. Hacon, T.R. King, E.G. Levinge, and J. Cremonini had the requisite British asylum experience and were therefore members of the

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30 Some provincial government salary anomalies survived into the 1880s. Other anomalies were caused by the role of Porirua as an adjunct to Wellington Asylum (1895), and the very long service of two of the lay superintendents at Hokitika (1890-1900, 1915-20).

31 AJHR, 1878, H-10, pp. 10-11.


33 T. Radford King was not related to Sir Truby King. T.R. King worked at Marlborough House, Slough, before he emigrated. His New Zealand career includes office as Medical Superintendent at Wellington (1881, 1894), Seaciff (1887-9) and Auckland (1889-90). King left the service on the ground of ill health but rejoined as an assistant to the Medical Superintendent, Porirua and Wellington, resident at Porirua, in 1895. Inspector-General's report, Wellington, 18 May 1896, AJHR, 1897, H-7, p. 11.

34 In 1876, E.G. Levinge, Medical Superintendent at Wellington (1882-7) and Sunnyside Asylums (1887-1905), was Assistant Medical Officer at Hampshire County Asylum. Levinge's experience also included service as Assistant Medical Officer at West Riding Asylum, Yorkshire, and Deputy Medical Superintendent of the Hampshire County Asylum. He worked at asylums in Newcastle on Tyne and Bristol. G.H. Scholefield, ed, Who's Who in New Zealand, First Edition, Wellington, 1908, p. 96; G.R. Macdonald Dictionary of Canterbury Biographies, Canterbury Museum, Christchurch, G.R. McDonald Canterbury Biographies, Canterbury Museum, L. 199.

35 Cremonini, Auckland's Medical Superintendent (1886-9), ran a large private English asylum, Hoxton House, before he emigrated. Cremonini in interview, Auckland Star, 19 November 1886.
After 1886, specialist membership was obtained by the Association's examination. Successful applicants were awarded the Certificate of Efficiency in Psychological Medicine (M.P.C.). MacGregor, Inspector-General (1886-1906), was more relaxed about the specialist standard. He never joined the M.P.A., nor did the Young brothers who ran the Auckland Asylum in the late 1880s. Truby King's specialist field was public health. The only specific preparation in insanity he had was a brief undergraduate course at Edinburgh under the eminent alienist, Sir Thomas Clouston.

Skae's 1:200 formula for full-time medical superintendents quantified for the first time departmental medical staff needs in relation to the number of patients. The early medical superintendents carried the entire clinical responsibility as well as their administrative duties, but at the cost of their health. During MacGregor's administration, burnt-out medical superintendents and the Inspector-General himself were granted extended leave to recuperate. By the late nineteenth century, institutions had grown too big and the clinical workload too large for single-handed

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36 The only early medical superintendents about whom there is no information are A.H. Neill, Medical Superintendent, Wellington (1881) and Seafcliff (1882-7), and T. Aickin, Medical Superintendent, Whau (1869-1878).

37 Nevertheless, they received the Journal of Mental Science. The University of Otago's early copies of the Journal are inscribed with the signature of A. Young.

38 MacGregor was sufficiently impressed by King's general competence and ambition as to lure him to Seafcliff in 1889 with the prospect of an academic appointment as Lecturer in Mental Diseases at the Otago Medical School. Testimonials and Application of F.T. King for the position of Resident Medical Officer, Wellington Hospital, 11 February 1888, Plunket Society Archives, Hocken Library, 89-098-44; W. Carmalt Jones, Annals of the University of Otago Medical School, Dunedin, 1945, p. 95. In evidence at Regina v. S. Maxwell, 31 August 1893, MH 1891/2511, pp. 16, 91, King said that he attended a special fortnight's training course in insanity under Sir Thomas Clouston. When King studied medicine at Edinburgh, Clouston, the Lecturer in Mental Diseases, had rearranged the undergraduate teaching to a summer course of three months with 12 weekly lectures at the University and twice-weekly visits to the Royal Edinburgh Asylum for clinical instruction. Towards the end of the course, he gave four systematic demonstrations on the pathology of insanity. Students normally undertook the course in their fourth year. Psychiatry did not become a compulsory part of the medical curriculum in Scotland until 1893. A. Beveridge, 'Thomas Clouston and the Edinburgh School of Psychiatry' in G.E. Berrios and H. Freeman, eds, 150 Years of British Psychiatry 1841-1991, London, 1991, p. 373.

39 E.g., Medical Superintendent's report, Sunnyside, AJHR, 1896, H-7, p. 3; Inspector-General's report, Auckland, 22 February 1897 and Medical Superintendent's report, Seafcliff, AJHR, 1897, H-7, pp. 5, 9; AJHR, 1903, H-7, p. 4, and 1905, H-7, p. 7. In 1895, King's health deteriorated badly. 'It is suicidal to remain at Seafcliff beyond the time when I feel able to travel to a warmer and more genial region', he wrote in applying for extended sick leave. Medical Superintendent, Seafcliff to Inspector-General, 29 July '895, Plunket Society Archives, Hocken Library, 89-098-25. Prior to taking extended leave in 1904, King fought a succession of colds but persisted with the paper work from his sick-bed. 'Lizzie' to Miss Mary King, n.d. [c. 1944], Plunket Society Archives, Hocken Library, AG 7 5-31. Wartime conditions precluded overseas leave for Hassell when his health collapsed under the strain of running a short-staffed institution. He merely swapped jobs with the Medical Superintendent, Nelson. AJHR, 1918, H-7, p. 6.
management. In 1890, W.E. Hacon, an ex-Medical Superintendent of Sunnyside and by then a strong critic of his former department, claimed that throughout the country there was only one doctor for every 240 asylum patients. In the four largest asylums, he reported a ratio of 1:364.⁴⁰ These ratios were a far cry from the acceptable standard of 1:150-200 Hacon cited to support his case for assistant medical officers (A.M.O's), following British practice. MacGregor staved off introducing a second level of medical staffing,⁴¹ and medical superintendents discounted the need for additional medical assistance for many chronic patients but, in deference to public demands, appointments were eventually made.⁴² The first A.M.O. was appointed at Seacliff because of the asylum's remoteness.⁴³ By 1912, appointments had been made to all major hospitals.

By the early twentieth century, the structure of the Department's medical staffing posed three policy issues about professional training. First, overworked and isolated medical superintendents ran the risk of losing touch with professional developments, especially in their firm reference point, the United Kingdom. Next, the establishment of a new level of medical staffing created a career structure for doctors who were content to work for the Department. A.M.O's provided a pool of 'apprentices, superintendents in training', to borrow Scull's description, from which promotions were made.⁴⁴ By 1912, responsibilities of medical officers were split between assistants and seniors. Senior medical officers acted as medical superintendents when necessary.⁴⁵ Third, New Zealand medical graduates would inevitably outstrip the number of immigrant practitioners. How could A.M.O's, and particularly New Zealand trained graduates, become specialist psychiatrists equipped for senior management positions in the Department? These policy questions became more pressing as medical staff needs grew.

⁴¹ AJHR, 1887, H-9, p. 3.
⁴² Inspector-General's report, Auckland, 3 October 1893, AJHR, 1894, H-7, p. 3.
⁴³ Inspector-General's report, 2-5 May 1885, AJHR, 1885, H-10, p. 13; Colonial Secretary, NZPD, 17 July 1890, 68, p. 16; Medical Superintendent, Seacliff to Inspector-General, 11 September 1893, DAHI D 264/15.
⁴⁴ Scull, Solitary, pp. 234-5. Cf. Truby King, evidence in Regina v. S. Maxwell, pp. 94-95, MH 1891/2511. One A.M.O. at Porirua was actually referred to as the Assistant Medical Superintendent. Inspector-General's report, Porirua, 23 September 1900, AJHR, 1901, H-7, p. 5.
Senior staff used several means to keep up to date in their specialty. With the exception of MacGregor, all departmental heads belonged to the Medico-Psychological Association and retained their membership for some years. The Department (and possibly some institutions) subscribed to leading British specialist journals. The dates of the earliest copies suggest that this was an innovation by the second Inspector-General, G.W. Grabham (1882-6). In 1901, Truby King proposed that medical superintendents should join the M.P.A. He also urged the Inspector-General to bring medical superintendents together in national conferences. Nothing came of his first idea but the idea of a medical superintendents' conference took hold in 1913. Extended leave enabled convalescent medical superintendents to undertake informal study tours of British institutions. In 1897, 1903 and 1908, a case was made for regular sabbatical leave. T.G. Gray, Director-General (1927-47), had two spells of sabbatical leave, in 1927 and 1934. H.M. Buchanan studied occupational therapy in Britain (1938). Medical staff visiting the United Kingdom on study or sabbatical leave helped choose applicants for jobs.

When he was in Britain on extended sick leave in 1894, Truby King whimsically followed up the suggestion of an old student friend to swot hurriedly for the M.P.C. examination. Despite his doubts, he passed the examination. This set a precedent for training New Zealand A.M.O's overseas. Otherwise they had to learn on the job alongside more experienced colleagues. The success of this method depended upon the rough and tumble of medical staff pressures. Cody quotes

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46 Bound copies and runs of the *Journal of Mental Science*, *British Medical Journal* and *Lancet* that were part of the head office library are now held in the Ministry of Health Library. Members of the M-P.A. would have received journals by virtue of membership.

47 Medical Superintendent, Seaciff to Inspector-General, 30 April 1901, DAHI D 264/23.


51 Medical Superintendent's report, Auckland, AJHR, 1939, H-7, p. 5.


53 King to wife, 10 July 1894, Sir Truby King Papers, Alexander Turnbull Library, MS 1004. King feared that he had failed the examination, though the *Journal of Mental Science* listed his name among those who passed the examination held at Bethlem Hospital on 21 July 1894. King to wife, 21 July 1894, cited in Mary King, *Truby King The Man*. London, 1948, pp. 97-98; *Journal of Mental Science*, 49 (1894), p. 704.
'Ruth', a woman psychiatrist who recalled that the medical staff shortage in the 1940s precluded any teaching or supervision on the job. Psychiatry was largely self-taught through sheer experience.54

In 1910, F. Hay (Inspector-General, 1907-24) wanted the small number of future psychiatrists to be better equipped. He mooted a post-graduate diploma in psychological medicine along the lines of those recently established overseas in public health or tropical medicine. A similar development had occurred in psychiatry when the post-graduate medical Diploma in Psychological Medicine (D.P.M.) was first offered at the Universities of Edinburgh, London, and Durham in 1911. The D.P.M. superseded the M.P.C.55 Hay’s plea to the University of Otago to follow suit by ‘extending the understanding of mental disease, and checking the tendency towards vague speculations’56 was not taken up until after World War II.57 The most practical alternative was to offer promising New Zealand educated graduates who became assistant medical officers limited opportunities to obtain experience and/or post-graduate qualification in Britain. H.E. Jeffreys was the first to do so, on leave without pay, in 1907.58 Gray took a similar line to Hay because he preferred a capable A.M.O to have had experience at a mental hospital in London or Edinburgh than to be a homegrown product.59 The Department’s report for 1928 mentions two medical officers on study leave in Britain, one of whom was studying for his D.P.M. at the prestigious Maudsley Hospital.60 Overseas training was an expensive policy that could be offered to a selected few who seemed destined to rise in a departmental career structure.

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56 AJHR, 1910, H-7, p. 5.
58 Inspector-General’s report, Porirua, 15 March 1907, AJHR, 1907, H-7, p. 29. Jeffreys remained with the Department and had charge of Porirua (1920-5) and Nelson (1925-31).
59 Director-General to Sir Lindo Ferguson, 13 August 1930, HMH 26/75.
60 AJHR, 1929, H-7, p. 4.
Policies to retain medical staff relied on an elongated career pathway with salary breaks at different steps. By 1912, the A.M.O class had been subdivided into junior and senior positions. In 1937 another tier, of deputy medical superintendent, was established in major institutions. Successful performance as the medical superintendent of a smaller or training institution could lead to promotion to a larger institution or to head office positions for those prepared to move around the service.

Within institutions, status was secured by the absolute salary margin of medical staff over other occupations. Table 14 shows only one instance when doctors were not the top-paid occupation in state run mental hospitals. Qualified specialists enjoyed further advantage within the medical salary range. Only twice between 1880-1947 did the minimum medical administrative salary advantage over all other occupational / functional managers slip below 100 per cent.

Institutional customs, like saluting, preserved medical pre-eminence on and off the job from early times. When necessary, the Department set policies to manage social relationships between medical and other staff. At the Seacliff Inquiry in 1887, the Matron testified that she told the A.M.O. that it was 'infra dig', or not done, for someone in his position to go strolling with the attendants. The doctor told the inquiry that he objected to 'messing' with the Clerk and Matron and preferred to take his meals in his own room. Jeffreys also objected to the cups and saucers provided, and deemed them to be common. The then Medical Superintendent, A.H. Neill, did not admit him to any friendship. After some lapses in the accepted social proprieties, Gray ruled on the expectations of social contact between medical and other staff in 1932. Social intercourse was strictly limited to institutional social events. Doctors could participate in sports gatherings. They were never to drink

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61 Inspector-General’s reports, Auckland and Seacliff, and Medical Superintendent’s report, Porirua, AJHR, 1912, H-7, pp. 11, 13, and 16.
62 AJHR, 1938, H-7, p. 4.
63 This can be accounted for by the unique role of the Chief Engineer, Porirua, who was also the electrician. His services seem to have been used in a national advisory role in the Mental Hospitals Department and the Public Health Department.
64 Matron C. Grundy, evidence to Inquiry into the Management of Seacliff Asylum, 1887, IA 102/1.
65 Head Attendant J. MacDonald, evidence to Inquiry into the Management of Seacliff Asylum, 1887, IA 102/1. MacGregor, incidentally, asked him if he were the ‘Chief Warder’.
66 Dr J.G. Jeffreys, evidence to Inquiry into the Management of Seacliff Asylum, 1887, IA 102/1.
## TABLE 14

**SALARY RELATIVITIES AMONG KEY OCCUPATIONAL GROUPS IN INSTITUTIONS, 1880-1947**

<table>
<thead>
<tr>
<th>Year</th>
<th>1880</th>
<th>1885</th>
<th>1890</th>
<th>1895</th>
<th>1900</th>
<th>1905</th>
<th>1910</th>
<th>1915</th>
<th>1920</th>
<th>1925</th>
<th>1930</th>
<th>1935</th>
<th>1940</th>
<th>1947</th>
</tr>
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<tbody>
<tr>
<td><strong>SUPERINTENDENCE</strong></td>
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<td></td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Maximum Lay</td>
<td>400</td>
<td>300</td>
<td>300</td>
<td>300</td>
<td>200</td>
<td>220</td>
<td>300</td>
<td>395</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Minimum Medical</td>
<td>400</td>
<td>400</td>
<td>450</td>
<td>300</td>
<td>525</td>
<td>600</td>
<td>600</td>
<td>590</td>
<td>550</td>
<td>1024</td>
<td>1050</td>
<td>840.1</td>
<td>1200</td>
<td>1425</td>
</tr>
<tr>
<td>Medical Advantage</td>
<td>-</td>
<td>33.3</td>
<td>50.0</td>
<td>-</td>
<td>75.0</td>
<td>300.0</td>
<td>272.7</td>
<td>63.9</td>
<td>140.5</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

| **OCCUPATIONAL MGMT** | | | | | | | | | | | | | | |
| Maximum Inst. Chief Clerk | 150 | 150 | 180 | 190 | 200 | 200 | 320 | 415 | 440 | 440 | 361.5 | 410 | 610 | 610 |
| Max. Head Attendant | 130 | 120 | 125 | 130 | 135 | 145 | 145 | 285 | 385 | 405 | 405 | 344.5 | 360 | 510 |
| Max. Farm Manager | 100 | 100 | 110 | 120 | 120 | 130 | 150 | 250 | 330 | 350 | 350 | 340.2 | 490 | 510 |
| Max. Works Overseer | - | - | - | - | - | - | - | - | 350 | 350 | 314.7 | 355 | 460 | 460 |
| Maximum Matron | - | - | - | - | - | - | - | - | - | 340 | 314.7 | 405 | 510 | 510 |
| Minimum Medical Advantage | 166.7 | 166.7 | 150.0 | 66.7 | 176.1 | 200.0 | 200.0 | 84.4 | 128.9 | 132.7 | 138.6 | 138.6 | 144.9 | 133.6 |

| **OTHER PROFESSIONAL** | | | | | | | | | | | | | | |
| Minimum Full-time Medical | 400 | 400 | 250 | 250 | 250 | 275 | 300 | 410 | 550 | 515 | 590 | 562.85 | 565 | 850 |
| Maximum Engineer | - | - | 100 | 208 | 208 | 250 | 275 | 425 | 7425 | 420 | 425 | 425 | 361.5 | 425 |
| Maximum Dentist | - | - | - | - | - | - | - | - | - | - | - | - | 515 | 800 |
| Maximum Paramedical | - | - | - | - | - | - | - | - | - | - | - | - | 310 | 234 | 300 |
| Max. [Senior] Male Attendant | 780 | 80 | 80 | 80 | 80 | 95 | 108 | 140 | 7200 | 250 | 250 | 224.45 | 275 | 365 |
| Max. Female [Staff] Attendant | - | - | 50 | 50 | 50 | 55 | 60 | 92.5 | 7155 | 160 | 160 | 143.65 | 170 | 300 |

| Salary Advantages | | | | | | | | | | | | | | |
| Minimum Overall Medical | - | - | 150.0 | 20.2 | 20.2 | 10.0 | 9.1 | -3.5 | 29.4 | 17.8 | 38.8 | 52.9 | 9.7 | 6.3 |
| Chief Clerk / Head Attendant | 15.4 | 25.0 | 44.0 | 38.5 | 40.7 | 37.9 | 37.9 | 12.3 | 7.8 | 8.6 | 8.6 | 4.9 | 13.9 | 19.5 |
| Head Attndt / Farm Manager | 30.0 | 20.0 | 13.6 | 8.3 | 12.5 | 11.5 | -3.4 | 14.0 | 16.7 | 15.7 | 15.7 | 1.3 | -36.1 | - |
| Paramedical / Attendant | - | - | - | - | - | - | - | - | - | 24.0 | 4.23 | 9.1 | 9.6 | 9.6 |
Salary includes housing allowance when paid as part of salary. Deductions for board and lodging, housing or meals have not been included.

Married allowance of £20 for married male staff included where applicable.

Unverifiable information is preceded with a question mark and represents the most likely figure.

Senior Attendant and Staff Nurse refer to the highest level of attendant below Charge Nurse category. These staff did not have management / supervisory responsibilities but, after 1907, they were expected to have qualified as attendants or nurses.

The 1947 paramedical / attendant advantage is based on the salary of a qualified occupational therapist (£400).

The Chief Engineer, Porirua (1893-1927) was also an electrician and salary levels reflect that skill.

Figures are stated in nominal £.

Sources: AJHR, 1880-1947, Estimates of Expenditure; AJHR, 1886, H-41, and 1905, H-7, p. 5; Public Service Classification Lists, New Zealand Gazette, 1913-47.
alcohol or to attend race meetings with subordinate officers. How far such etiquette was observed is debatable.

Medical staff shortages and departmental growth ensured that organized recruitment of British immigrant doctors remained a valuable stand-by. Qualified psychiatrists were recruited from Britain as assistant and senior assistant medical officers. Special campaigns were organized in 1910-14, 1927-8, 1934, 1938, 1944-5 and 1947, long after the medical workforce was predominantly New Zealand trained. In a crisis, Gray plugged gaps in the medical ranks with inexperienced recent graduates, unsuitable older practitioners, or sixth year medical students.

Many explanations can be offered for the limited success of medical recruitment and retention policies in attracting an adequate number of staff. Psychiatry never overcame its low status in a medical profession whose hierarchical positioning of specialities was (and remains) important. Gray recalled that doctors who entered

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67 Director-General, Circular to Medical Superintendents (personal), 18 August 1932, MH Circulars.

68 For example, in 1952, attempts by the wife of the new Medical Superintendent at Seacliff to limit social contact between doctors' wives and the wives of other staff were ignored. Personal communication, J.O. Mackie, 20 March 2000.

69 Inspector-General to Professor C. Hercus, 18 October 1927, HMH 8/36/0(1).

70 E.g., Dr Burns was appointed to Seacliff in 1893 on the strength of several years' experience in a Scottish asylum. Inspector-General's report, Seacliff, 6 November 1893, AJHR, 1894, H-7, p. 5. H. Barraglough was an A.M.O. at an English asylum before he was recruited from advertisements in Britain and New Zealand. Medical Superintendent's report, Porirua, AJHR, 1901, H-7, p. 9. Those recruited from the United Kingdom between 1911-4 included Dr Ross, formerly A.M.O. at Aberdeen Royal Asylum; A.C. McKillop, Senior Assistant Medical Officer (S.A.M.O.) at Inverness District Asylum; and T.G. Gray, S.A.M.O. at Kingsseat Asylum, Aberdeen. Each held the M.P.C. AJHR, 1912, H-7, pp. 13-14. Other examples were Dr Simpson, from Inverness District Asylum, who came to Porirua. He also held the M.P.C. Medical Superintendent's report, Porirua, AJHR, 1913, H-7, p. 16. Medical officers selected in Britain in 1927-8 were also qualified specialists. AJHR, 1928, H-7, p. 3, and 1929, H-7, p. 4.

71 E.g., AJHR, 1911, H-7, p. 6; High Commissioner to Prime Minister, 5 February 1914 and Inspector-Genera to Public Service Commissioner, 5 May 1914, HMH 8/62; AJHR, 1927, H-7, p. 8, 1928, H-7, p. 3, and 1929, H-7, p. 4; Director-General to Minister, 23 March 1945 and 7 May 1945, HMH 8/36/0(2); Deputy Public Service Commissioner to Minister, 29 July 1934, and Minister to High Commissioner, London, 16 July 1938, HMH 8/36/0(1); Director-General to Public Service Commissioner, 26 October 1944, MH 8/71; Director-General to Minister, 23 March 1945, HMH 8/36/0(2); AJHR, 1947, H-7, p. 3.


73 AJHR, 1939, H-7, p. 4.

74 AJHR, 1946, H-7, p. 4.

75 Cody, p. 123.
psychiatry were thought to be eccentric and personifications of the adage *similia similibus*. Some women doctors entered psychiatry when they found their entry to other specialties or private practice blocked. The first woman doctor was employed at Seacliff, once the Minister supported the idea in 1903, but only until a male doctor could be appointed. Cody names several women doctors who took jobs in mental hospitals early in their medical careers. Thompson's thesis points to many advances in professionalization, but it does not indicate that the status of psychiatrists in New Zealand was affected by their being salaried government officials. The medical profession did not measure professional excellence by bureaucratic accountability but in terms of the individual doctor-patient relationship, specialist private practice, and honorary consultancy in public hospitals. Stipendiary medical staff in general hospitals were better off than their mental hospital counterparts because they could use their position as a stepping stone to lucrative consultancy and private practice. The virtual public sector monopoly of psychiatry did not provide the same prospects.

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77 Anderson, pp. 67-68, attributes this to the prevalence of the notion of an ideology of separate spheres, whereby women doctors tended to work more in health services affecting women, children, or the poor, or they worked in low status hospital specialties. Cody, p. 37, reports that 8/145 women registered medical practitioners spent part of their career working in a mental hospital. The problem was not unique to New Zealand, as Cody, pp. 18-20, 30-34 notes.

78 NZPD, 18 September 1903, 125, p. 605.


80 Cody, pp. 34-35. Women brought their own skills to the area. Even the irascible Beattie found them a great success. Having appointed two lady assistants, he wished it were made compulsory for institutions to have them because they were loyal and faithful in their work beyond all dispute. Medical Superintendent's reports, Auckland, AJHR, 1921, H-7, p. 6 and 1922, H-7, p. 8.


82 Inspector-General to Secretary, Public Service Commissioner, 13 April 1915, HMH 8/62.

83 Inspector-General to Secretary, Public Service Commissioner, 24 September 1920, HMH 8/62.
Although medical superintendents were granted status as honorary consultants at some general hospitals,\(^{84}\) relativity was sought with the pay of salaried doctors in general hospitals and, to a lesser extent, private practitioners. The first obvious comparison was made in 1921, when departmental medical salaries were found to have lagged far behind those paid in general hospitals.\(^{85}\) They stayed that way for some years. Gray noted that attractive career options elsewhere continued to lure junior and middle level medical staff away from mental hospitals.\(^{86}\) Between 1926-36, 24 A.M.O's left to further their prospects in private practice or overseas.\(^{87}\) This is not surprising given that in 1937 the Department paid junior medical staff £560 and gave them free board. General practitioners were reputed to earn £1,000 a year.\(^{88}\) In 1934, Gray cited the case of a general practitioner who, without any administrative background, could be appointed as the medical superintendent of a general hospital at a salary of £1,250 and a rent-free house. A mental hospital equivalent, with 20 years service, was paid £755 with a free residence, free fuel, lighting and laundry service. Gray's pleas brought about some improvement but never parity.\(^{89}\)

Gray initiated or supported attempts to enhance the prestige of somatic psychiatry as a branch of scientific medicine. This is consistent with Thompson's account of the professionalization of psychiatry in New Zealand.\(^{90}\) During the period under review, the number of psychiatrists in New Zealand was probably too small to sustain an association with the usual hallmarks of professionalization. There was no New Zealand specialist journal. Specialist education was unavailable. At best, attempts to form a national specialist society were short-lived. Gray tried to direct intere: in

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\(^{84}\) File note, 2 August 1936, Secretary, Auckland Hospital Board to Director-General of Health, 17 September 1935, and Secretary, North Canterbury Hospital Board to Director-General of Health, 24 September 1936, H 53/977 (42436).

\(^{85}\) Inspector-General to Minister (personal), 27 January 1921, HMH 8/62.

\(^{86}\) Director-General to Minister, 25 November 1936, HMH 8/62; Director-General to Public Service Commissioner, 16 October 1941, HMH 8/0/1; Director-General to Public Service Commissioner [?], 26 October 1944, MH 8/71; Director-General to Secretary, Consultative Committee, Public Service Commission, 21 May 1945, H 30/7/5 (31097); AJHR, 1945, H-7, p. 3.

\(^{87}\) Director-General to Minister, 25 November 1936, HMH 8/62.


\(^{89}\) Director-General to Secretary, Public Service Commission, 22 June 1934, HMH 8/36/0(1); Deputy Public Service Commissioner to Minister, 29 June 1934, HMH 8/36/0(1); NZPD, 26 October 1934, 240, p. 852.

the mental hygiene movement toward setting up a New Zealand branch of the Royal Medico-Psychological Association. His idea was consistent with moves in other medical specialties in Australasia as they branched from their British parentage. Departmental medical officers dominated the first (and apparently only) scientific meeting, held at Christchurch in February 1929. This organization was intended to break down barriers between institutional work and general medical practice by providing a forum and for stimulating mutual interest in scientific psychiatry. The Association soon ‘petered out’ through lack of support. Efforts to revive the Otago Council for Mental Hygiene in 1947 also showed the fragility of a solely New Zealand endeavour. The year before, though, the Australasian Association of Psychiatrists was formed. New Zealand was not represented at the inaugural meeting held in Australia at Australian instigation, but at Gray’s suggestion, up-and-coming departmental psychiatrists became foundation members, some as New Zealand councillors. Gray and Lewis did not join. A New Zealand Branch was


92 Inspector-General to Secretary [?], Royal Medico-Psychological Association, 30 October 1928, and President’s reply, 24 December 1928, Royal College of Psychiatry Archives. In this matter Gray had the support of A.R. Falconer who thought that the New Zealand Council of Mental Hygiene should be the tool of the proposed branch of the Medico-Psychological Association and psychiatrists. Medical Superintendent, Ashburn Hall to Director-General, 14 February 1929, HMH 4/4/6.


94 *AJHR, 1929, H-7, p. 4; D.M. MacDonald to Inspector-General (personal), 27 June 1925, HMH 21/28/1*. Marshall MacDonald, the President of this meeting, was not a departmental officer. This physician and neurologist retained a life-long interest in the nervous disabilities of ex-servicemen following his own service in the Great War. He was active in attempts to persuade the Otago Hospital Board to develop psychiatric services. Obituary, *New Zealand Medical Journal, 55* (1956), pp. 414-5.

95 Director-General to Professor W.S. Dawson, Sydney, 30 July 1946, Health Department Archives, National Archives, Wellington, H 30/1/1 (28610).

96 H. Palmer to Director, 14 April 1949, MH 26/68. The New Zealand Council apparently lingered on for several years but was described as somewhat shaky and inactive. Its future was to be decided when a new senior lecturer in psychiatry arrived. Director to Official Secretary, New Zealand High Commissioner, London, 1 August 1952, MH 26/68.

not formed until 1955. The Association quickly restricted its membership to psychiatrists. The difficulties of forming a specialist association in New Zealand were not confined to the somatic branch of psychiatry. Psychoanalytically oriented professional societies formed at Auckland and Christchurch in 1942-4 also struggled.

Throughout its history, the Department favoured qualified specialist psychiatrists for appointment at different levels of the medical hierarchy. The greatest gains were made through the appointment and training of medical staff in the speciality at all levels of the Department. Psychiatrists then completely controlled policy development and the management of institutional staff and services. A number of individuals retained links with the Medico-Psychological Association but efforts to form a similar body in New Zealand largely failed. Local efforts were fragile and belated. Although the Department and the University of Otago Medical School had interests in the teaching of psychiatry, the Department could only influence, not control, the content and depth of medical education. Some gains were made in the recognition of psychiatry in the undergraduate curriculum between 1889-1947, but post-graduate teaching failed to eventuate.

In spite of professional gains, the small number of practitioners, their geographical isolation, their status as government officers, and the low standing of psychiatry within the medical profession, all hampered the attractiveness of psychiatry as a profession. Persistent shortages made numerical ratios somewhat academic. By 1924, the accepted ratio was 1:300 but nominal ratios, which made no allowance for the administrative responsibilities of medical superintendents, generally exceeded that. In 1936, the New Zealand ratio varied from 1:303 - 1:775 with effectively one A.M.O. for every 501.6 patients. London mental hospitals, however, still had a ratio

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98 Rubinstein and Rubinstein, p. 4 ff.
100 Personal communication, Mr J.O. Mackie, 20 March 2000.
101 Inspector-General to Secretary, Public Service Commission, 18 June 1924, HMH 8/36/0(1).
102 Based on the number of doctors in the Public Service Classification Lists and the average patients resident in institutions, the ratios for 1913, 1920, 1930 and 1940 were 1:325, 1:330, 1:326 and 1:315. The 1940 figure takes account of doctors on active service overseas.
of 1:250.103 Regular on-call work at night was automatically expected and accepted as a professional responsibility. Little wonder that Janet Frame, writing of the mid-1940s, described the ward round as cursory with doctor-patient contact carefully managed by the ward sister and matron.104 In Kennedy's fictionalized Porirua Mental Hospital of the 1940s105, five qualified doctors, only three of whom were trained psychiatrists, had their hands full with 2,000 patients. 'It was a vicious circle,' she observed, 'poor conditions owing to lack of psychiatrists and lack of psychiatrists owing to poor conditions'.106 This acute shortage added to other post-war pressures upon the Department as more outpatient services were demanded, three new institutions were opened, and therapeutic developments required intensive medical involvement. The war had swollen the paperwork by requiring psychiatric reports on armed services personnel and applicants for war pensions.107 Frustrated by the pressure, some medical superintendents and medical officers by-passed the traditional route for addressing labour concerns. In the past, departmental heads personally championed their cause,108 but to speed up action the Psychiatric Medical Officers' Association (P.M.O.A.) was formed in 1948.109

ATTENDANTS

Male and female attendants were by far the largest group of departmental employees, as Table 13 shows. They were employed on a ratio of approximately 1:10 patients, based on the number of budgeted positions for day and night staff.

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103 Director-General to Minister, 25 November 1936, HMH 8/61.
104 Frame, pp. 27-28, 118.
105 Kennedy, p. 32.
107 AJHR, 1945, H-7, pp. 3-4.
108 E.g., Inspector-General to Secretary, Public Service Commission, 13 April 1915 and 24 September 1920, HMH 8/862; Inspector-General to Minister (personal), 27 January 1921, HMH 8/862; Director-General to Minister, 25 May 1934, HM 7/3/5; Director-General to Minister, 25 November 1936, HMH 8/862; Director-General to Public Service Commissioner, 16 October 1941, HMH 89/1; Director-General to Public Service Commissioner, 25 October 1944, MH 8/71.
109 K.R. Stallworthy (Secretary) and B.D. Hart (Chairman) to Secretary, Public Service Commission, 23 April 1948, H 30/110 (34259); Director to Secretary, Public Service Commission, 11 May 1948, and Association’s first report, 17 June 1948, Director to Secretary, P.M.O.A., 23 December 1948 and 16 January 1949, H 30/110 (34269). This Association did not enjoy whole-hearted support among institutional medical staff. It upset management both by directly approaching the Public Service Commission and by its concern about employment rather than clinical matters.
That ratio generally corresponded with the more precise 1:10 formula suggested by Burdett\textsuperscript{110} and Mercier in their authoritative texts on asylum organization in the 1890s. That ratio was adequate, Mercier held, for wards of mixed patients, for escort duties outside, and for providing special individual attention to suicidal, dangerous or gravely ill patients. Mercier’s formula also made due allowance for staff on leave.\textsuperscript{111} This formula generally corresponds with the situation in nineteenth century New Zealand public asylums. Nationally, male attendant ratios rose from 1:10.7 in 1876 to 1:11 in 1890, dipped to 1:9.91 in 1890 before they recovered to 1:10.3 in 1905. Female patients had a better ratio of attendants, starting at 1:8.6 in 1876 and peaking at 1:9.5 in 1890 before settling to 1:9.1 in 1905.\textsuperscript{112}

The custodial and domestic nature of attendants’ work was sometimes compared with that of male prison officers and female domestic servants. Until the early twentieth century, attendants’ pay levels invited such comparisons.\textsuperscript{113} Attendants’ hours of work were also reminiscent of those of Victorian household servants.\textsuperscript{114} In 1884, Hokitika attendants worked 12 hours daily in summer and 11 in winter, less 1.5 hours for meals. They were off-duty for only one weekday and one Sunday and a half every five weeks. No overtime was paid.\textsuperscript{115}

From 1885, a depressed economy and fiscal prudence left pay rates and hours of work unchanged for most of MacGregor’s administration.\textsuperscript{116} Pay scales for artisan-

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\textsuperscript{112} Based on staff numbers in Table 14 and average number of resident patients.

\textsuperscript{113} For the comparison with domestic servants, see editorial, \textit{Press}, 28 April 1904. The minimum female attendant’s pay was static at £40 per annum from 1890-1905. Under the new scale introduced in 1905, the lowest paid female assistant cook and assistant laundress in the Department received salaries of £45 and £50 respectively. A household’s wardswoman received £32. AJHR, 1905, B-7, pp. 69-71. Belgrave, ‘Rise’, p. 11, noted that the New Zealand census classified hospital nurses as domestics until 1891. For the comparison with prison officers, see A.P. O’Callaghan (Lincoln), NZPD, 1 August 1883, 45, p. 229 and 7 June 1886, 55, p. 341, T. Peacock (Auckland North), NZPD, 14 October 1884, 49, p. 422, W.H. Field (Otaki), 18 September 1903, 125, p. 602; Star, Christchurch, 4 November 1884; AJHR, 1886, H-41.

\textsuperscript{114} In 1912, British attendants worked than 70 hours weekly (meal breaks excluded) and sometimes as much as 90. Superintendents sometimes justified this length on the grounds that the duties were light. Mick Carpenter, ‘Asylum Nursing Before 1914: A Chapter in the History of Labour’ in Celia Davies, ed, \textit{Rewriting Nursing History}, London / Totowa, N.J., 1980, p. 133.

\textsuperscript{115} Superintendent, Hokitika to Inspector-General, 6 November 1884, CAHW 10 CH 22, p. 330.

\textsuperscript{116} Medical Superintendent’s report, Sunnyside, AJHR, 1902, H-7, p. 6.
attendants’ were increased in 1900 in response to labour market conditions\textsuperscript{117} but those of ordinary attendants stayed static for another five years. MacGregor was not inclined to extend the eight-hour day movement to attendants (or hospital nurses)\textsuperscript{118} because of the cost of engaging 25 per cent more attendants.\textsuperscript{119} According to T. Wilford (Wellington Suburbs), who was probably fed the information by dissatisfied attendants in his electorate in 1902, attendants worked an average of ten hours and 52 minutes daily, including Sundays. Single staff had four and one-half hours for recreation every 48 hours and married staff got 12 hours off duty, in addition to an annual leave entitlement of 30 days. The figures were not disputed.\textsuperscript{120} In 1904, staff dissatisfaction at Sunnyside Asylum erupted to force the Department to cede new pay and conditions. The new national roster was based on alternate short (6:30 a.m.-5:30 p.m.) and long days (6:30 a.m. - 8 p.m.). Twenty-eight days annual leave were granted. Every fortnight, attendants had one weekday and a Sunday afternoon off-duty. A whole Sunday’s leave was granted each month. The average working week was 67.5 hours.\textsuperscript{121}

From events in the early years of MacGregor’s inspectorate, it seems safe to surmise that attendants were a motley group. Their calibre disturbed him because:

of all the [government] departments, the Asylum service is that in which discipline must be most rigidly maintained in the interests of the helpless who cannot speak for themselves. The utmost vigilance and promptitude of action are required to prevent cruelty and neglect especially in the present overcrowded state of our institutions ...

\textsuperscript{117} AJHR, 1901, H-7, p. 3.
\textsuperscript{118} AJHR, 1898, H-22, p. 7; Inspector-General’s report, Sunnyside, 20 January 1900, AJHR, 1900, H-7, p. 9.
\textsuperscript{119} C.H. Mills (Wairau), NZPD, 11 July 1902, 120, p. 271.
\textsuperscript{120} T. Wilford (Wellington Suburbs), NZPD, 11 July 1902, 120, p. 270.
\textsuperscript{121} AJHR, 1905, H-7, p. 5. For the events which led to the revision, see editorials, \textit{Press}, 28 April, 23 August and 9 and 20-21 December 1904; ‘Sympathiser’, letter to \textit{Press}, 4 July 1904; ‘An Attendant’, letter to \textit{Press}, 27 August 1904; editorials, \textit{Lyttelton Times}, 11 May, 4 July, 22 August, 9 September, 1 October, and 1 and 19 December 1904. The 1904 scheme generally fitted later Public Service leave provisions for staff who generally worked more than six days a week. In addition to equivalent statutory holidays, they were entitled to take their leave in two fortnightly periods a year if desired. Public Service Regulations 1913, RR. 49, 66.
\textsuperscript{122} Inspector-General to Minister of Justice, 26 June 1896, Inspector-General’s Letter Book 6, p. 467, formerly held in the Department of Health head office but current whereabouts unknown.
MacGregor’s policy of creating a disciplined staff had many facets. Standards were set out clearly in staff rulebooks. These evolved as various local editions until 1901 when a national code was adopted. On opening any early edition of the rulebook, the reader is confronted by a recitation of those sections of the law pertaining to offences by staff. The rulebook was studded throughout with the standards expected of attendants, usually expressed as prohibitions. The growing list of prohibitions indicated by successive editions of the rulebook must have been formulated after experience with unsatisfactory staff. The exemplary standards expected of staff are summarized in appendix 6. To take the 1910 edition as an example, rules forbade disobedience to any order, drunkenness, immoral conduct, foul language, falsehood, dishonesty, insubordination, disrespectful conduct towards superior officers, breaches of regulations, ill-treatment of patients, absence without or beyond leave, neglect of duty, loss of stock, or general inefficiency. Rulebooks also incorporated core values of the wider Civil Service or Public Service, such as obedience to superiors, dedicated whole-time service, and non-disclosure of official information, and the use of proper (bureaucratic or hierarchical) channels of communication.

123 E.g., Nelson Lunatic Asylum, Rules and Instructions for the Guidance of Attendants, Wellington, 1886; Medical Superintendent, Auckland to Inspector-General, 19 August 1900, HMH 8/94/1. The national code was probably developed when the Auckland rules, which were contained in the above memorandum, were followed soon afterwards by a request from Seaciff to revise the local rules. Medical Superintendent, Seaciff to Government Printer, 27 June 1900, DAHI D 264/22; Medical Superintendent, Auckland to Inspector-General, 19 August 1900, HMH 8/94/1. The national rulebook was based upon Christchurch Lunatic Asylum, Regulations for the Guidance of Attendants, Wellington, 1883. National rulebooks were revised in 1910, 1928 and 1940.

124 Mental Hospitals Department, General Rules and Instructions for the Guidance of the Nursing Staff and other workers, Wellington, 1910, p. 5.

125 After 1922, all Public Servants had to sign a declaration of secrecy. See Secretary, Public Service Commission, Circulars to Permanent Heads, 19 November 1920, H 181/87 (34208); Press, 8 February 1921. That requirement simply extended the general rule about unauthorized disclosure of official information set out in the Civil Service Regulations 1867, RR. 20-1, 23 (New Zealand Gazette, 31 December 1867, p. 507). Departmental rules refined the general precept by forbidding staff to make the affairs of the institution in any way a subject of gossip, as shown in Nelson Lunatic Asylum, Rule No. 3; Medical Superintendent to Inspector-General, 19 August 1900, HMH 8/94/1; New Zealand Lunacy Department, Rules and Instructions for the Guidance of Attendants in Lunatic Asylums in New Zealand, Wellington, 1901, p. 10; Mental Hospitals Department, General Rules, Wellington, 1910 pp. 5-6; Mental Hospitals Department, Rules and Regulations for Nurses, Wellington, 1928, p. 7; Mental Hospitals Department, Mental Hospitals: Rules for Staff, Wellington, 1940, p. 5. Application of this rule was sufficient to generate occasional suspicion that mental hospitals were cloaked in secrecy (e.g., editorial, Otago Workman, 10 December 1887; editorials, Dunedin Evening Herald, 23 and 28 January 1888; editorial, Evening Post, 7 February 1893; 'Compos Mentis', letter to Auckland Star, 14 October 1921; undated press cutting, c. October-November 1923, H 54/79 (11305); A. J. Wilson, letter to Eden Gazette, Auckland, 11 March 1924, Taranaki Daily News, 15 September 1925, New Zealand Truth, 9 February 1928, Press, 27 April 1938, all HMH 26/39). The rule about public comment on policy or services, however, was interpreted more flexibly for medical than for other staff. Medical superintendents sometimes used their annual reports to raise criticisms. A few departmental doctors expressed their policy (as opposed to scientific) views in professional journals, public addresses or the
MacGregor sternly enforced the rules. He had a powerful weapon in the Civil Service Reform Act Amendment Act 1887, in the drafting of which the Inspector-General probably had a hand. The section that backdated to 1886 the tenure of asylum ‘warders’ and prison officers as monthly servants provides the clue:127 the date corresponded with his appointment. MacGregor was wont to describe attendants as warders.128 MacGregor started at the top to impose institutional order. Within 18 months of taking office, he held formal inquiries and weeded out the medical superintendents of Auckland,129 Sunnyside,130 and Seacliff.131 E.G. Levinge, media, apparently after scrutiny by superiors (Director-General to Medical Superintendent, Tokanui, 28 November 1930, HMH 2/7/10).

126 Civil Service Regulations 1867, Regulations 5-6, 9, 20, 21, 23, New Zealand Gazette, 31 December 1867, pp. 506-7; Public Service Regulations 1913, RR. 5-6, 23, 30-1, New Zealand Gazette, 1 April 1913, pp. 977-8, 980.

127 Civil Service Reform Act Amendment Act 1887, s. 2(1). MacGregor was related to Stout by marriage and the two were close friends. Alan Henderson, The Quest for Efficiency: The origins of the State Services Commission, Wellington, 1990, p. 18, suggests that Stout’s motive was to strengthen political influence over the Civil Service. Limited tenure gave governments the chance to get rid of officers and to avoid expensive pensions to those who might be laid off during periods of retrenchment. The imposition of a shorter tenure for attendants and prison officers than for other civil servants was not debated in either House. Nor was the measure as a whole debated. The Act also served political ends, and politicians no doubt saw the potential for extended patronage appointments to the Civil Service latent in the only other clause of the Bill. NZPD, 3 November and 12-15 December 1887, 59, pp. 134, 573, 597, 616, 757.


129 After Alexander Young’s death, the superintendence passed to his brother, who resigned after a few months because of the low salary. Auckland Star, 7 August 1886. The same paper, in an editorial of 24 September 1886, said that the superintendence had been offered to Levinge at £500. He refused to take it, so the position was again offered at the old rate of £400.

130 In 1887, an inquiry was held and Hacon left, rather than face transfer (demotion) to Wellington. The reasons are obscure, though in urging MacGregor to state publicly why Hacon left the Department’s employ, Truby King hinted that there had been a problem with post-mortem examinations. Medical Superintendent, Seacliff to Inspector-General [?], n.d. [1891], Plunket Society Archives 89-098-16. Seager’s services were dispensed with a month before Hacon resigned, Evening Herald, Dunedin, 18 April 1887; Return of 26 August 1890, LE 1 1890/114. Seager may well have stayed on so long in the hope of obtaining retiring allowances. He was one of a very few officers whose continuity of employment in the Civil Service was broken by the provincial administration of asylums. Having transferred into the Civil Service from provincial government, he was disqualified from the right to the allowance. Civil Service Act Amendment Act 1878, s. 8; Madeleine Seager, Edward William Seager: Pioneer of Mental Health, Waikanae, 1987, pp. 271-5.

131 MacGregor was initially concerned about Schilling, the Storekeeper, whom he considered totally unfitted for his duties. Despite the Medical Superintendent’s protest, Schilling was dismissed. Neill then unwisely allowed his personal friendship with Schilling, who was also Neill’s ‘ward’, to disrupt asylum discipline. After he had been dismissed, Schilling stayed as a guest in Neill’s apartment, but was given access to the rest of the asylum. The Medical Superintendent protected Schilling from the consequences of flirting with female staff. Minutes of the Inquiry into the Management of Seacliff Lunatic Asylum, IA 102/1. Schilling’s continued presence obliged MacGregor to formally forbid any dismissed person to enter the asylum precincts. One newspaper, fanned no doubt by local sources, reported that Neill was suspended for his prevarication to orders and that a system of espionage had taken the place of proper control. A royal commission was held behind closed doors and, despite public concern, the report was never published. Neill was called upon to resign. Inspector-General’s report, Seacliff. 29 May 1886, AJHR, 1887, H-6, p. 7; Inspector-General to G. Schilling, 11 June 1886,
In his uniform, bearing and demeanour, this attendant at Auckland Asylum, c. 1900, epitomised MacGregor’s view that attendants were warders. (Auckland Institute and Museum photo, negative 133452.)
MALE ATTENDANTS

Attendants on parade at Auckland Lunatic Asylum, c. 1900. (Auckland Institute and Museum photo, negative C1236.)
then in charge of Mount View, was the only medical superintendent to retain MacGregor's confidence.\textsuperscript{132}

MacGregor's appointees were expected to personify Mercier's dictum that a medical superintendent should be

master, not only by mere position, but by right of a masterful nature. He should exercise a personal ascendancy, so that both staff and patients should feel that absolute unquestioning obedience is not only necessary and unavoidable, but is consistent with their highest self-respect... The superintendent must be master, not only of his subordinates, but of himself and his work. He must have an absolute mastery of every detail of his work, and must in case of need be able not only to tell his subordinates what is to be done, but to show them how to do it.\textsuperscript{133}

MacGregor strongly backed his new superintendents throughout their 'baptism of fire'\textsuperscript{134} in imposing staff obedience. The approach of J. Cremonini, the first of these appointments, portended MacGregor's approach. Told to 'redeem' the Auckland Asylum because some attendants began 'to think themselves masters of the situation,'\textsuperscript{135} Cremonini ordered staff to salute the medical superintendent, in line with English asylum practice. Staff rebelled\textsuperscript{136} because, to use the words of the \textit{Auckland Star}, 'frills and starch fit badly upon the throats of colonists and invariably cause

\textsuperscript{132} Inspector-General's report, Wellington, 13 February 1886, AJHR, 1886, H-6, p. 13. MacGregor recommended an increase or bonus to raise his salary from £400 to £500, such as he seemed to have previously offered Levinge to move to Auckland. Inspector-General's report, Wellington, 7 August 1886, AJHR, 1887, H-9, p. 11; Inspector-General's report, Wellington, 1 November 1887, AJHR, 1888, H-6, p. 6.
\textsuperscript{133} Mercier, pp. 197-8.
\textsuperscript{134} Inspector-General's report, Ashburn Hall, 12 January 1900, AJHR, 1900, H-7, p. 11.
\textsuperscript{135} Inspector-General's report, Auckland, 1 December 1886, AJHR, 1887, H-6, p. 6.
\textsuperscript{136} Editorial, \textit{Auckland Evening Bell}, 17 December 1887.
chafing and uneasiness. He asked Macgregor for assistance, and the Inspector-General promptly held a formal inquiry. Cremonini persevered with 'ruling the asylum' but he failed and left in 1889.

Similar authoritarian patterns were established at Christchurch, Seacliff, and Auckland. Newly promoted to Sunnyside in 1887, Levinge said that attendants easily fell into the habit of

looking to the patients to perform all the menial services which at least should be shared with them, and thus they often become slothful, indolent, and careless, or too authoritative and domineering, regarding themselves more as the master or mistress than as the companions or nurses of the patients.

There was an exodus of older staff in reaction to Levinge's 'admittedly vigorous' regime. Nevertheless, the Inspector-General disregarded staff disaffection. 'Every attendant who is able and willing to do his or her work', MacGregor wrote, 'finds in Dr. Levinge a just though determined ruler ... a vigorous administrator whose heart is in his work.' Truby King was also commended for the 'vigour with which the rules are enforced and the cases of discipline which have occurred in the process of securing their enforcement.

King survived the battering from several organized staff rebellions within a few years of taking charge. At Auckland, R.M. Beattie,

\[\text{137 Editorial, Auckland Star, 19 November 1886.}\]
\[\text{138 Cremonini telegraphed Macgregor on 15 November 1886, and asked for assistance. After the inquiry, Macgregor dismissed the drunken clerk. The Inspector-General also accepted the resignations without notice of the others. Because of his past valuable service, Macgregor was prepared to appoint Hardy, the Head Attendant, elsewhere but because such an action might seem to condone bad conduct, Hardy's resignation was accepted. Inspector-General to G. Hardy, 2 August 1887, JA 1/514, L. 87/2609.}\]
\[\text{140 Medical Superintendent's report, Sunnyside, AJHR, 1901, H-7, p. 8.}\]
\[\text{141 'One of the Old Hands', letter to Press, 23 October 1888.}\]
\[\text{142 Inspector-General's report, Wellington, 1 November 1887, AJHR, 1888, H-8, p. 6.}\]
\[\text{143 Inspector-General's report, Sunnyside, 13 August 1890, AJHR, 1891, H-2, p. 4.}\]
\[\text{144 Inspector-General's report, Seacliff, 23 January 1891, AAJHR, 1891, H-2, pp. 5-6.}\]
\[\text{145 E.g., 'Settler (Evansdale)', 'Woodchopper', 'Woodchopper No. 2', 'An Old Colonist', 'Old Colonist', letters to editor, Globe, Dunedin, 18, 27-28 July, 3-4 August 1891, editorials, Globe, 30 July and 1 August 1891; Globe, 3-5, 10 August 1891; 'Impartial', letter to editor, Evening Star, Dunedin, 6 August 1891; editorial, Otago Daily Times, 23 December 1889; Inspector-General's report, Seacliff, 4 August 1891, AJHR, 1892, H-4, p. 4. The Globe was the vehicle for this unrest, which prompted King to seek a public inquiry (Medical Superintendent, Seacliff to Inspector-General, 18 July 1891, Plunket Society Archives, Hocken Library, 69-096-25, and 19 July 1891, DAHI 264/13). In the brouhaha, readers of the Evening Star and Otago Daily Times generally supported the administration, as shown by 'Fair Play', 'Really Impartial', 'Disgusted' letters to editor, Evening Star, 7 August and 8 September.}\]
the Medical Superintendent (1897-1925), also ruled with a firm hand. With MacGregor's full backing, Beattie took 'resolute action' against several staff members who supplied allegedly libelous information to a 'wretched' newspaper in 1905.\textsuperscript{148}

Imposing the new order took what MacGregor called 'extreme measures',\textsuperscript{147} that is, powers to transfer or dismiss staff. Other sanctions were also available.\textsuperscript{148} In addition, three months probationary appointment\textsuperscript{149} helped superintendents assess the suitability of new attendants. During this period, their services could be terminated for incompetence or misconduct. Considerable authority was vested in or delegated to medical superintendents to appoint attendants\textsuperscript{150} or remove staff in particular circumstances.\textsuperscript{151} The Inspector-General played a limited direct role in staff discipline,\textsuperscript{152} dealing with tricky cases\textsuperscript{153} or senior staff.\textsuperscript{154} The use of extreme

1891 and the Otago Daily Times editorial of 18 August 1891. The Otago Daily Times also published and defended editorially on 17 September 1891, King's refutation of the charges (Medical Superintendent, Seacliff to Minister of Justice, 29 August 1891, Plunket Society Archives, Hocken Library, 89-098-25). W.F. Kitchen, the editor, then left. See letter to editor, Globe, 22 August 1891. Despite the setback, one or two discontented attendants got up 'an agitation' about the quality of care, with allegations of neglect and ill treatment. Medical Superintendent, Circular to Charge Attendants, December 1892, DAHI D 264/14; editorials, Globe, 7 and 24 April 1893; 'Ex-Attendant', 'J.G.', 'Ex-Patient', 'Another Fx-Attendant', 'Fx-Attendant No. 3', 'W.L.', 'Justice', 'A.L.T.', Matthew Impey Ex-Attendant, and 'Citizen', letters to Globe, 10, 13-5, 17-9, 22, 26, 29 April and 5 May 1893. At that point, King took an action for criminal libel. Medical Superintendent, Seacliff to B.C. Haggitt, 8 May 1893, DAHI D 264/15. King won and Maxwell, the ex-attendant who was the ringleader, was fined £25. The jury considered him a tool of others and asked for leniency. The Globe ceased publication on 9 September 1893. The Liberal Party failed to rescue the paper. To the last, it pleaded for a public inquiry into Seacliff Asylum. AJHR, 1893, H-4, p. 2; Globe, 7 September 1893.

\textsuperscript{146} Inspector-General's report, Auckland, 27 April 1906, AJHR, 1906, H-7, p. 3; Medical Superintendent, Auckland to Inspector-General, 9 February 1905 and reply, 14 February 1905, I-MH 1906/944.

\textsuperscript{147} Inspector-General's report, Seacliff, 23 January 1891, AJHR, 1891, H-2, p. 6.

\textsuperscript{148} The Civil Service Regulations 1867, R. 33, New Zealand Gazette, 31 December 1867, pp. 506-7, provided for penalties of dismissal, demotion, or forfeiture of future annual increment or leave. Transfer, as a form of demotion, was anticipated by R. 15, which provided for a reduced payment for transfer expenses. MacGregor had the personal authority to transfer and demote staff or to accept resignations in lieu. Inspector-General's report, Auckland, 17 August 1899, AJHR, 1900, H-7, p. 9.

\textsuperscript{149} Christchurch Lunatic Asylum, p. 8.

\textsuperscript{150} J.H. Whitelaw (Superintendent), Harriet Kettle (Matron and Whitelaw's mother), Elizabeth Brigden (Acting Matron and "niece" of Matron) and Skae, evidence to Royal Commission on Wellington Asylum, IA 101/1, 23 February 1881, pp. 14, 21, 25 February 1881, p. 18, 10 March 1881, pp. 13, 16, 30-32, 55, and 21 March 1881, IA 101/1, p. 62; Report of the Royal Commission of Inquiry into Wellington Lunatic Asylum (1881), IA 101/1, p. 14; Inspector-General to J. Hurst, 3 May 1895, Inspector-General's Letter Book 6, p. 88; Ministers' statements, NZPD, 1 August 1894, 84, p. 241 and 29 July 1893, 124, p. 54; Inspector-General to J. Burgess, Reefton, 17 December 1906, HMH 1906/1135.

\textsuperscript{151} Medical Superintendent, Seacliff to Inspector-General, 2 and 9 January 1885, DAHI D 264/10; Medical Superintendent, Seacliff to Deputy Inspector, Dunedin, 13 May 1886, DAHI D 264/10; Colonial Secretary, NZPD, 17 July 1890, 68, pp. 15-16.

\textsuperscript{152} Minister, NZPD, 1 September 1893, 81, pp. 549-50.
powers in the 1890s and 1900s earned medical superintendents a fearsome reputation as 'veritable autocrats' in the view of one contemporary politician.\textsuperscript{155} According to special returns ordered by the House of Representatives,\textsuperscript{156} in the first seven years of MacGregor's inspectorate, 500 or more asylum staff left or were dismissed. Normal staff turnover cannot be ascertained from these figures, which were drawn upon to depict MacGregor as a management tyrant. Most left during the first five years, when the three principal asylums were reorganized. Thereafter the managed exodus slowed, although not to MacGregor's satisfaction.\textsuperscript{157} Dismissals numbered 113 staff in the financial years 1893-9, 64 of them from Sunnyside and Seacliff, the hotbeds of staff unrest.\textsuperscript{158} Ringleaders of staff disruption at Sunnyside Asylum in 1904 were also transferred.\textsuperscript{159}

\textsuperscript{153} Medical Superintendent, Seacliff to Inspector-General, 19 July 1891, DAHI D 264/13; Medical Superintendent, Seacliff to Inspector-General, 7 May 1896, Plunket Society Archives, 89-038-25.

\textsuperscript{154} Inspector-General's report, Auckland, 28 April 1886, AJHR, 1887, H-9, p. 11; A.H. Neill in evidence to Seacliff Asylum Management Inquiry, 1887, IA 102/1; Superintendent, Hokitika to Inspector-General, 2 March 1891, CAHW 11 CH 22.

\textsuperscript{155} A.W. Hogg (Wairarapa), NZPD, 11 August 1904, 129, p. 417.

\textsuperscript{156} C.B. Izard (Wellington South and Suburbs), NZPD, 4 January 1890, 67, p. 329; Return of the Names of All Civil Servants who have Left the Service of the Lunacy Department since the Appointment of the Present Inspector of Asylums, 26 August 1890, LE 1/1890/114.

\textsuperscript{157} Inspector-General to Minister of Justice, 26 June 1896, Inspector-General's Letter Book 6, p. 467.

\textsuperscript{158} Fourteen Sunnyside dismissals were for incompetence or unsuitability, and the services of eight staff were terminated at the end of the probationary period. The Seacliff return indicated 37 dismissals, excluding probationers, of whom 13 were considered unsuitable; the work of six was unsatisfactory. The rest consisted of a miscellany of reasons including private employment of patients, neglect of duty, refusing duty, absence without leave, allowing a patient to escape, inciting a patient, insolence, cruelty to a patient, or assaulting a patient. AJHR, 1899, H-7a; Medical Superintendent, Seacliff to Inspector-General, 9, 16 and 17 August 1899, DAHI D 264/21.

\textsuperscript{159} Editorial, \textit{Lyttelton Times}, 1 December 1904; editorial, \textit{Press}, 6 December 1904. The outstanding case of transfer as penalty occurred not among attendants but in the management shake-up of 1925. Beatte and H.E. Jeffreys were removed from their charge of Auckland and Porirua to second grade hospitals, Tokanui and Nelson, respectively. Tizard and Prins swapped from Auckland and Porirua; Gray was promoted from Nelson to Auckland; McKillop swapped from Seacliff to Sunnyside (as Crosby retired); and Buchanan was promoted from Seaview to Seacliff. Evening Post, 23 May 1925; J. Armstead, President. Auckland Mental Hospital Reform Association, letter to \textit{Auckland Evening Star}, 9 May 1925. Surviving records point to Beatte as the main target of the purge. According to Beatte's late son, in a personal communication to the author on 18 December 1970, Sir Truby King and Beatte had numerous arguments. In an exceedingly frank statement of opinion, King said that for a quarter-century Beatte had 'presided over the institution' with his ascetic and austere outlook. Draft reply, Inspector-General to Minister [?], n.d. [April 1926?], HMH 71/1. His latter years at Auckland were certainly characterized by a reluctance to adopt new ideas or to improve the ward environment (e.g., Official Visitor's report, 12 August 1922, HMH 71/3; Medical Superintendent's report, Auckland, AJHR, 1922, H-7, p. 8; reverse side of letter from Director to H. Black, 6 March 1347, HMH 27/2). Hay conceded that Beatte's administration was 'very economical ... too much so at times' (Inspector-General to Public Service Commissioner, 10 February 1924, MH 3/17). A disciplinarian of the old order, Beatte's relations with staff deteriorated as he suspected conspiracy against his rule by union elements (e.g., Medical Superintendent, Auckland to Inspector-General, 19 July 1919, HMH 8/16/0(1), 4 October 1920, HMH 8/621, 3 April 1922, HMH 8/941(1)). Finally, his manner upset the official visitors whose suggestions he took as interference with internal
After 1890, externally imposed discipline was complemented by a policy to transform attendants into a profession modelled upon female hospital nurses. MacGregor sought to devise some means by which such a sentiment could be created regarding the honourable though arduous duties of asylum nurses as has arisen in the case of hospitals. I hope by systematic lectures on nursing to raise their ideal of their duty, and remove the prejudice which at present exists against this as affording a career for educated young women.¹⁶²

Female attendants were the first priority because MacGregor thought that female staffing was the weak spot of the “service”. Professionalization of female attendants was attractive for fiscal and disciplinary reasons. The sample of salary scales set out in Table 15 shows the fiscal attractiveness. Ordinary female attendants were paid about two-thirds as much as their male counterparts, so more could be employed. From the standpoint of staff discipline, female nurses were likely to prove a tractable ‘semi-profession’, to use Moore’s description. They were likely to follow the instructions of male doctors, prefer collegiality, be generally unambitious, and submit to bureaucratic control.¹⁶¹ On the other hand, MacGregor had a low opinion of male warders and was wary of their resistance to change. Staff revolts were fresh in his memory. From about 1887, too, attendants established some links with the nascent labour movement to further their cause.¹⁶² MacGregor referred obliquely to organized labour as ‘the conditions of our colonial society’ and he saw it as a potential threat to the management of large public institutions.¹⁶³

¹⁶⁰ AJHR, 1890, H-12, pp. 2-3.
¹⁶² E.g., petition by attendants at Wellington Asylum, Journal of the House of Representatives, 1887, p. XIII; Auckland Evening Star, 6 January 1893. The Knights of Labour and the local labour organ took up cudgels on behalf of disgruntled ex-attendants to obtain formal inquiries into Seacliff Asylum’s management in 1891 and 1893. See AJHR, 1891, H-29, p. 11; Medical Superintendent, Seacliff to Inspector-General, 11 September 1893, DAHI D 264/15; editorial, Otago Workman, 16 September 1893; D. Pinkerton (City of Dunedin), R.M. Taylor (City of Christchurch), W. Hutchison (City of Dunedin), H.S. Fish (City of Dunedin), W. Earnshaw (Peninsula), in reporting on the petition of R.G. Brinsley, NZPD, 29 September 1893, 82, pp. 853-6.
¹⁶³ Inspector-General’s report, Seacliff, 4 August 1891, AJHR, 1892, H-4, p. 4.
**TABLE 15**
SALARY DIFFERENTIALS BETWEEN MALE AND FEMALE ATTENDANTS, 1880-1947

<table>
<thead>
<tr>
<th>Year</th>
<th>1880</th>
<th>1885</th>
<th>1890</th>
<th>1895</th>
<th>1900</th>
<th>1905</th>
<th>1910</th>
<th>1915</th>
<th>1920</th>
<th>1925</th>
<th>1930</th>
<th>1935</th>
<th>1940</th>
<th>1947</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Not in Charge</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>M</td>
<td>60-80</td>
<td>70-80</td>
<td>70-80</td>
<td>70-80</td>
<td>70-95</td>
<td>78-103</td>
<td>115-140</td>
<td>175-205</td>
<td>220-250</td>
<td>220-250</td>
<td>197.6-224.5</td>
<td>245-275</td>
<td>325-365</td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>30-60</td>
<td>40-65</td>
<td>40-50</td>
<td>40-50</td>
<td>40-55</td>
<td>45-60</td>
<td>80-92.5</td>
<td>115-130</td>
<td>120-160</td>
<td>120-160</td>
<td>107.8-143.7</td>
<td>130-170</td>
<td>230-300</td>
<td></td>
</tr>
<tr>
<td>F/M salary (%)</td>
<td>64.3</td>
<td>70.0</td>
<td>60.0</td>
<td>60.0</td>
<td>57.6</td>
<td>58.0</td>
<td>67.6</td>
<td>64.5</td>
<td>59.6</td>
<td>59.6</td>
<td>59.8</td>
<td>57.7</td>
<td>76.8</td>
<td></td>
</tr>
<tr>
<td><strong>Ward Charge</strong></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>M</td>
<td>100-109.5</td>
<td>80-90</td>
<td>80-90</td>
<td>80-90</td>
<td>80-90</td>
<td>100-120</td>
<td>118-133</td>
<td>145-170</td>
<td>240-255</td>
<td>260-280</td>
<td>260-280</td>
<td>224.5-238.2</td>
<td>295-310</td>
<td>410</td>
</tr>
<tr>
<td>F</td>
<td>760-65</td>
<td>760-65</td>
<td>760-65</td>
<td>50-60</td>
<td>60-70</td>
<td>65-85</td>
<td>100-110</td>
<td>145-180</td>
<td>190-210</td>
<td>190-210</td>
<td>170.6-188.6</td>
<td>200-220</td>
<td>325</td>
<td></td>
</tr>
<tr>
<td>F/M salary (%)</td>
<td>73.5</td>
<td>73.5</td>
<td>67.6</td>
<td>82.4</td>
<td>59.1</td>
<td>59.8</td>
<td>66.7</td>
<td>65.6</td>
<td>74.1</td>
<td>74.1</td>
<td>77.6</td>
<td>70.0</td>
<td>79.3</td>
<td></td>
</tr>
<tr>
<td><strong>Head Attdt / Matron</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>70-100</td>
<td>70-100</td>
<td>70-105</td>
<td>70-100</td>
<td>75-100</td>
<td>70-110</td>
<td>75-125</td>
<td>145-220</td>
<td>210-270</td>
<td>245-300</td>
<td>250-370</td>
<td>224.5-314.7</td>
<td>285-405</td>
<td>410-510</td>
</tr>
<tr>
<td>F/M salary (%)</td>
<td>68.0</td>
<td>73.9</td>
<td>77.8</td>
<td>75.6</td>
<td>68.6</td>
<td>73.5</td>
<td>67.8</td>
<td>70.9</td>
<td>65.8</td>
<td>71.7</td>
<td>81.6</td>
<td>83.4</td>
<td>87.3</td>
<td>92.5</td>
</tr>
</tbody>
</table>

Notes:
1. For consistency, the "Not in Charge" category includes later staff groups of probationers, junior / senior attendants or nurses, and staff nurses.
2. "Ward Charge" does not include deputy charges.
3. "Matrons" do not include assistant matrons.
4. Percentages are calculated at the mid-point range.
5. Salary figures exclude non-valued allowances such as meals, board and lodgings, and uniforms prior to 1915.
6. Male salaries are given at the married rate from 1905.
7. Values shown in nominal £.
8. Some information prior to 1915 represents the best estimate from the salary range. This arises from the evolution of jobs like charge attendant / nurse positions, which were not uniformly established throughout the Department.

Sources: AJHR, 1880-1947, Estimates of Expenditure; Public Service Classification Lists in supplements to the New Zealand Gazette, 1915-47.
An Auckland Asylum nurse photographed about 1895 in the uniform intended to instil a sense of professionalism in the asylum service. The uniform closely resembled that worn by general hospital nurses of the period. Note the prominent bunch of keys attached to the belt. Starched collars and cuffs remained part of the uniform until the 1920s. (Auckland Institute and Museum, Negative C2842.)
Matron Beswick (centre back), sisters and nurses at Seacliff Asylum, c. 1900. (Author’s collection.)
MENTAL NURSES IN TRAINING, c. 1915

Some asylums began to train attendants in the 1890s, but the first national training scheme was not for Nurse training at Seacliff, c. 1915. The top photograph shows nurses rolling bandages. In the lower photograph, nurses are carrying a stretcher.

(Author's collection.)
STAFF AMENITIES

Mental hospitals provided cheap accommodation to staff. That meant that there were always staff on hand in the event of an emergency, but it also meant that staff were subject to institutional discipline off-duty as well as at work. In the top photograph, female attendants at Auckland Asylum relax off-duty, c. 1900. (Auckland Institute and Museum, Negative C1235.) The lower photograph, taken about 1955, shows the Seaview Hospital nurses' home (erected 1940). (Author's collection.)
Professionalization of attendants advanced in April 1895 when MacGregor felt 'driven' by social and political events to recommend that an Assistant Inspector be appointed to his office, in part to help manage female nurses in hospitals and asylums. The suggested appointee, Mrs Grace Neill, was a Nightingale-trained hospital nurse and matron, already known to the Minister. Mrs Neill was given national responsibility for improving attendants' training that was still embryonic, localized, limited and inconsistent. In the 1880s, for instance, Seacliff attendants were instructed about their duties solely from the rulebook. Attendants were tested on this knowledge. The rest was left to what the Medical Superintendent, Truby King, called the 'tradition of the institution' that was handed down from time to time.

In 1890, some asylums expanded staff training, most likely with instruction on first aid, dispensing medicine, and physical drill.

To establish consistent and thorough training, Mrs Neill turned to the Medico-Psychological Association for guidance in 1896. Copies of the Association's Handbook for Attendants on the Insane were obtained and distributed to all staff. A.M.O's were told to commence regular classes on this text and to hold examinations. Training was geared to the 'simple and practical' interest of attendants. They were given some knowledge about body structure, bodily functions, proper digestion, and dealing with an injury. Charge nurses or attendants who

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164 Inspector-General to Minister, 4 April 1895, H 45/14 (no closed file number). See also M.A. Tennant, 'Neill, Elizabeth Grace (1846-1926)’ in DNZB, Vol. 2, Wellington, 1993, pp. 347-9. The Minister, W.P. Reeves, as a former Minister of Labour, knew her personal attributes from her work with the factories inspectorate.


166 Medical Superintendent, Seacliff to Inspector-General, 13 July 1890 in AJHR, 1891, H-29, p.16; Medical Superintendent's report, Auckland, AJHR, 1897, H-7, p. 2.


169 Medico-Psychological Association Council minutes, May and July 1896, pp. 43-44, 55-56, Archives of the Royal College of Psychiatrists, London.

170 The first edition was issued in 1893. It drew upon an 1885 text produced by several Scottish superintendents. Sections on general anatomy, physiology and nursing, self-assessment questions and information about training and examinations were added in 1896. Robert Dingwall, Anne Marie Rafferty and Charles Webster, An Introduction to the Social History of Nursing, London, 1988, p. 128.

demonstrated special interest or intelligence were given extra clinical instruction in the wards.\footnote{172}

The handbook and the method of instruction by asylum doctors articulated the image of the ideal nurse or attendant. Nurse training had a medical orientation with lectures on anatomy, physiology and pharmacology. Borrowed from the role model of the Nightingale-trained hospital nurse were the principles of endurance, forbearance, quietness, gentleness, patience and obedience.\footnote{173} Carpenter attributes the Handbook with making direct comparisons between the asylum and the hospital, with routine, order, discipline and hygiene.\footnote{174} The text, which staff nicknamed the 'Red Book' from its coloured cover, came to assume what Dingwall, Rafferty and Webster called 'canonical importance' in mental nursing education in Britain for the best part of a century.\footnote{175} The same statement could be made about New Zealand. An indigenous version was not considered until 1944.\footnote{176}

Pride in a professional and disciplined service was also instilled by the adoption of attendants' uniforms. Prior to the 1890s, this was apparently a matter decided locally. A.H. Neill objected when Seacliff nurses wore their aprons to a patients' dance, as they did in English asylums, to distinguish staff from patients.\footnote{177} Most superintendents and many staff thought differently. Gribben wanted male attendants at Hokitika to wear a quasi-military uniform.\footnote{178} At Sunnyside, staff uniforms were discontinued as an economy measure in 1895, much to Levinge's regret. 'Those unacquainted with the administration of an institution,' he wrote in a sentiment shared by others, 'can hardly realise the difference it makes, alike in its

\footnotesize{\begin{itemize}
\item Medical Superintendent, Seacliff to Superintendent, Nelson, 19 April 1901, DAHI D 264/23; Inspector-General's report, Seacliff, 24-5 October 1906, AJHR, 1907, H-7, p. 23.
\item J.A. Rogers, 'Nursing Education in New Zealand, 1883-1930: The Persistence of the Nightingale Ethos', MA Thesis, Massey University, 1985, pp. iv-v.
\item Carpenter, p. 128.
\item Dingwall, Rafferty and Webster, p. 128.
\item Director-General Circular, 6 April 1944, HMH 8/94/6.
\item Matron C. Grundy's evidence, Seacliff Asylum Inquiry 1887, IA 102/1.
\item Superintendent, Hokitika to Inspector-General, 2 December 1885, CAHW 10 CH 22. Gribben wanted attendants to wear striped trousers and caps with a distinguishing badge of rank: an oak leaf band for attendants, and a silver lace band and crown for the Head Attendant.
\end{itemize}}
effects on the patients and the *esprit de corps* of the staff.179 When the Liberal Government baulked at the expenditure of £1,000 on uniforms for male attendants in 1895,180 nurses at Sunnyside and Auckland adopted their own. Hokitika attendants also wanted to wear uniforms, but because they were not paid a uniform allowance, no particular type of cloth could be insisted upon.181 Such moves anticipated the adoption of attendants' uniforms throughout the Department in 1898, first for men then for women.182 The standard male uniform consisted of a blue serge jacket and trousers and a peaked cap, brass buttons and gold braid.183 The female attendant's uniform was nearly identical to that worn by general hospital nurses with starched caps, aprons, collars and cuffs. Charge nurses and matrons adopted the hospital sister's veil.

Nursing reform was implemented through this emergent hierarchy in a manner reminiscent of Maggs' description of Nightingale nursing reform in British hospitals.184 First, matrons were carefully selected as role models and change agents. By the early 1890s, two of the largest New Zealand asylums had appointed general hospital trained nurses as matrons with 'most satisfactory results.'185 An exchange of nurses between Dunedin Hospital and Seacliff Asylum was proposed in 1892.186 Next, the policy decision to place female charge nurses in male wards represented a marked break with the strict tradition of gender-based administration. Beattie followed with interest journal discussion on the topic and took advantage of his extended leave in 1905 to visit Larbert Asylum, Stirlingshire, where the idea had been tried. Like

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180 NZPD, 2 July 1895, 87, p. 235, and 26 June 1896, 92, p. 387.
182 NZPD, 2 August 1898, 102, p. 169; Return Showing to what extent the Vote for Uniforms for the Staffs in the several Lunatic Asylums of the Colony has been given effect to, 10 August 1898, LE 1/1899/127; Superintendent to Inspector-General (telegram), n.d. [May-June] 1898, and Superintendent, Hokitika to Hill and Sons, Wellington, 30 June 1898, CAHW 13 CH 22, L. 61/98.
183 The buttons, braid and caps were dispensed with to cut costs in 1930-31 but otherwise the winter uniform was not greatly modified until the 1970s. Director-General, Circulars, 10 July 1930, MH 13/69 and 17 March 1931, Porirua Hospital Records, Porirua Hospital, Administrative File G-17.
185 AJHR, 1892, H-4, p. 2.
186 Medical Superintendent, Seacliff to Chairman, Dunedin Hospital Trustees, 1 August 1892, DAHI D 264/14.
MacGregor, who had previously visited Larbert, Beattie was impressed. MacGregor thought the practice particularly important in the infirmary portion of an asylum, as it had been tried at Seacliff in 1903. Finally, nursing management structures and training were complemented by the provision of supervised nurses' homes whose rules and etiquette reinforced professional values that emphasized obedience and respect for doctors and senior nurses.

A policy on staff accommodation was motivated as much by recruitment and retention considerations as by the need for 24-hour cover and emergency back up. This policy originated at Sunnyside and Dunedin Asylums where cottages were provided for married male attendants. Rural institutions needed staff cottages more than city asylums to help retain staff. The point was noted as early as 1884. Staff who worked in remote asylums needed compensation for the loss of the 'temptations' of living in the heart of a town, as Hay claimed. Married male staff first became eligible for a housing allowance in 1905, the same year that Truby King earned MacGregor's praise for a unique and 'admirable scheme for the attendants' hamlet' which would allow staff to acquire their own home.

Unmarried staff also benefited from the policy on staff accommodation. In the nineteenth century, the usual practice was to allocate staff a barely furnished single room, although overcrowding sometimes made even that arrangement a luxury. The proximity of staff rooms to the wards meant that 'one does not get the freshest, and therefore the best, work from officials who have little leisure, and who cannot in

187 Medical Superintendent's report, Auckland, AJHR, 1900, H-7, p. 4; R.M. Beattie, interview, New Zealand Herald, 27 September 1905.
188 AJHR, 1904, H-7, p. 4; Medical Superintendent's report, Seacliff, AJHR, 1904, H-7, p. 10.
190 Inspector-General's report, Seacliff, 28 November 1884, AJHR, 1885, H-10, p. 11.
194 Overcrowded conditions at the Whau in 1882 meant that the clerk slept in his office, the Head Attendant in the Medical Superintendent's office, the cook in the pantry. Only six male staff and a laundress could be accommodated in patients' single rooms. Deputy Inspector's and Medical Superintendent's reports, Auckland, AJHR, 1882, H-9, p. 4.
their hours of rest be disassociated from their office. The first nurses' home was provided at Seacliff, in 1900. This policy brought asylums into line with hospital practice. The practice was adopted elsewhere until every mental hospital had a nurses' home complete with recreational amenities. Male staff quarters were developed more slowly and most live-in attendants continued to do so in single rooms adjacent to wards.

The foundations of nursing professionalism laid during MacGregor's time were built upon by his successors. Hay believed that 'every nurse passing through the general hospital will raise the status of the profession of mental nurses, and help to place it where it should be'. So he continued the policy of appointing hospital-trained nurses to senior positions in mental hospitals. He also requested public hospitals to accept mental nurses for general training. The proportion of females in the total number of attendants climbed haltingly from 38.9 per cent in 1905 to 48.9 per cent by 1925.

Hay also developed the educational strategy begun under Grace Neill. Both as Deputy and as Inspector-General, Hay consolidated local training programmes into a national scheme once the Government warmed to the idea. Hay's scheme resembled the Medico-Psychological Association's model three-year course for training and certificating attendants in the United Kingdom and some colonies. Attendance was compulsory and 'Registered Mental Nurses' took precedence in promotions. The Department registered successful candidates, male or female, who were then eligible to practise in New Zealand. Nurses' uniforms retained

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195 MacGregor wanted part of the attic to be turned into sleeping cubicles and a sitting room. Using them for staff accommodation would speed the evacuation of patients in the vent of a fire, he reckoned. Inspector-General's report, Sunnyside, 6 March 1906, AJHR, 1906, H-7, p. 4. Cf. Inspector-General's reports, Sunnyside, 31 July 1906 and 16 February 1907, AJHR, 1907, H-7, pp. 20, 22.

196 Medical Superintendent, Seacliff to Inspector-General, 22 June 1899, Plunket Society Archives, Hocken Library 89-008-16; Medical Superintendent, Seacliff to Inspector-General, 9 December 1899, DAHI D 264/21.


198 AJHR, 1908, H-22, p. 5. The Assistant Inspector of Nursing regarded the move as less desirable than making mental nursing a post-graduate programme for registered general nurses.

199 NZPD, 29 July 1903, 124, p. 54; Interview with Minister, Lyttelton Times, 22 February 1904; AJHR, 1904, H-7, p. 3; Deputy Inspector-General, Circular, 15 June 1905, HMH 8/97/1; AJHR, 1905, H-7, p. 5.

200 The present whereabouts of the departmental registers is unknown.
their similarity to those worn in hospitals. As fashions changed, colour coded dresses replaced the starched attire of earlier uniforms. During Hay's administration, decisions to establish separate occupations of wardsmaid or housemaid (1907), and to discontinue the category of artisan-attendant (1913) were slowly implemented. Both policies were intended to clarify and emphasize the nursing role of attendants, though in practice attendants continued to undertake many non-nursing duties, as noted in appendix 6.

Hay also expanded the gender-based attendants' career structure. A probationer attendant became a junior nurse or attendant, and a senior after he/she successfully passed the final examination after three years. Promotion to ward charge was tied to professional registration. Ward or shift charges reported to the head attendant or matron, as the case may be. Intermediate level jobs introduced by Hay helped to retain senior attendants. Positions of deputy head attendant and deputy ward charge were established in 1911 in a move that was probably intended to recognise the different employment characteristics of male and female attendants. Male attendants could expect to work in the service until retirement at age 65, with the prospect of superannuation. Female Public Servants had to resign if they married. The marriage barrier increased the turnover of female staff and hastened promotion prospects for career-minded single women. Male attendants waited much longer for promotion. In 1907, for example, the average length of service of head attendants was 15.5 years; matrons 8.25 years; 9.75 years for male charge attendants; and 6 for charge nurses.

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201 Inspector-General to Medical Superintendent, Auckland, 19 October 1926, Carrington Hospital Archives, National Archives, Auckland, YCAA 1079/9C, File 6/32/2; Director-General Circular, 5 November 1927, MH 8/117/0(1); Deputy Director-General Circular, 7 November 1934, MH 8/117/0(1). Probationers wore pink and white striped frocks, and nurse a blue uniform. Charge nurses wore cream but later white uniforms. Collars, cuffs and aprons were discontinued as a depression economy measure. Director-General Circular, 31 July 1931, HMH 8/117/0(1). The system lasted throughout the era of central government administration of mental hospitals.

202 Mental Hospitals Department, General Rules, pp. 3-4.

203 AJHR, 1912, H-7, p. 10.

204 The value of emoluments was a sore point in assessing the level of superannuation paid to retired attendants until the 1920s. In the face of Liberal and Reform Government opposition, a special arrangement was sought for attendants. The battle continued for more than a decade, with the Public Service Commission sympathetic to the Department's viewpoint but powerless to deal with it in the face of Government intransigence. AJHR, 1908, H-7, pp. 6-7, 1909, H-7, p. 7, 1910, H-7, pp. 7, 1912, H-7, pp. 10-11, 1913, H-7, p. 12 and H-14, p. 13, 1914, H-7, p. 9, 1915, H-7, p. 6 and H-14, p. 13, 1916, H-14, p. 7, and 1925, H-14, pp. 4-5; Sir Thomas McKenzie to Prime Minister, 7 July 1908; NZPD, 28 October 1909, 147, p. 669.

205 AJHR, 1907, H-7, p. 16.
Raising staff qualifications alone did not recruit and retain good attendants in sufficient numbers to meet the needs of the service. From the turn of the twentieth century, officials blamed the attractions of town life, new job opportunities for women with better hours, and a general shortage of labour.\textsuperscript{206} In 1909, Beattie complained that he had to 'pander to the nurses in every way' to keep them.\textsuperscript{207} Rural institutions had to make do with transient workers, as well as with staff from families that had settled nearby and provided, in some cases, generations of institutional workers.\textsuperscript{208} By 1909, the Department was obliged to recruit from Britain suitable soldiers, navy sailors or lowland Scots farmers' daughters\textsuperscript{209} to fill the gaps at Seacliff left by restless colonials who had never had to look for work, as Truby King termed local labour.\textsuperscript{210} With one-quarter of the employees on active service during the Great War, the Department had to employ itinerant or undisciplined staff 'what offered' as attendants.\textsuperscript{211} Even so, by 1918, one exasperated medical superintendent complained that

We are asking people to do highly specialized work which is always trying and often repulsive, and we are paying wages that not only do not attract the right class of people, but actually fail to supply sufficient numbers of the itinerant, unsettled class of unskilled labour.\textsuperscript{212}

Hay relied upon the English ratio of one daytime nurse or attendant for every ten patients as his guide,\textsuperscript{213} but this standard was not always attainable because of the

\begin{itemize}
\item Medical Superintendent, Seacliff to Inspector-General, 9 March 1909, and Medical Superintendent, Auckland to Inspector-General, 8 October 1909, HMH 8/618; Inspector-General's report, Auckland, AJHR, 1912, H-7, p. 11; Auckland Star, 22 February 1915; Inspector-General to Minister, 18 February 1918, HMH 8/116/0(1); Inspector-General to Public Service Commissioner, 16 September 1920, YCAA 1079/8C, File 6/26/-.\textsuperscript{206}
\item Medical Superintendent, Auckland to Inspector-General, 8 October 1909, HMH 8/618.\textsuperscript{207}
\item Medical Superintendent, Auckland to Inspector-General, 8 October 1909, HMH 8/618.\textsuperscript{208}
\item See, for example, Frank Tod, 'Outside Looking In' in Anon., The End of an Era, Dunedin, 1972, p. 15.\textsuperscript{209}
\item Inspector-General to A.H. Crosby, 30 September 1910, HMH 8/618. Crosby was given overseas leave following the closure of Mount View Asylum, where he had been Medical Superintendent.\textsuperscript{210}
\item Medical Superintendent, Seacliff to Inspector-General, 9 March 1909, HMH 8/618.\textsuperscript{211}
\item AJHR, 1917, H-7, p. 4. Cf. Inspector-General to Chairman, Efficiency Board, 2 June 1917, HMH 8/310; Inspector-General to Minister, 18 February 1918, HMH 8/116/0(1).\textsuperscript{212}
\item Medical Superintendent, Sunnyside to Inspector-General, 30 June 1916, Sunnyside Hospital Records, Christchurch, Administration File No. 184.\textsuperscript{213}
\item Inspector-General to Medical Superintendent, Auckland (confidential), 11 April 1922, YCAA 1079/k, File 6/5/-.\textsuperscript{214}
\end{itemize}
post-war labour shortage, the ‘spirit of restlessness’, and the corresponding wage boom.\textsuperscript{214} Hay was ‘fairly put to it to excuse and explain’ the staff shortage, he confided to his minister, knowing full well that people could not be fooled indefinitely.\textsuperscript{215} Porirua staff said that 5-6 nurses looked after 91 refractory female patients in 1919, whereas before the War, there would have been 7-8 nurses.\textsuperscript{216} The hospital had staff strength of 32 nurses but needed at least 70. The nurse-patient ratio was 1:14.75.\textsuperscript{217} The problem was not as extreme elsewhere. The male ratio varied from 1:8 at Hokitika to 1:13.5 at Auckland, and the female ratios ranged from 1:5.4 at Hokitika to 1:11.2 at Christchurch.\textsuperscript{218}

Hay tried to tackle problems with the quality of staff in various ways. He pressed for a longer probationary period for attendants. The special case was conceded when the Public Service Act 1912 placed new staff in mental hospitals on probation for 12 months.\textsuperscript{219} The Minister’s power to transfer superintendents and medical officers was included at the committee stages of the Mental Defectives Bill 1911.\textsuperscript{220} Following departmental concern, a three-year probationary period was instituted in 1921.\textsuperscript{221} In 1918-9, irritated staff took their grievances about conditions of work directly to the Public Service Commissioners.\textsuperscript{222} Pay rates were then increased in the hope of attracting and retaining suitable staff.\textsuperscript{223}

\textsuperscript{214} Medical Superintendent, Auckland to Inspector-General, 19 July 1919, HMH 8/115/0(1); Medical Superintendent’s report, Sunnyside, AJHR, 1921, H-7, p. 8.
\textsuperscript{215} Inspector-General to Minister, (personal), 27 January 1921, HMH 8/62.
\textsuperscript{216} Notes on Deputation of Porirua Mental Hospital Nurses to Public Service Commissioners, 13 March 1919, HMH 12/94.
\textsuperscript{217} Medical Superintendent, Porirua to Inspector-General, 9 September 1920 and Inspector-General to Minister, 28 September 1920, HMH 8/818. In June 1920, there were 486 female patients resident at the hospital. AJHR, 1920, H-7, p. 2.
\textsuperscript{218} Inspector-General to Medical Superintendent, Auckland, 11 April 1922, YCAA 1079/7k, File 6/5/-; AJHR, 1924, H-7, p. 4.
\textsuperscript{219} Public Service Act 1912, s. 44. Staff in gaols and reformatory schools also fell within this provision (s. 43). Under s. 39 of the Act, other Public Servants spent six months on probation.
\textsuperscript{220} NZPD, 15 August 1911, 154, p. 432; Mental Defectives Act 1911, s. 43(8).
\textsuperscript{221} Inspector-General to Medical Superintendent Auckland, 27 June 1919, YCAA 1079/1; File 2/10/-; Report of Interview between Medical Officers [Superintendents] of Mental Hospitals and Public Service Commissioners, 23 August 1919, HMH 8/591; Inspector-General to Public Service Commissioner, 30 September 1921 and approval of 7 October 1921, MH 8/24.
\textsuperscript{222} Notes of deputation of Hokitika Mental Hospital Staff to Public Service Commissioner, 4 January 1918, HMH 12/99; Notes of deputation of female Porirua Mental Hospital Staff to Public Service Commissioner, 13 March and 23 July 1919, HMH 12/94. According to W.H. Field (Otaki), NZPD, 4 August 1911, 154, p. 201, Sunnyside attendants followed up their success in obtaining new pay and conditions in 1905 with overtures to staff in other mental hospitals for further improvements. This trend towards national solidarity foreshadowed the formation of the Public Service Association (P.S.A.) in 1913. The P.S.A. was set up to safeguard the interests of all Public Servants when pay
Gray, no less than Hay, also encountered constant problems of staff recruitment and retention. His policies built incrementally upon those of his predecessors. Rulebooks responded to the professional ethos. Female nurses were implicitly acknowledged as the norm in the style of the 1928 and 1940 editions. Seen from that perspective in 1937, J.U. Williams, Medical Superintendent at Nelson, commented that the warder qualities in a nurse were exhorted at the expense of those of 'guide' or 'mentor'.

Tokanui's Medical Superintendent, G.M. Tothill, thought likewise. He considered that active nursing was the foremost duty, so the role of the 'male nurse' should be favoured over that of the 'attendant'. For the first time, Gray's introduction to the 1940 rulebook appealed to a nurse's intelligence, humanity, vocation, service, a sense of nursing professionalism, and hospital pride.

Attendants' training was important to Gray. A medallion for registered mental nurses was instituted in 1933 in emulation of the general nurse's medal. Doubly qualified nurses were sought for a promotion pathway to matronhood, a move that was supported by the New Zealand Trained Nurses Association. Registered general nurses were given a year's credit towards their three-year training as mental nurses. The titles of 'sister' and 'staff nurse' replaced the titles of charge nurse and deputy charge nurse in female wards in 1945. Nurses' homes had a supervisor whose mix of strict discipline and staff welfare could reassure the parents of young women living away from home that their daughters were safe.

In a plan for 'psychiatric nurses', as he wanted them to be known, Gray argued that registered

fixing and conditions of employment throughout the Public Service were transferred from departments to the Public Service Commission. The Association had a low profile in mental hospitals.

223 AJHR, 1920, H-7, p. 5.
224 Medical Superintendent, Nelson to Director-General, 2 September 1937, H 30/35/89 (28739).
225 Medical Superintendent, Tokanui to Director-General, 15 September 1937, H 30/35.89 (28739).
226 Mental Hospitals Department, Rules for Staff, Wellington, 1940, p. 1.
227 Director-General Circular, 16 February 1933, HMH 8/94/0; AJHR, 1933, H-7, p. 3.
229 Director-General Circular, 20 May 1943, HMH 8/94/0.
230 Director-General to Secretary, Public Service Commission, 16 February 1945, MH 8/131.
231 Director-General to Medical Superintendent Porirua, 24 February 1939, HMH 8/12/5/1.
mental nurses should share equally with general nurses and midwives the perceived
superior status of 'state' registration. That would give the New Zealand qualification
Empire-wide reciprocal recognition, enhance employment prospects, improve
recruitment and help raise the standing of mental hospitals.232 The attainment of
state registration for psychiatric nurses in 1945 was a major triumph.

Gray's actions were partly motivated by an underlying prejudice against male
attendants as a class. He considered them a relic of the tradition of the prison
warder233 who were needed only to work with outside gangs.234 Several of Gray's
policies could be regarded as discriminatory. Convinced that seniority was an
impediment to the appointment of the right people to top positions,235 he sought to
stream long-serving staff for promotion to more senior positions by way of
examinations.236 During Gray's administration, career progression for female
attendants was stretched with new jobs (such as nurses' home supervisors and tutor
sisters). Salaries were also used to encourage single women to remain in the
service. Table 15 shows that during Gray's administration, the salary gap between
male and female attendants narrowed at higher levels of the hierarchy. By 1947 the
gap had narrowed to 21 per cent. Matrons were paid at 83 per cent of head
attendants' average pay. In 1947, parity was reached at the upper end of the scale.

The latter part of Gray's administration was dominated by a staffing shortage of crisis
proportions. There were many reasons for this. In spite of the drive towards
professionalism, mental nursing was never popular. In a job described as 'nerve-
wracking',237 attendants needed a high level of physical, mental and emotional
maturity to tolerate the discomfits and difficulties and to face the sights and sounds of
infirmary or refractory wards. Many mental hospitals were isolated geographically.
All were isolated by their unique organizational culture and by social stigma. Poor

232 Rotorua Morning Post, 4 August 1944; 'Ten Years a Visitor' in letter to Auckland Star, 4
September 1944.
233 Director-General to Minister, 2 May 1944, HMH 8/0/1; Director-General to Secretary, Public
Service Commission, 16 March 1945, H 30/35/89 (28739).
234 Director-General Circular, 16 February 1933, HMH 8/94/0.
235 Director-General to Minister, 19 November 1937, HMH 4/4/1.
236 Director-General to Public Service Commissioner, 20 April 1938 and Secretary, Public Service
Commissioner to Director-General, 20 June 1938, HMH 8/98/0; Director-General Circular, 7 January
1942, HMH 8/94/0.
237 Epitome of the Report of the Royal Commission of Investigation into Sunnyside Mental
Hospital, 1 November 1913, HMH 1913/961.
pay and strict working conditions also contributed to a general shortage of attendants of the right calibre. Other reasons included the lack of professional status, and insufficient attention to staff welfare.\(^{238}\)

Just prior to the Second World War, the problem was sufficiently bad for the Department to have contemplated overseas recruitment. A vigorous national recruiting campaign, which used press advertisements and radio broadcasts, obviated that necessity. ‘One of Them’ (a mental nurse) extolled the conditions of work and the advantages of the job over hospital nursing.\(^{239}\) The relief gained, however, was only temporary. Institutions were critically short of nursing staff during the Second World War. In 1940, the policy of deploying female charge nurses in male wards had to be suspended and eventually abandoned.\(^{240}\) By 1942, female nurses were 27 per cent and male attendants 17 per cent below establishment.\(^{241}\) In 1943-44, the overall shortage of nurses reached 20-30 per cent. The worst affected hospitals occasionally fell to 50 per cent of their establishment.\(^{242}\) A Seacliff nurse complained that there was no time to help patients get well.\(^{243}\) Seacliff threatened to close down part of the hospital or to restrict admissions.\(^{244}\) At Auckland, in 1944, one nurse looked after a ward of 100 patients.\(^{245}\) Nurses were constantly rotated and could not get to know their patients. Even matrons were reported to do ward work.\(^{246}\) Several medical superintendents commented on the problem in their reports for 1947. Kingseat, 30 miles from Auckland and 10 miles from the nearest township, stressed the problem of recruiting and retaining staff because it was so

\(^{238}\) Welfare Officer to Director, 3 December 1948, HMH 8/135/2.
\(^{239}\) ‘One of Them’, ‘Be a Mental Hospital Nurse!’, New Zealand Women’s Weekly, 28 April 1938.
\(^{240}\) Medical Superintendent, Kingseat to Director-General, 20 May 1940 and Director-General to Secretary, Public Service Commissioner, 29 May 1940, HMH 8/0/1; Director-General to Chairman, Manpower Appeal Committee, 1 June 1943, HMH 8/116/4. The policy was abandoned in 1947 when the acting appointments of males to female charge nurse positions in male wards were made permanent. Acting Director-General to Secretary, Public Service Commission, 4 August 1947, HMH 8/0/1.
\(^{241}\) Director-General to Minister, 13 January 1942, HMH 8/116/0(1); Director-General to Public Service Commissioner [?], 14 January 1942, HMH 27/10.
\(^{242}\) Director-General to Minister, 22 April 1943, HMH 8/116/0(2); Director-General to Minister, 17 March 1944, HMH 26/40/1; Acting Director-General to Director of National Service, 12 November 1945, HMH 8/0/1.
\(^{243}\) Otago Daily Times, 22 March 1944.
\(^{244}\) Medical Superintendent, Seacliff reported in Southland Times, 22 January 1945, Southland Times, 10 November 1945.
\(^{245}\) Auckland Star, 5 August 1944.
\(^{246}\) Director-General to Minister, 22 April 1943, HMH 8/116/0(2).
remote from social amenities. The hospital had to provide a feeder service to public transport routes so that staff could get away from the campus on their evenings off.\textsuperscript{247} Attendants wanted staff residences as an incentive to work at Tokanui.\textsuperscript{248} That year, when patient accommodation for about 166 patients was built, 33 staff residence were also under construction at rural hospitals.\textsuperscript{249}

The deterioration in staffing numbers could not be overcome by customary means. The recruitment of Maori nurses\textsuperscript{250} or paroled conscientious objectors\textsuperscript{251} was considered. Nurses worked call-backs (double shifts) and days off with little relief. By 1942, staff had to work four days in succession, then five, before they could take a day off.\textsuperscript{252} More drastic measures were inevitable. Mental nursing was declared an essential wartime undertaking in 1942,\textsuperscript{253} just ahead of the whole Public Service.\textsuperscript{254} Women could then be directed to work in mental hospitals.\textsuperscript{255} Manpower direction, however, was criticized by sections of the press and some directed nurses because patients could not get individual attention.\textsuperscript{256} The scheme was modified slightly to screen out temperamentally unsuitable or immature women,\textsuperscript{257} and to streamline appeal procedures.\textsuperscript{258} The Department countered adverse publicity that was based

\begin{itemize}
\item \textsuperscript{247} Medical Superintendent's report, Kingseat, AJHR, 1948, H-7, p. 7.
\item \textsuperscript{248} Medical Superintendent's report, Tokanui, AJHR, 1948, H-7, p. 8.
\item \textsuperscript{249} AJHR, 1948. H-7, p. 4.
\item \textsuperscript{250} Recruitment Liaison Officer to Secretary, Public Service Commission, 28 July 1941 and Chief Clerk to Secretary, Public Service Commission, 11 August 1941, HMH 8/116/0(1).
\item \textsuperscript{251} Acting Director-General Circular, 16 July 1945, HMH 27/34; Deputy Prime Minister, NZPD, 25 July 1945, 268, pp. 611-12.
\item \textsuperscript{252} Director-General to Minister, 13 January and 13 April 1942, HMH 8/116/0(1).
\item \textsuperscript{253} Director-General to Public Service Commissioner [?], 14 January 1942, HMH 27/10.
\item \textsuperscript{254} Henderson, p. 166. Montgomerie comments that industries that employed large numbers of women figured prominently in the first lists of essential industries. She mentions hospitals (but does not specifically mention mental hospitals). Deborah Montgomerie, 'Man-powering Women: Industrial Conscription During the Second World War', in Barbara Brookes, Charlotte MacDonald and Margaret Tennant, eds, \textit{Women in History 2}, Wellington, 1992, p. 185.
\item \textsuperscript{255} Controller of Employment to District Manpower Officer, Wellington, 10 July 1942, HMH 8/116/0(1)
\item \textsuperscript{256} E.g., 'Not Cricket' in letter to \textit{Press}, 4 February 1944; 'Fair Play' in letter to \textit{Press}, 17 March 1944; \textit{Otago Daily Times}, 22 March 1944; \textit{Nelson Evening Mail}, 19 April 1944; \textit{Press}, 4 May 1944; Director-General's press statement in \textit{Dominion}, Wellington, 21 July 1944; Director-General to Minister, 14 December 1944, MH 8/116/0(5).
\item \textsuperscript{257} Director-General to Minister, 27 August 1942, HMH 8/116/0(1); NZPD, 9 March 1943, 232, pp. 258-9.
\item \textsuperscript{258} Director-General to Minister, 2 February 1943, HMH 8/116/0(2).
\end{itemize}
on popular prejudice against mental hospitals. Part-time employment was also considered. In 1943, like other lower-paid Public Servants, attendants became eligible for overtime pay in excess of 40 hours at time and a half.

Mental nurses were expected to patriotically and stoically tolerate the added job stress caused by extreme staff shortages. Many did, sustained by the strengths and weaknesses of a closed institutional life that in one sense, institutionalised staff as well as patients. Nurse Kennedy hinted at an esprit born of shared adversity, common values, and a strong sense of loyalty to the service. ‘Everyone looks after everyone else round here. It’s the first law of self-preservation,’ a fellow nurse told Kennedy. Kennedy also called the tendency to talk shop off-duty an occupational disease. The Health Department’s Director of Nursing stated the problem differently when she criticized mental hospital matrons for being inured to the trying conditions. Having coped with them for so long, the matrons became oblivious to the effects upon young women starting work as mental hospital nurses. The same criticism could have been levelled at the innately conservative Gray. He may have attributed his difficulty with staffing the Department with a good body of doctors to Treasury’s niggardliness, but his own budgetary responsibility made him reluctant to accept shorter hours for the more numerous body of attendants. In 1936, he had shown caution about the cost of additional staff needed to implement the first Labour Government’s policy of a general working week of 40 hours. Attendants were then

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259 The positive message of E. Harper, a manpowered nurse at Nelson was publicized as part of the press campaign. Her letter to the Dominion was reprinted in the New Zealand Nursing Journal, 37, 7 (1944), p. 154. The broadcaster ‘Aunt Daisy’ was used, as she had been in the 1939 recruitment campaign. The campaign also included articles, local talks, shop window displays and a brochure. Director-General to Minister, 14 December 1944, MH 8/116/0(5). See also Y.W.C.A. Review, 8, 6 (1943), pp. 6-7 and 8, 7 (1943), pp. 5-6; New Zealand National Review, 15 August 1943, p. 19; New Zealand Listener, 15 June 1945, pp. 14-15 and 22 June 1945, p. 15.


262 Kennedy, p. 160.

263 Kennedy, p. 69.

264 Director of Nursing to Director, August 1948, HMH 8/94/0.

265 Director-General to Minister, 5 July 1938, HMH 8/36/0(1).

266 Director-General to Minister, 13 March and 26 May 1936 and 14 June 1937, HMH 8/81(2); Director-General Circular, 4 October 1946, Director-General to Secretary, Public Service Commission, 14 November 1946, Director to Medical Superintendent, Sunnyside (personal), 16 February 1948, H 30/35/53 (34604).
working the equivalent of 50-52 hours weekly over an average 50-week year. The best that could be negotiated, Gray thought, was an approximate 42-hour week. Introducing an evening shift in the three-day cycle reduced the long day to 13 hours and the short day to 10.25 hours (or 11 hours and 8 hours 10 minutes when meal breaks were included). Attendants were given one month's paid leave every six months. Implementing the government's policy required 272 new nursing jobs at an additional cost of £42,557.

Gray's fiscal caution, combined with his institutionalized attitude, made him personally reluctant to accept significant improvement in working conditions. He also expected staff to carry a far heavier workload during the staffing crisis, more than they were prepared to carry. By 1945, staff forbearance reached the limit. Some staff at Hokitika Mental Hospital tried to break away from the P.S.A. to get better representation of their concerns. Although unsuccessful, the move did attract greater recognition of the special problems of mental hospital staff. In April 1945, delegates from each mental hospital drew up a constitution to become a special group within the P.S.A. with a representative on the national executive. The P.S.A. showed its growing radicalization by readily backing two Porirua nurses who faced disciplinary action for refusing to work 9 successive days without a break. Supported by the P.S.A. Executive, nurses refused to work their days off. The Public Service Commission retaliated by threatening to withdraw industrial recognition of the Association. The dispute was eventually settled by arbitration.

267 Director-General to Minister, 13 March 1936, HMH 8/81(2); Director-General to Secretary, Public Service Commission, 19 August 1936, and Deputy Director-General to Minister, 11 September 1936, HM 8/81(2); AJHR, 1937, H-7, p. 3.
268 Secretary, Public Service Association and Head Attendant, Sunnyside to Director-General, 17 June 1936, HMH 8/81(2).
270 Roth, p. 111. This was akin to a move by hydro-electricity workers, many of whom also worked and lived in isolated locations.
271 Shortly before World War II, the Wellington branch of the P.S.A. agitated for internal change and for representation of isolated special groups like hydroelectric and mental hospital employees. Roth, p. 98.
272 Medical Superintendent, Porirua to Director-General, 9 July 1946, MH 8/72/3; Evening Post, 7 August 1946, HMH 26/39.
273 Director-General Circular, 4 October 1946, H 30/35/53 (34604); Secretary, Public Service Commission to Director-General, 8 November 1946, HMH 8/60/1. This was indicative of a more adversarial relationship between the P.S.A. and the Public Service Commission. Henderson, p. 131.
In 1945, Sunnyside nurses petitioned against the strenuous overtime.274 A year later, at the Association’s request, the Public Service Commission, Department and the P.S.A. set up a committee of inquiry to find solutions to the acute shortage of staff in mental hospitals. The Inquiry documented some general points and a litany of more than 600 local concerns raised during its visit to every institution. The Inquiry made relevant recommendations.275 A departmental Staff Welfare Officer was appointed in 1946 to improve staff conditions and to channel suggestions from staff.276 Pay issues were defused during the inquiry by the announcement of a new salary scale but a dispute arose over the date for introducing new overtime rates. This was settled, at the eleventh hour, thanks to the Prime Minister’s intervention.277

The staff shortage continued after the War and prompted another recruitment campaign when manpower direction ended.278 The extreme shortage in 1945 prompted a recruitment drive for up to 200 British nurse trainees and 25 cooks.279 To speed up the process, Gray proposed that they be airlifted.280 Immigrant nurses were bonded, but few remained after the completion of their bonded service.281 Local recruitment campaigns had only limited success. Between October 1946 and January 1947, 179 nursing staff left the Department. Of these, 26 were dismissed, 37 gave no reason, 44 looked for a change of occupation, and 24 left because of ill health. In order to marry, 18 had to resign, 12 were needed at home, and two retired.282 By 1947, the departmental (nurse) recruiting committee agreed that traditional methods (newspaper advertisements, screen slides, posters, window displays and radio talks) were stale and had largely failed. A subtler approach was

274 Sunnyside Mental Hospital nurses’ petition, 14 (?) November 1945, MH 8/72/3.
275 Report to the Public Service Commissioner by the Committee of Enquiry on the Staffing of Mental Hospitals, 15th August 1946, Wellington, 1946.
276 File Note, 3 September 1946, HMH 8/0/5.
277 Director-General Circular, 4 October 1946, H 30/35/53 (34604); Secretary, Public Service Commission to Director-General, 8 November 1946, HMH 6/80/1; Henderson, pp. 192-3, Roth, pp. 118-19.
278 Minister to Director-General, 23 November 1945, HMH 8/116/0(6).
279 AJHR, 1947, H-7, p. 2. The Director of Clinical Services, R.G.T. Lewis, made the selection when he was on sabbatical leave in the United Kingdom.
280 Director-General to Minister, 16 July 1946, HMH 8/116/0(6).
281 Truman, p. 73.
282 Schedule of Reasons for Resignations of Nursing Staff, October 1946-January 1947, HMH 8/45/0.
adopted, directed at rural areas, and relying on personal canvass, local propaganda, and liaison with women's organizations.  

Male attendants must have suspected Gray's views and jealously guarded their separate but parallel career pathway. But they were trapped by the distinctive system of professional registration. Training was not portable and there were few career opportunities in nursing outside the Department. Attendants had no alternative specialist professional society to belong to. The New Zealand Trained / Registered Nurses' Association remained a virtual "sorority" despite an increased interest in mental nursing from the 1930s. In 1931 the Association considered opening its membership to trained "mental hospital nurses" but because of the perceived inferior registration, they could only be admitted as associate members. In 1944, the Association's Mental Hygiene Committee recommended that the 411 eligible male attendants and 291 females registered as psychiatric nurses be granted full membership to avoid the 'grave danger' of a separate association 'or even an industrial union' being formed. The constitution was amended to admit only registered female psychiatric nurses to full membership. Registered mental nurses hardly rushed to join. By 1947, attendants had clearly thrown in their lot with the P.S.A. rather than with the Registered Nurses' Association.

283 Mental Hospital Staff Recruiting Committee minutes, 30 September 1946, HMH 8/116/9.
284 Acting Director-General, Circular, 2 July 1947, HMH 8/137.
285 The name was changed in 1934. Marie E. Burgess, Nursing in New Zealand Society, Auckland, 1984, p. 118.
286 Following the lead of the International Council of Nurses (New Zealand Nursing Journal, 26, 5 (1933), p. 204), the Association began to consider the relationship of general and mental nursing in the 1930s. Talks were sometimes given at branch meetings on mental health topics, e.g., to the Otago and Wellington Branches, New Zealand Nursing Journal, 22, 3 (1929), pp. 100-1; Otago Branch, New Zealand Nursing Journal, 26, 5 (1933), p. 169; Auckland Branch, New Zealand Nursing Journal, 27, 6 (1935), p. 248; Wellington Branch, New Zealand Nursing Journal, 31, 1 (1938), p. 8. Next, the Association decided to set up a Mental Hygiene Committee because of the importance of that branch of nursing. Care was taken to ensure that members were selected with special qualifications to serve. The committee consisted solely of women. The qualifications of the members cannot be established precisely because the departmental register of mental nurses is no longer extant. Only one member of the original committee can be identified as a registered mental nurse, although this imbalance was later rectified. New Zealand Nursing Journal, 28, 1 (1935), pp. 59, 63.
290 New Zealand Nursing Journal, 35, 3 (1945), p. 61. Mrs Dick, the Social Service Worker, chaired the Mental Hygiene Committee. Matron Kelly of Porirua Hospital was a key member.
291 As late as 1967, only 49 psychiatric nurses employed in public mental hospitals belonged to the Association. B. Buick-Constable, 'New Zealand Professional Associations: A Case Study' – The
OTHER SPECIALIZED TREATMENT STAFF

Other paramedical occupations also became semi-professionals. Dietetians or catering supervisors, social service workers, and occupational therapists were employed in small numbers and can be considered together.

The Department recruited specialist staff from Britain when the requisite expertise was unavailable in New Zealand. When Sir Truby King, then departmental head (1924-7), wanted a professional dietitian to review and supervise feeding arrangements in all mental hospitals in 1925, he appointed a New Zealand graduate in domestic science who had trained as a hospital dietitian at Johns Hopkins University. On the other hand, H.M. Buchanan thought that the best chance to develop occupational therapy was to recruit a graduate from the Dorset House School of Occupational Therapy in England, which Buchanan had visited. Miss M. Inman, who was a qualified nurse and graduate of the School, was appointed and arrived in 1940, along with another specialist in the field. Inman then set up the National School of Occupational Therapy at Auckland Mental Hospital that produced sufficient graduates to meet New Zealand needs. Graduates were bonded to work in mental hospitals.

All three occupations were identified as professions for women. Gray's ideal social service worker was a 'decent motherly' woman who had borne children. 'High-brow, tight-lipped, flat-chested, hipless creatures' could never give real service to anyone, he claimed. Virtually all occupational therapy volunteers were women, and when


293 AJHR, 1925, H-7, p. 3.
295 Medical Superintendent's report, Auckland, AJHR, 1941, H-7, p. 4.
the work was put onto a professional footing throughout the Department, a woman was appointed to head it.297

Occupational therapy and social work were seen as career options for nurses. The original social service workers were both registered nurses298 although the first appointee, Mrs M.E. Dick, conceded that a social worker did not have to be a nurse provided that her previous training gave her insight into the ordinary life of everyday people.299 Qualified nurses were among those eligible for admission to the New Zealand School of Occupational Therapy at Auckland Mental Hospital. They predominated among the early intakes.300 Using such relativity, the Supervisor of Occupational Therapy was paid the same as a matron’s maximum salary301 to recognize her national responsibility and post-registration certificate.

Staffing establishments for other treatment and paramedical staff followed a trickle-down pattern. In the case of dentistry and occupational therapy, a national appointment was made. In the 1940s, an establishment of one occupational therapist and one psychiatric social worker was then set for each major hospital or for every institution. These establishments were later increased according to service needs and available funding.

As for formal training, Gray thought that a social service worker needed something between 'untutored enthusiasm' and 'false intellectualism'.302 Numbers were too small for formal training or professional registration to have emerged as an issue in psychiatric or other branches of social work before 1947. This was not so for occupational therapy, which rapidly acquired the hallmarks of professionalism. Formal training was expedited to anticipate wartime rehabilitation needs. A six-months' course began at Auckland Mental Hospital in 1940, with lectures in the principles and practice of occupational therapy, elementary anatomy and physiology.

300 Skilton, pp. 4-5, 112.
301 Public Service Classification List, New Zealand Gazette, 15 October 1947, pp. 1654-5.
302 His concern here may have been the impression he gained that social service workers he met in New York were influenced too much by 'pseudo-psychological' theories ad nauseam. Gray, Error, p. 146.
and the needs of sick persons. Lectures were complemented by practical work in different wards of the Auckland Mental Hospital. Graduates were awarded a Certificate of Proficiency in Occupational Therapy, the first of which was issued in 1945. The certificate preceded state registration of occupational therapists under their own registration board after 1950. Occupational therapists started their own regular newsletter in 1948. A professional association was formed that year, apparently at the instigation of the Health Department's Director of Nursing, who vetted the draft constitution.

For both social workers and occupational therapists, mental hospitals were only one avenue of employment, and a small one at that, so that professionalism assumed a health or even social service perspective. They joined in the quest for state registration, as a prize of professional status, just as earlier on, nurses and dentists and others had aped the medical practice. At no time were any of these groups able to dislodge the medical profession's control over diagnosis and prescription of treatment. Nevertheless, clinical responsibility was valued more than day-to-day nursing care.

CONCLUSION

Staffing policies set the numbers, quality and mix of specialized staff needed to provide mental health services within the funding allocated to the Department. These policies were based on the division of labour needed to care for and treat patients, manage institutions, and maintain the plant and estates. Personnel policies regulated the recruitment and retention of staff. With a regard for economy and efficiency, administrators in the Department's head office and Public Service Commission shaped personnel policies so that the staff numbers and mix were affordable. These policies were hardly ideal as the service grew and diversified. Marginal policy adjustments eased the tension from time to time but never resolved for long the stresses caused by shortages of specialist staff in mental hospitals.

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303 Skilton, p. 10.
304 Skilton, p. 53.
Professionalization, staffing and personnel policies gradually moulded the Department's staff into a tightly organized, highly disciplined and specialized national career service under clear medical leadership. This was a process driven bureaucratically from the top down, so that medical superintendents shared with the Inspector-General the tasks, personnel powers, disciplinary authority and management style to weld the staff (particularly attendants) into a disciplined workforce. Rules for staff, pay scales and conditions of employment, and special recruitment drives, were slowly but systematically centralized. As a career service, departmental employment shared many values and features of the wider civil or Public Service. Codes of conduct, relative security of tenure, career ladders, job classification and relativities, and appointment and promotion criteria, to name a few, stretched into the Department or were adapted by it to meet specialized requirements. It inculcated staff with particular values expressed as rules enforced through acculturation, discipline and penalties. Because mental hospitals were residential communities, hierarchical arrangements were supported by off-duty proprieties. These were usually defined by professional custom or local rules, augmented by national policy as the need arose.

The ordering of staff into occupational hierarchies was a key feature of bureaucratic personnel policies and management practice. The general principle of occupational organization was generally retained except that psychiatric social work and occupational therapy provided career opportunities for psychiatric nurses who wanted to progress to regular hours from shift work. Hierarchical organization though did lead to career progression that was premised on four unwritten principles of job responsibility. National service management or professional advisory positions were considered to have greater responsibility than institutional positions. This meant that the top positions in head office were generally paid more than institutional equivalents. The second principle assigned greater responsibility and remuneration to management or supervisory staff than to supervised staff. The third principle of job size was shown by the classification of institutions into large and small. Salary and promotion barriers encouraged qualified staff to progress upwards. The disciplined and secluded nature of institutional life created a social as well as a professional hierarchy. Doctors were at the top. Next came the clerical staff, the regimented and uniformed nursing staff, farming and artisan staff. Then came worker-patients and other patients. Social intercourse between these groups was governed by
institutional etiquette, professional considerations, and power relationships, all backed by national and local policy.

Professionalization complemented the bureaucratic concepts of organizational discipline and hierarchy. Professionalism was introduced in a top-down fashion and then spread throughout the Department in a trickle-down way. The policies of professionalism differentiated between staff with a direct treatment or care role (which was defined as professional) and non-care roles on the other. The first group were characterized by very similar attributes: formal training programmes, qualifications, state-licensed monopoly of practice, standards of acceptable and unacceptable practice, and some element of dress code.

The transformation of key care and treatment occupations into professions followed in the same direction as contemporary events in the United Kingdom. The pattern was reinforced through the spread of knowledge and ideas through British journals, membership of professional bodies, specialist training, study tours, and immigration. Professionalization had many advantages for patients, staff and the service. Professional staff offered the prospect of a higher standard of care. The nursing model opened up reciprocal career opportunities in general and mental hospitals for the enterprising. Professionalism offered staff higher status and strengthened their loyalty. Key professions involved in patient care and treatment helped project a therapeutic image of institutions and thus paved the way for the integration of mental hospitals into the health system and mental health into wider health professionalism.

The medical profession, under whose umbrella attendants, social service workers and occupational therapists were encouraged or sought advantage, provided the model for other occupational groups. These groups, however, remained under the ultimate management and clinical control of psychiatrists, set apart by the quality and depth of their specialist training, limited clinical discretion, significant pay differentials, and the ultimate management, clinical and policy authority of medical practitioners. Thus other occupations became paramedical professions, the term by which Larkin describes any occupation which has organized itself in connection with medical work, shares its conventional concepts of disease, and has successfully sought or clearly
aspired to some form of state licensure. Departmental administrators saw women as suited for these semi-professional roles whereas good doctors were identified as a body of men. Women were thought to bring special qualities to patient care and to the ward environment. They were cheaper to employ than men and they were thought to be more accepting of medical authority than male attendants. A large workforce of male attendants and a gender-based dual hierarchy, however, were never dislodged.

Attempts to strengthen professionalism through specialist societies and communication within wider professional groups had limited success because of the small number of specialists, the attitude of the wider professional group towards them, or in the case of attendants, an industrial rather than professional outlook. As a means of improving pay and conditions of service, particularly for attendants, industrial organization proved effective as pay scales of 1904, 1920 and 1946 demonstrate. Industrial agitation, however, was concerned with pay and conditions of employment in institutions upon which the national career service was built. Mental hospital attendants threw in their lot with the P.S.A. than with the New Zealand Registered Nurses' Association.

By 1947, the Department was virtually the only career for specialist psychiatrists and psychiatric nurses. A mere handful of psychiatrists practised privately. For others who chose to remain in that branch of the Public Service, departmental employment offered a nation-wide career pathway until retirement. Staff who tolerated the difficult working conditions and long hours within this specialized service developed a strong loyalty to the Mental Hospitals Department. This was partly a product of shared adversity, organizational and professional culture, the inward-looking nature of residential institutions, and wariness about their future when the Department was amalgamated with the Department of Health. Poised on the edge of a new therapeutic era, the Department's mental hospitals faced desperate shortages of specialist psychiatrists, medical officers, and female attendants.

306 Larkin, p. 1330.
307 Inspector-General to Secretary, Public Service Commission, 16 March 1928, and Director-General to Minister [?], 13 March 1935, HMH 8/36/0(1).
10.

CARE AND TREATMENT POLICIES

'There is no panacea.'

In this chapter, I will show how the Department responded to therapeutic developments in its policies. This chapter must be read in the context of the previous three chapters, because the "how" of treatment policies depended upon the "where" of a residential setting for psychiatric care and the "who" of specialized skills needed to provide them. Care and treatment meshed with the principles and policies of institutional development, rational classification, and institutional community building. The system of care and treatment also attempted to prevent further mental or behavioural deterioration.

Inside an institution, a mix of prognosis and diagnostic classification, changes in a patient's behaviour, nursing needs, and the subtle effects of institutionalization influenced care and treatment. On the whole, therapeutic effort and specialist resources were concentrated on acute cases. An acute patient was more likely to be alert to the quality of the care, conditions and environment. Long-standing practice was articulated officially in 1947, when the Acting Director-General, J. Russell, stated that priority would be given to the 'best medical attention and treatment of Recoverable [sic] cases', then 'the best institutional care possible' for other patients.

National policies on proper care and treatment were detailed in statutes, staff rule books, and circular memoranda. For example, the statutory medical journal elicited reasons for the number of patients under restraint, confinement, who were not employed, did not join in recreation, did not look after themselves, or who were wet or dirty. The reasons for deaths also had to be stated. When Hay incorporated that

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1 Appendices to the Journals of the House of Representatives (AJHR), 1910, H-7, p. 5.
2 E.g., Inspector-General's report, Wellington, November 1876, AJHR 1877, H-8, p. 15.
3 Acting Director-General, Circular, 15 August 1947, Health Department, Mental Health Division, Archives National Archives, Wellington, File HMH 25/21.
4 Lunatics Act 1868, Fourteenth Schedule; Lunatics Act 1882, Schedule No. 12.
information into a weekly report from every institution, he had immediate access to the 'salient factors in the life of the whole body of patients'.

The values underlying care and treatment can be found in the narrative reports made by departmental heads, district inspectors and official visitors after their inspections. W.E. Hacon, Medical Superintendent at Sunnyside, was probably referring to these values in his tribute to his late Inspector-General, F.W.A. Skae (1876-81). Skae took 'the greatest interest in every particular', and pointed out the defects he observed firmly but in a conciliatory manner. His inspections were 'a stimulus for "better things" beyond the daily routine work – for higher aims and motives.' G.W. Grabham, the Inspector-General between 1882-6, like his predecessor and successors, made 'statutory inquiries' to be satisfied that patients were lawfully detained, and that the habits or behaviour justified the level and forms of personal restraint used. Checking on the condition of the patients and their environment, however, involved subjective judgments. Professional ethics, respect for individuals and humanity, and ideas of material comfort helped shape the values behind the standards. Inspectors-general also wanted to be satisfied that each institution was running smoothly, economically and efficiently.

The initial reports of the first four departmental heads, from Skae to F. Hay (1907-24) give a good cross-section of the consistent values and standards of care and treatment. The first annual report of each of these administrators has been chosen because they usually contained a philosophy of care, fresh observation, and greater

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5 AJHR, 1910, H-7, p. 7.
6 Medical Superintendent’s report, Christchurch, AJHR, 1882, H-9, p. 15.
7 Inspector-General’s report, Nelson, 26 April 1883, AJHR, 1883, H-3, p. 10. The statutory areas for inquiry were set out in the Lunatics Act 1868, ss. 53, 56; Lunatics Act 1882, ss. 133-4, 136; and the Mental Defectives Act 1911, ss.70-3, 78(1). Provisions in the 1868 legislation were copied from English legislation, 8 & 9 Vict., c. 100, ss. 51, 64, 66, 25 & 26 Vict., c. 86, s. 19, and 25 & 26 Vict., c. 111, s. 35.
8 E.g., Inspector-General’s reports, Christchurch, 4-12 December 1876, Dunedin, December 1876-January 1877, Auckland, January-February 1877, Nelson, 9-12 February 1877, Napier, 9-10 April 1877, AJHR, 1877, H-8, pp. 17, 21, 24, 25; Inspector-General’s reports, Christchurch, 18 January 1883, Auckland, 29 March 1883, and Napier, 17 April 1883, AJHR, 1883, H-3, pp. 5-6, 9; Inspector-General’s reports, Auckland, 28 April 1886, and Wellington, 7 August 1886, AJHR, 1887, H-9, pp. 10-12; Inspector-General’s reports, Christchurch, 31 July 1906 and 26 February 1907, Hokitika, 13 July 1907, and Porirua, 15 March 1907, AJHR, 1907, H-7, pp. 19-20, 23, 25, 29.
description than later reports, which were published only in summary form after 1913 and ceased altogether in 1925. Common themes that emerge show that proper care and treatment involved a balance between liberty and confinement, the quality and extent of activation programmes, medical and nursing care, an acceptable standard of living conditions, and the personal appearance and comfort of the patients. I will look at the particular attributes sought in each of these areas and then discuss the policies and their effectiveness in addressing these facets of care and treatment.

In such discussion, especially of the deficiencies of policies on care and treatment, I should explain the nature of the documentation available. First, official correspondence and memoranda tended to highlight exceptional or unusual situations. These were not necessarily characteristic of every part of every institution at every time between 1876-1947. Extremes are also apparent in the limited photographic evidence of institutional environments. Some photographs or lanternslides proudly publicized attractive and very modern conditions, usually in front wards. Administrators realized that first impressions counted in allaying what Hay called the ‘natural anxieties’ about mental hospitals of patients, relatives, and the public generally. Other photographs were not publicized but recorded grossly outdated ‘institutional’ conditions. The clearest images were sequences taken before and after major refurbishment of the main buildings at Auckland and Sunnyside in the early 1960s. The ‘before’ pictures which I have used, verify the conditions at the Auckland, Sunnyside, Seacliff and Porirua Mental Hospitals.

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11 The first Medical Superintendent, Dr H.M. Buchanan, took two sets of photographs of the broken-down buildings at Hokitika Mental Hospital in 1921. Buchanan sent one set to the Department’s head office as proof of the conditions publicized by the Anglican Bishop of Christchurch and others in the press. The photographs were considered to be so sensitive that they were still held under lock and key in the Director’s office 50 years later. Buchanan retained the other set of photographs. Personal communication, the late Dr H.M. Buchanan, 21 December 1970.
12 Janet Frame, Faces in the Water, Christchurch, 1961, calls the Auckland Mental Hospital Treecroft. It can be identified by references to Wards 7 (female admission ward) and 451 (i.e., 145) on pp. 59, 67. Mount Eden Prison (p. 89) and radio station 1ZB (p. 104) are also in Auckland.
13 In Frame’s Faces, Cliffhaven is readily identified as Seacliff Mental Hospital through the references to the hour-long train ride north of the city (Dunedin), where the smoky train stopped at a nearby station to collect mail (p. 15). Cliffhaven had a slate roof and bell tower (p. 46). Seacliff’s prominent tower was unique in New Zealand mental hospitals. There is a further identifying feature of Seacliff in the reference to the tragic fire of 1942 (pp. 121-2). Frame has subsequently written about her experiences as a patient at Seacliff in An Angel at My Table, An Autobiography, Volume 2, Auckland, 1984, pp. 72-76, 108-112.
14 Marion Kennedy, The Wrong Side of the Door, London, 1963, is based on a large mental hospital called ‘Greenlands’ in the early 1940s. Greenlands matches Porirua. It was situated several miles beyond the city boundary (p. 16), near a railway and stream (p. 51). Information about the main entrance and short-cut to the nurses’ home (pp. 20-21), the design of the nurses’ home (pp. 22, 107), site of the female admission ward block (pp. 64-65), general topography of the Tawa valley (p. 192).
described in published accounts by two patients (Janet Frame and Iris Wilkinson, writing under the nom de plume of Robin Hyde) and a psychiatric nurse (Marion Kennedy). Hyde's book, *A Home in this World*, contains details of her time as a patient at Auckland in 1933.\textsuperscript{15} The other works are more substantive and cover a good cross-section of female wards. References to therapeutic developments and contemporary events suggest they relate to older mental hospitals in the 1940s and early 1950s. Frame's book, *Faces in the Water* (1961) is better known than Kennedy's *The Wrong Side of the Door*. Frame's work is a stated work of fiction\textsuperscript{16} but in her autobiography, she carefully explains that the fiction of the book lay in the portrayal of the central character. Otherwise she said she 'described in detail the surroundings and events' and 'wrote factually' of her own treatment and thoughts about it. If anything, she says, she understated the conditions she experienced.\textsuperscript{17} The perceptiveness and essential veracity of *Faces in the Water* was such that the Division of Mental Hygiene / Health used it for staff training purposes for a number of years.\textsuperscript{18} Some of Frame's observations about mass care and treatment can be corroborated from Kennedy and from the more plentiful official records of the end of the study period. This means that we have a much clearer understanding of conditions in the system in the 1940s than earlier in the period. Even if these works refer to the conditions in older buildings, it should be noted that by a very generous estimate, in 1947 probably only 48 per cent of patients in state mental hospitals lived in modern purpose-built villas.

**LIBERTY AND CONFINEMENT**

Mental health law expounded the state's right to deprive a citizen of liberty and to detain him or her in order that the person could receive proper care and treatment.\textsuperscript{19}

\textsuperscript{15} Hyde chose to enter the hospital as a voluntary boarder following a suicide attempt. She had been admitted previously to Queen Mary Hospital for depression. Robin Hyde, *A Home in this World*, Auckland, 1984, p. xiv.

\textsuperscript{16} Frame, *Faces*, p. 6. Her biographer, however, cites Frame's own correspondence that shows the work was an 'autobiographical sketch of a few years in hospital', intended to assist her to come to grips with painful memories and to help improve mental hospitals. Michael King, *Wrestling with the Angel: a life of Janet Frame*, Auckland, 2000, p. 207.

\textsuperscript{17} Frame, *Angel*, pp. 73, 102. Cf. p. 99.

\textsuperscript{18} Personal communication, the late Dr S.W.P. Mirams.

\textsuperscript{19} See, for example, the form of medical certificates under the Lunatics Act 1868, Seventh and Eleventh Schedules; Lunatics Act 1882, Schedules No. 2, 4 and 7. For voluntary boarders, see Mental
Writing in the 1900s, when every patient was committed, asylum officials argued that dignified care and treatment had to begin even before the person was admitted to an institution. They sought changes to admission procedures for all patients, but particularly those 'more sensible and sensitive'. Officials also worked hard to minimize the public involvement of police and the courts in committal proceedings. The insane should be seen as 'sick persons and not as criminals', declared Truby King, Medical Superintendent at Seacliff (1889-1921), with his emphatic underlinings in 1902. One of the 'greatest blots on our system', he continued, was the way constables brought some allegedly violent lunatics to Seacliff bound by leather straps or manacles. But that was not all. The unfortunate person could have been temporarily locked in a police cell and made a court appearance. King condemned these practices as inimical to mental well-being. His colleagues held similar views, but King remembered long enough to be able to formalize changes in 1925 when he was Inspector-General. King's new rules required police officers to wear mutti when escorting people to an institution by taxi and not in a black maria. Observation wards were to be used for overnight care rather than gaols and lock-ups.

King's new policy confirmed what by then was a general trend. King's predecessor, Hay, told the Commissioner of Police that the Mental Defectives Act

Defectives Act 1911, s. 39(1)-(2) and Mental Defectives Regulations 1912, Form No. 8. Statutory Form Nos 1, 4 and 6, under the Mental Defectives Regulations 1912, omitted the references to care and treatment for committed patients in favour of 'reception and detention'. New Zealand Gazette, 29 February 1912, pp. 891-6. The omission was not rectified by a specific legal mandate to treat committed patients for 40 years. Director to Law Draftsman, 1 June 1951, Mental Hospitals Department File, MH 25/23, formerly held in Health Department records storage but current whereabouts unknown.

20 Medical Superintendent's report, Seacliff, AJHR, 1900, H-7, p. 8.
21 Medical Superintendent, Seacliff to Minister, 28 May 1902, Healthcare Otago Ltd Archives, National Archives, Dunedin, DAHI D 264/24.
22 Medical Superintendent's report, Seacliff, AJHR, 1898, H-7, p. 10; Medical Superintendent, Seacliff to Minister, 28 May 1902, DAHI D 264/24.
24 Deputy Inspector-General, Circular, 12 August 1927, MH 13/109; AJHR, 1927, H-7, p. 2, and 1928, H-7, p. 2. There were occasional lapses in implementing these directions.
1911 intended the nearest relatives of a mentally defective person to apply for a reception order. Failing that, any person willing to assume that responsibility could apply. The police should not be directly involved unless the particular person was neglected, cruelly treated, suicidal, dangerous or offensive. Policemen should act more as ‘responsible citizens’ in applying to have lonely individuals committed.\textsuperscript{28} Prison statistics in Table 16 show that gaols were generally used only in towns far removed from mental hospitals. As general hospitals were more widely used for transit care, gaol usage dropped rapidly. In 1941, the last year the information was published, 14 “lunatics” were received in the country’s gaols, half of them in minor prisons or police gaols.\textsuperscript{29}

Minimizing possibilities for patients to harm themselves or to endanger the lives of others, was a prerequisite of good physical and mental care. Institutions contained many visible reminders that patients were detained under care and treatment. An ethos of safe-custody, essential for maintaining the physical health of patients, informed New Zealand’s mental health legislation, as Busfield noted for England.\textsuperscript{30} Staff rules made this abundantly clear, as shown in appendix 6. Attendants had to wear the universal “service” key and an alarm whistle chained to their clothes. A great deal of locking and unlocking of doors took place. Windows were fixed so that they could only be opened six inches or so. Rigid security and a lack of privacy generally surrounded the dining, bathing, shaving and toileting of patients. Knives were religiously counted before and after every meal and then locked away in a special chest. Staff had to use a service key to open the bathroom taps. Mixers controlled the temperature of bathing water. Staff rules throughout the period repeatedly used phrases like constant vigilance, close observation and reporting, careful supervision, and the maintenance of a high standard of physical care.\textsuperscript{31}

\textsuperscript{28} Inspector-General to Commissioner of Police, 24 July 1917, HMH 2/1/6.
\textsuperscript{29} AJHR, 1942, H-20, p. 5. Prison reports always referred to lunatics.
TABLE 16
LUNATICS RECEIVED IN GAOLS AND PRISONS, 1881-1940

<table>
<thead>
<tr>
<th>Year</th>
<th>Males</th>
<th>Females</th>
<th>Total</th>
<th>% Male</th>
<th>No. Received in Distant Gaols</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1881</td>
<td>131</td>
<td>18</td>
<td>149</td>
<td>87.9</td>
<td>30</td>
<td>20.1</td>
</tr>
<tr>
<td>1890</td>
<td>65</td>
<td>15</td>
<td>80</td>
<td>81.2</td>
<td>58</td>
<td>72.5</td>
</tr>
<tr>
<td>1900</td>
<td>46</td>
<td>11</td>
<td>57</td>
<td>80.7</td>
<td>53</td>
<td>93.0</td>
</tr>
<tr>
<td>1910</td>
<td>24</td>
<td>5</td>
<td>29</td>
<td>82.7</td>
<td>26</td>
<td>89.6</td>
</tr>
<tr>
<td>1920</td>
<td>15</td>
<td>3</td>
<td>18</td>
<td>83.3</td>
<td>15</td>
<td>83.3</td>
</tr>
<tr>
<td>1930</td>
<td>19</td>
<td>5</td>
<td>24</td>
<td>79.2</td>
<td>6</td>
<td>25.0</td>
</tr>
<tr>
<td>1940</td>
<td>10</td>
<td>-</td>
<td>10</td>
<td>100.0</td>
<td>6</td>
<td>60.0</td>
</tr>
</tbody>
</table>

Notes:
1. National records were first collected in 1881. Information was not published after 1940.
2. Distant gaols are those outside the towns and cities where there were established mental hospitals.

Source: Prison Department reports, AJHR.
Suicidal or violent patients were secluded or physically restrained. By the 1880s and 1890s, judicious use of mechanical restraint was an accepted part of the therapeutic repertoire necessitated by the failure of asylum authorities to provide the labour-intensive staffing essential to sustain the non-restraint system. The forms of mechanical restraint used included seclusion in a locked single room ( padded if necessary to cushion a patient from injury), straitjackets, locked gloves, camisoles, and a combination garment which came part way down the leg. Mechanical restraint was regulated more closely, along English lines, following an inquiry into the death of A.C. at Wellington Asylum in 1893. Local, then national, rules were promulgated to curb the use of continuous restraint and confinement. Highly dangerous patients were “specialled” with their own attendant or nurse to watch them constantly. Up to four or even five attendants might be needed to restrain particularly disturbed patients.

Getting the right balance between liberty and confinement, activity and inactivity for mentally disturbed patients in large numbers was never an easy judgment call. ‘I find the more liberty given them’, Hokitika’s Superintendent wrote in 1882, ‘the less
tendency there is to escape'. On the other hand, the need to adopt 'prison like methods' for criminal lunatics meant unnecessarily restricting other patients in the ward. Patients risked self-harm or accidental injury that could not be guarded against entirely without 'absolutely unjustifiable restriction'. From Hay's perspective:

As a general rule obvious restriction raises the desire for liberty, and directs the attention to the devising of means to obtain freedom. It is found that where a large measure of liberty is part of the routine treatment, chafing against detention is not so great, and the number of escapes is fewer.

Inspectors-general reviewed the balance between liberty and safe-custody when they visited institutions. Systems were monitored through the various statutory records and gave an instant snapshot. Furnished with that information, they commented on the appropriate extent of confinement to bed, seclusion or mechanical restraint. Hubbard found that the total number of patients subject to seclusion or mechanical restraint at Seacliff in 1900 was 4.2 per cent, 3.3 per cent in 1905, and 11.5 per cent in 1910, all within tolerable limits.

There was less tolerance for confinement in airing courts. Close confinement would confirm insanity instead of curing it; it would even 'drive a sane man mad', in Skae's opinion. According to Inspector-General Duncan MacGregor (1886-1906), needless confinement left patients with nothing to do but brood over their 'morbid feelings'. Inspection reports sometimes recorded the extent to which groups of patients were escorted on excursions beyond the campus. Inspectors-general also

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37 Inspector-General to Minister, 9 July 1924, Health Department Archives, National Archives, Wellington, File H 30/28/17 (45235).
42 Inspector-General's reports, Napier, 10 April 1878, and Christchurch, 11 December 1878, AJHR, 1878, H-10, pp. 3, 6. See also Kennedy, p. 162.
43 Inspector-General's report, Seacliff, 5 September 1889, AJHR, 1890, H-12, p. 6.
44 E.g., Inspector-General's report, Christchurch, December 1876, AJHR, 1877, H-8, p. 16; Inspector-General's report, Auckland, 29 March 1883, AJHR, 1883, H-3, p. 6; Inspector-General's
Locked and barred doors of secure single rooms, F Ward, Sunnyside Hospital (1872). The doors have an inspection hole and a hinged flap through which meals could be passed without opening the door. The bars had not been used for some years prior to this photograph being taken in January 1968. (Author's collection.)
Seacliff (1891). “New open airing court with picket fence 5' high except at the back and a small portion adjacent to airing court shown above where the fence if 8' high.” Note the shelter. The airing court overlooks the Otago coast. (Author's collection. Original in Medical Superintendent to Minister of Native Affairs, 29 August 1891, MH 1891/2511, Appendix I, formerly held in the Department of Health head office but current whereabouts unknown.)
Paved airing court of original F Ward, Sunnyside Hospital. The fences were removed in February 1968, just after this photograph was taken. (Author’s collection.)

Hokitika Mental Hospital (1921). The wall of the exercise yard must be between 15’ and 18’ high. (Author’s collection, copied from an original held by the late Dr H.M. Buchanan.)
praised local efforts to give patients greater freedom within the limits of the institution (ground parole), so adopting the practice of Scottish asylums. MacGregor transferred attendants to Auckland just to show the local staff how patients, whom they thought were dangerous and untrustworthy, could become useful if liberated from constant idleness in the airing courts. MacGregor exclaimed in 1894 that universal experience held that the greatest possible freedom and regard to individual tastes for employment did more for the insane than any drugs.

The effects of liberalized parole conditions are not easily obtainable before 1922, but it is reasonable to suppose that later trends continued an earlier pattern foreshadowed by the views expressed above. Table 17 shows the liberalizing effect of open (unlocked or partially unlocked) wards and parole upon patients hitherto confined to airing courts, not that they could be entirely dispensed with for some classes of patient. Of course, graduated liberty was much easier under the villa system. In 1922, only 14 per cent of patients could freely venture beyond the confines of their ward. By 1945, this total had risen to 38 per cent. According to Hyde, full parole gave a patient at Auckland’s Lodge the right to leave the grounds but he / she had to return before 9 p.m.

Hay expected patients confined to bed to receive ‘proper’ nursing care and attention. From Table 17, it can be seen that the number of patients confined to bed in an infirmary or other ward because of age, infirmity, profound mental and physical disability, or danger, grew slowly. Unfortunately the figures are not age specific. In 1908, a total of 32 per cent of patients were held under what was called “special care” in that patients were confined to bed or to a locked ward, or they were not allowed outside the airing courts. These included epileptics (6.7 per cent), G.P.I.
### TABLE 17

**PAROLE AND CONFINEMENT IN MENTAL HOSPITALS, 1922-1945**

<table>
<thead>
<tr>
<th>Year</th>
<th>Patients Resident</th>
<th>Ground Parole No.</th>
<th>Parole Outside</th>
<th>Confined to:</th>
<th>Confined to:</th>
<th>Confined to:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Parole %</td>
<td>Airing Courts No. %</td>
<td>Airing Courts No.</td>
<td>Wards No. %</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1922</td>
<td>4875</td>
<td>418</td>
<td>8.6</td>
<td>247</td>
<td>5.1</td>
<td>1843</td>
</tr>
<tr>
<td>1925</td>
<td>5132</td>
<td>411</td>
<td>8.0</td>
<td>117</td>
<td>2.3</td>
<td>1801</td>
</tr>
<tr>
<td>1930</td>
<td>6171</td>
<td>1825</td>
<td>24.4</td>
<td>840</td>
<td>11.2</td>
<td>1516</td>
</tr>
<tr>
<td>1935</td>
<td>7481</td>
<td>1757</td>
<td>23.5</td>
<td>607</td>
<td>8.1</td>
<td>1473</td>
</tr>
<tr>
<td>1940</td>
<td>7931</td>
<td>1953</td>
<td>24.6</td>
<td>450</td>
<td>5.7</td>
<td>1534</td>
</tr>
<tr>
<td>1945</td>
<td>8086</td>
<td>2475</td>
<td>30.6</td>
<td>587</td>
<td>7.3</td>
<td>1459</td>
</tr>
</tbody>
</table>

**Notes:**
1. Information refers to weekly report nearest 30 June.
2. Includes voluntary boarders and committed patients.
3. No return was received from Nelson in 1922.
4. No return was received from Tokanui in 1925.

**Source:** Unpublished institutional weekly reports, 1922-45, Health Department Archives, National Archives, Wellington, W 4415, ABQU, Boxes 614-7.
(1.0 per cent), suicidal patients (3.1 per cent), dangerous patients (2.8 per cent), and those liable to be or actually wet and dirty (18.4 per cent). Anecdotal information abounds about the priority given to and the pride nurses derived from the prevention of bedsores in patients who required constant nursing care. This was widely accepted in the Department as a standard of care and sign of professionalism. Writing of her experience as a new nurse at Porirua in the mid-1940s, Kennedy qualified these standards:

... The care and attention given to the physically ill was in direct contrast to the almost complete lack of treatment available for the mental ailments of the great majority of patients.

True, the patients were well-fed, warmly clothed, and carefully supervised. Those who were unable, or unwilling, to feed themselves, were fed. They were given tonics, aperients, and sedatives as required. They were given frequent baths, and no patient was permitted to have even dandruff in her hair, let alone anything of a more active nature. Those with suicidal tendencies were prevented from doing away with themselves; those with homicidal ideas, from doing away with others. But beyond this supervision their treatment was almost negligible. Time was the great healer upon which the authorities were obliged to pin their hopes - time assisted perhaps, by occupational therapy.

MENTAL STIMULATION

On their institutional visits, inspectors-general remarked upon figures in the medical journal that showed how many patients participated in work, regular recreation and worship. These were markers of mental stimulation and its converse, idleness.
Idleness was deplored;\textsuperscript{56} patients who were kept busy were quiet and orderly.\textsuperscript{59} Good physical care and occupational therapy, in the sense of activation and mental diversion, were mainstays of the Department's care and treatment policies. For instance, T.G. Gray, Director-General (1927-47), enunciated policy in 1929 in terms that bore a strong resemblance to the philosophy of moral management adopted in provincial lunatic asylums. Gray stated that:

\begin{quote}
our main resources are to be found in providing the elementary requirements, namely fresh air, sunshine, hydrotherapy in its broadest sense, suitable diet, exercise, recreation, rest and sleep, everything indeed conducive to the establishment of active, regular, daily habits, and the restoration of full enjoyment of the day time - thus inclining the organism to the normal reaction of sound and refreshing sleep at night.\textsuperscript{60}
\end{quote}

Diet and nutrition were essential parts of physical care and mental treatment. The earliest dietary policies attempted to control the use of alcoholic liquor. Skae had no time for these 'medical comforts' or for their use as an incentive for patients to work.\textsuperscript{61} His successor thought that feeble and helpless patients suffered nothing by being deprived of stimulants.\textsuperscript{62} Like his two predecessors, MacGregor monitored expenditure on liquor, which was a favourite item for cost-cutting in the late nineteenth century.\textsuperscript{63}

MacGregor scrutinized dietary scales because he disapproved of the colonial idea of diet as unlimited quantities of meat three times a day. MacGregor was apprehensive about making changes for fear of public outcry, but he was happy to allow the zealous Truby King to do so at Seacliff in the early 1890s.\textsuperscript{64} Convinced that patients' food was far too rich in nitrogenous material,\textsuperscript{65} King set about scientifically reforming

\textsuperscript{56} E.g., AJHR, 1877, H-8, pp. 1-3; Inspector-General's report, Christchurch, December 1876, AJHR, 1877, H-8, p. 16; Inspector-General's reports, Auckland, 28 April 1886, and Wellington, 7 August 1886, AJHR, 1887, H-9, pp. 10, 12.
\textsuperscript{59} E.g., Inspector-General's report, Christchurch, December 1876, AJHR 1877, H-8, p. 16; Inspector-General's reports, Hokitika, 16 February 1883, Auckland, 29 March 1883, AJHR, 1883, H-3, pp. 5, 9.
\textsuperscript{60} Director-General to Minister, 17 October 1929, HMH 8/1041.
\textsuperscript{61} AJHR, 1878, H-10, p. 11.
\textsuperscript{62} AJHR, 1886, H-6, p. 4.
\textsuperscript{63} Expenditure on these items was very modest, only 4.2 per cent of net departmental expenditure in 1876. By 1900, expenditure on wines, spirits, ale and porter had been reduced to 0.7 per cent of net departmental expenditure. AJHR, 1877, H-8, p. 12, and 1901, H-7, p. 21.
\textsuperscript{64} Inspector-General's report, Seacliff, 4 August 1891, AJHR, 1892, H-7, pp. 4-5.
\textsuperscript{65} One contemporary expert, C.A. Mercier, considered that the insane were conspicuous for their 'dynamical abnormity'. They tended to exhibit mechanical energy in excess, as in acute mania, or in
the dietary scale. He introduced more vegetables, reduced meat consumption, increased the volume of meals, and gave special attention to invalids' diet.\textsuperscript{66} Adopting a public health approach and expressing views that foreshadowed his later regimen for infant feeding, King said:

\begin{quote}
... we cannot expect any marked reduction of mental disease, or, indeed, of ill health in general until there is a more widespread recognition of the universal need for fresh air, regular daily exercise, and the avoidance of excesses and carelessness in regard to food, as well as drink.\textsuperscript{67}
\end{quote}

King returned to this theme as Inspector-General (1924-7) in order to effect system-wide change. A professional dietitian reviewed overall arrangements.\textsuperscript{68} Her assessment echoed King's earlier concerns. Few, if any, patients were underfed. In any case, records in patients' weight books would have drawn attention to any need to order special diets.\textsuperscript{69} Although it is clear from the review that many of King's earlier ideas had been implemented, it seems that the comprehensive 500 page report was presented too close to King's retirement to be systematically followed up.

For the majority of patients, work was the prime therapy and the primary criterion of therapeutic and management efficiency. National information available in Table 18 shows the high value placed on encouraging patients to work.\textsuperscript{70} Fluctuations can be explained by the gradual shifts in the dependency levels of the patient population and periodic campaigns against 'loafer' patients.\textsuperscript{71} For instance, in 1943, Gray directed medical superintendents to specially mention staff who actively interested
### TABLE 18
**PATIENTS WORKING ABOUT MENTAL HOSPITALS, SELECTED YEARS, 1908-1945**

<table>
<thead>
<tr>
<th>Year</th>
<th>Resident No.</th>
<th>Employed No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1907/8</td>
<td>3178</td>
<td>2242</td>
<td>70.5</td>
</tr>
<tr>
<td>1922</td>
<td>4875</td>
<td>2290</td>
<td>50.1</td>
</tr>
<tr>
<td>1925</td>
<td>5132</td>
<td>2686</td>
<td>51.9</td>
</tr>
<tr>
<td>1930</td>
<td>6171</td>
<td>3685</td>
<td>59.7</td>
</tr>
<tr>
<td>1935</td>
<td>7481</td>
<td>4033</td>
<td>53.9</td>
</tr>
<tr>
<td>1940</td>
<td>7931</td>
<td>4416</td>
<td>55.7</td>
</tr>
<tr>
<td>1945</td>
<td>8086</td>
<td>4787</td>
<td>59.2</td>
</tr>
</tbody>
</table>

**Notes:**

1. 1907/8 information based on inspection reports at each institution in the course of the year.
2. 1922 figure excludes Nelson from which no return was received.
3. No return received from Tokanui in 1925.
4. Information based on week nearest 30 June 1922-1945.

**Sources:** AJHR, 1908, H-7, pp. 10, 12, 14-15, 17, 18, 20-1; Institutional weekly reports, Health Department Archives, National Archives, Wellington, W4415 ABQU, Boxes 614-617.
Both of these photographs show the importance attached to outdoor work, especially for male patients. (Top) Scrub-cutting gang at Stoke Farm, near Nelson (1922). (Lower) Vegetable garden gang, Cherry Farm, c. 1947. (Author's collection.)
themselves in the campaign against the ‘idle’ patient at the next annual promotion review.\textsuperscript{72}

G. Hassall, the Medical Superintendent of Porirua, neatly summarized the rationale of work therapy throughout the period, although he wrote in 1900:

\begin{quote}
Work is, and doubtless always will be, the chief curative agent in mental alienation. This fact is, of course well known to those who are responsible for care and treatment of the insane, but is probably not yet fully recognised by the general public.\textsuperscript{73}
\end{quote}

As Inspector-General (1924-7), Truby King’s mentor on this matter remained Sir Thomas Clouston,\textsuperscript{74} who preached a sound ‘gospel of open-air occupation and useful work for the insane.’\textsuperscript{75}

MacGregor noted the benefit of outdoor work at Seacliff, where farm workers looked fresh and healthy\textsuperscript{76} and where, in 1887, the Inspector-General instructed the Medical Superintendent to run the farm as a paying one, not as a model estate.\textsuperscript{77} MacGregor thought that outdoor work aided recovery far more than all the drugs of the pharmacopoeia.\textsuperscript{78} ‘Idle and listless patients’ removed from the gloomy airing-courts showed immediate improvement when they started working about the place.\textsuperscript{79} Without farm work, patients would become noisy, complaining, troublesome and often dangerous, and there would be a larger residuum of chronic cases.\textsuperscript{80} Hay shared that philosophy:

\begin{flushleft}
\textsuperscript{72} Director-General Circular, 11 October 1943, HMH 2/7/10.
\textsuperscript{73} Medical Superintendent’s report, Porirua, AJHR, 1900, H-7, p. 7.
\textsuperscript{74} Sir Thomas David Clouston (1840-1915) was described in an obituary as ‘the doyen of British alienists’. Clouston was Medical Superintendent of the Royal Asylum, Morningside, Edinburgh (1873-1908), first lecturer in mental diseases at the Edinburgh University (1879), a prolific writer on psychiatry, and president of the Medico-Psychological Association. Obituary, \textit{British Medical Journal}, I (1915), pp. 744-5.
\textsuperscript{75} AJHR, 1925, H-7, p. 7. Cf. Medical Superintendent, Seacliff to Minister, 19 February 1902, DAHI D 264/66.
\textsuperscript{76} Inspector-General’s reports, Seacliff, 5 September 1889 and 8 March 1890, AJHR, 1890, H-12, pp. 3, 6.
\textsuperscript{77} Inspector-General to Medical Superintendent, Seacliff, 13 August 1887, Internal Affairs Department Archives, National Archives, Wellington, File IA 102/2.
\textsuperscript{79} Inspector-General’s report, Seacliff, 26 March 1888, AJHR, 1888, H-8, p. 4, and 5 September 1889, AJHR, 1890, H-12, p. 6.
\textsuperscript{80} [Deputy?] Inspector-General’s report, Seacliff, 24 October 1906, AJHR, 1907, H-7, p. 25.
\end{flushleft}
Every patient who is physically able and can be trusted is encouraged to work according to his or her capacity. That work is not merely a matter of supplying milk, vegetables, and other produce, of cooking the food, of washing and mending the clothing, and of keeping the institutions clean; it is mainly a form of treatment which engenders a feeling of contentment, most valuable to the administration, and promotes the physical well-being of the workers and the cure of the curable.  

Even if the institutional farms had to be worked at a loss, Hay thought that their primary and therapeutic purpose made farming a necessity. Farming helped diffuse 'a sentiment of privacy and freedom' while providing 'normal healthy occupation in the open air.' Those patients who worked outside were 'subdued by the environment.'

Male patients provided the bulk of workers in farm or garden gangs, but MacGregor held no 'sentimental prejudices' against using women too. A 'little mild field work' such as cultivation of linen flax, lawn mowing or 'sundry light gardening operations' might help quieten noisy women patients. The Premier's aversion to women having to use wheelbarrows may have stopped the idea proceeding far at that time, but it was not lost. In 1932, C.A. Corban, an assistant medical officer at Tokanui revived it. Gray agreed and urged the local medical superintendent to set an example to other hospitals by finding ways to employ women patients on the farm. By the late 1930s, however, the heyday of institutional farms and gardens was past, as urbanization gradually dried up the number of patients with experience of agricultural and pastoral methods. Porirua's medical superintendent nostalgically lamented the
gradual but very real decrease in the amount of work actually done by patient labour.89 In 1947, medical superintendents at Kingseat and Seaview spoke of farming activities having been carried on as usual, whilst Porirua's gardens yielded 229 tones of vegetables and 16.5 tons of fruit for hospital consumption.90

Men and women helped in the main kitchens and laundries, with males doing the heavy work. Men also helped out at the bakery, store and butchery, transported supplies around the wards, or refilled the straw mattresses.91 At Seacliff, one patient was a rat-catcher.92 Only women worked in the sewing rooms.93 The sewing and clothing departments at Christchurch in 1900 were 'busy hives of industry', according to their medical superintendent.94 Patients confined to their wards could help with domestic chores. Nurse Kennedy recalled that in the 1940s work therapy in Porirua's back wards consisted mainly of monotonous sweeping, dusting, and polishing the floors with the heavy, blanket-encased wooden polishers known as 'bumpers'.95

No doubt it was better for patients to be kept occupied, if only by pushing a bumper up and down, than to be sitting around doing nothing all day. There may even have been some sedative value in the monotonous movement entailed, or a possible release of tension with the physical effort involved; but none the less, there was a crying need for proper, supervised occupational therapy for all the patients who were up and about. ... For in wet or cold weather these patients were confined to the dreariness of the day-room from the time they got up in the morning until they returned to bed at night. For twelve hours of the twenty-four those who were capable of doing so filled in their day by reading, writing, knitting, or cleaning. Those whose mental condition precluded even such occupations as these stared into space, walked excitedly up and down, or disturbed the peace in some manner peculiar to their mental state.96

89 Medical Superintendent, Porirua to Director-General, 1 June 1937, HMH 4/4/2.
90 Medical superintendents' reports, Kingseat, Seaview and Porirua, AJHR, 1948, H-7, pp. 7, 10, 12.
91 Frame, Angel, p. 74; unidentified nurse quoted in Williams, p. 208. Although the nurse referred to the early 1950s, mattress filling from the straw room was a daily occurrence in mental hospitals. Straw mattresses were smoothed flat with a broom handle. Mrs S. Connelly-Spence in Seaview School of Nursing Reunion Committee, Memories, Hokitika, 1992, p. 16.
92 Medical Superintendent, Seacliff to Director-General, 10 February 1931, HMH 3/9/3.
94 Medical Superintendent's report, Christchurch, AJHR, 1900, H-7, p. 6.
95 Kennedy, pp. 54, 236; Frame, Faces, p. 38.
96 Kennedy, pp. 54-55.
Even in the neuropathic hospital at Auckland, patients were given 'no real outlet except this polish-and-mop business', Hyde wrote.97

Work therapy was also valued for feeble-minded and imbecile patients:

... For the bulk of the trainable cases, field or domestic employment, or methodical work at simple handicrafts, useful to their limited community, are most likely to bring content [sic] to themselves, and lighten the burden which their care and control places upon the conscience and resources of the community.98

Children admitted to asylums or mental hospitals received no formal education,99 although a school was set up for 45 children at Templeton Farm Colony in 1942.100 Templeton grew as a 'colony school' for feeble-minded children. Very few of the early inmates had benefited from the educational system but with 'proper training', Gray thought, they became surprisingly proficient at gardening and farming pursuits, knitting and sewing and other domestic duties.101 Patients sent to Levin in 1945 remembered pushing lawn-mowers in large circles at Templeton. It took several days to complete the job. Other patients transferred to Levin remembered the boredom of being too young to do anything.102

Because work was regarded as therapeutic, patients were very rarely paid.103 Non-payment sometimes led to allegations of exploitation.104 Although patients were given every encouragement to do some work, however menial, evidence of "sweating" is

97 Hyde, p. 16.
100 Ilalio, 'From Levin Mental Deficiency Colony to Levin Hospital and Training School, 1945-70', MA Thesis, Victoria University of Wellington, 1972, p. 32.
102 Ilalio, p. 32.
103 Inspector-General, Circular, 16 December 1918, H 30/28/24 (35137). Inspector-General to Medical Superintendent, Auckland, 23 October 1924, YCAA 1079/1/E, File 1/16/1. The 1918 circular was probably the first statement of policy on the topic. It authorized medical superintendents to approve a token payment (up to 2s. 6d. weekly) for patients who regularly worked as domestics in doctors' quarters. A sum of £567.16s. Od. for patients' gratuities was included in departmental expenditure for the first time in 1921/22, and each year thereafter. AJHR, 1922, H-7, p. 24. In January 1935, gratuities were paid to some indispensable patients employed on the garbage or laundry carts, or as a bricklayer's labourer (which saved the hospital another salary). See Williams, p. 99.
104 E.g., 'F.D.M.', letter to Evening Post, Wellington, 9 August 1911; Prime Minister to Minister, 12 July 1923, H 30/28/24 (35137); New Zealand Truth, Wellington, 19 April 1924, YCAA 1079/1/E, File 1/16/1; Official Visitor's report, Auckland, 12 July 1924, HMM 7/14; T.K. Sidey (Liberal, Dunedin South), New Zealand Parliamentary Debates (NZPD), 7 October 1914, 170, p. 459; Minister, NZPD, 11 September 1925, 208, p. 253; Otago Daily Times, 4 May 1938, and 'Sympathiser', letter to Otago Daily Times, 6 May 1938, HMM 26/39.
hard to find. Truby King once said that patients worked in a ‘somewhat leisurely fashion’. In 1925, Gray said that it took 40 male patients to do the work of ‘one boy and one old horse and plow’. He estimated the value of a day’s work at 3d. and found. If patients needed money, they had to use funds from their estates or relatives. In 1924, patients were entitled to be paid up to 2s.6d. to purchase ‘extras’ or private clothing if their funds permitted and maintenance was paid up. Nor was the value of patient labour deducted from maintenance charges. In defending the long-standing policy of not paying patients, it was sometimes implied that patients would not appreciate the money. Worker patients might be useless in the future and have to be kept by the institution for years. Bribery was held to be wrong in principle, but patients were given other incentives to work. Parole, outings, entertainments, food, and tobacco were customary incentives. Beer was also used until 1926. A few very reliable long-stay worker patients might be given their own particular privileges. ‘Maud’, the archetypal worker patient at Porirua in the 1930s-40s, wore her own private clothing, and had her own single room, which she adorned with knick-knacks and possessions like a bedroom. Patients did not generally receive pocket money until 1947, when a £20,000 “Comforts Fund” was set up to enable all patients thought to be capable of appreciating them to purchase sweets, cakes, cigarettes, outings or clothing.

Professionally run occupational therapy was a latter day variant of traditional work therapy. Occupational therapy originated in the United States as part of medical and
rehabilitation services for wounded or disabled soldiers in World War I. Occupational therapy grew rapidly as a profession there between the wars. Handicrafts were advertised as part of the programme at Ashburn Hall in the late 1920s, and they may have been part of the rehabilitation programme at Queen Mary Hospital. As early as 1925, H.M. Buchanan, then [acting?] Medical Superintendent at Seacliff, acknowledged the benefits of handicrafts and music for those 'more or less intelligent beings' unsuited for work gangs. It was particularly valuable for women, few of whom worked outdoors. Buchanan used volunteers to introduce occupational therapy at Auckland Mental Hospital in 1935. The Director-General changed his mind about the value of occupational therapy when he saw it used at overseas mental hospitals. Classes were then commenced at Porirua, Sunnyside, Seacliff, Auckland and Templeton. Buchanan followed an interest in getting occupational therapy organized on a professional basis during his overseas study tour in 1938. After that, Buchanan was determined to implement professional occupational therapy on the same scale he saw in British institutions. By 1943 Buchanan claimed that 27.5 per cent of patients could derive some benefit from occupational therapy, and a further 44 per cent would find it of utility value. Occupational therapy was said to encourage happier conditions for people otherwise liable to be idle, or brooding escapes and mischief. Occupational therapy also gave patients better individual care, had a 'tranquillising effect', and made it easier to manage refractory patients.

Occupational therapy, in the broad meaning of the term, was part of an ordered rhythm of daily life in mental hospitals that continued to be directed towards the 'inducement of regular habits and reasonable occupation', as Truby King termed it. Daily routines were similar in most wards although there was less opportunity for

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118 Medical Superintendent, Seacliff to Inspector-General, 15 June 1925, H 30/28/24 (36157). A file note says the matter was discussed with King and Gray on 17 July and 25 November 1925. In a personal communication to the author, the late Dr Buchanan could not recall the outcome of this correspondence.


120 Director-General to Minister's Private Secretary, 31 March 1937, HMH 26/8; AJHR, 1937, H-7, pp. 3-4, and 1938, H-7, pp. 3-4.

121 Medical Superintendent's report, Auckland, AJHR, 1939, H-7, p. 5; Medical Superintendent, Auckland to Director-General, 24 April 1939, HMH 2/7/10.


123 Medical Superintendent, Seacliff to Minister, 19 February 1902, DAHI D 264/66.
MENTAL TREATMENT – OCCUPATIONAL THERAPY

Occupational therapy classes at the Auckland Mental Hospital, 1940. The patients are making frames for padded stools. (Occupational Therapy Department, Otago Polytechnic. The original photograph is in the New Zealand Association of Occupational Therapists' deposited records, Auckland Institute and Museum.)
individual recreation and leisure the further one moved from front wards to back wards. Frame described the daily routine at Seacliff in the 1940s, in a series of orders barked by the ward sister:

"Rise, Ladies". "Laundry, ladies, Sewing-room, ladies, Nurses' Horne, ladies." ... "Lavatory, ladies" ... Day-room, ladies. Rise Ladies. Bed, ladies. You learned with earnest dedication to "fit in." 124

As Frame put it, she became 'part of a group ... "she", one of them'. 125 Under these conditions and monotonous routines of daily living, Frame's fictional psychiatric patient felt

There is no past, present or future. Using tenses to divide time is like making chalk-marks on water. 126

There was 'Sausage Day, Apple-pie day, Visiting Day, Operation Day. Every Day. And there was Picture Night'. 127 Such occasions and, after 1947, canteen and library visits were treats. 128 The monotony of institutional routine was also broken by community-building 'important events' like Christmas, church-going, dances, the annual hospital sports day, the annual picnic, and games played on hospital sports grounds. 129 Special civic occasions, like royal or peace celebrations, were also honoured. 130

Voluntary effort played an important part in bringing 'a little brightness into the lives of the unfortunate inmates'. 131 The focus of such voluntary groups was local and practical rather than political and critical, so they generally enjoyed good rapport with medical superintendents. Institutional annual reports referred to the involvement of local sports clubs, musical and drama societies, clergymen, and service clubs. They provided reading matter, radios, gramophones and cinematographs, comforts,

124 Frame, Faces, pp. 18, 21, 37-38.
125 Frame, Angel, p. 73. Cf., p. 101.
126 Frame, Faces, p. 35.
128 Frame, Faces, pp. 139-40, 206-9; Kennedy, pp. 90, 95, 186-7.
130 E.g., Medical Superintendent's report, Dunedin, AJHR, 1882, H-9, p. 16; Inspector-General to Medical Superintendent, Auckland (telegram), 17 July 1919, YCAA 1079/8m, File 6/25/6; Official Visitor's reports, Seacliff, 28 June 1897 and 24 June 1901, DAHI D 264/7; Official Visitor's report, Seacliff, 27 August 1945, DAHI D 264/6.
131 Medical Superintendent's report, Porirua, AJHR, 1922, H-7, p. 9.
luxuries, Christmas treats, and outings. Free passes were given to local entertainments and sports events. Some groups ran concerts and dances. Clergymen of different churches made local arrangements to organize worship and pastoral care in mental hospitals. There was no specialist hospital chaplaincy.\textsuperscript{132}

Accounts of daily routine show a gap between therapeutic ideals and reality. Institutional routines and work therapy changed very little over time. As Busfield says, in relation to English mental hospitals, treatment in the mass was inevitable when institutions expanded and faced constant shortages of key staff.\textsuperscript{133} Referring to American mental hospitals, Caplan said that humane care was still provided but in a way that acknowledged that institutions could no longer be devoted almost exclusively to active therapy and the cure of recent cases. They also had to provide a sheltered environment for chronic misfits. The custodial era was not marked by lowered concern for the unfortunate, but by the loss of faith in an easy cure.\textsuperscript{134} Similar comments applied to care and treatment policies in New Zealand. Mass treatment was not intentionally callous or indifferent but it was inevitable when too few resources were given to meet high ideals.

**MEDICAL TREATMENT**

Routine care and treatment programmes discussed so far were largely unchanging. More active or dramatic therapeutic intervention was harder to find for much of the period before the 1940s. In 1910, Hay conceded that there was no panacea.\textsuperscript{135} Nor did Truby King hold out great hope:

> As long as the comparatively simple chronic degenerations of the spinal cord remain, as they still are, incurable, and for the most part little affected by "treatment," we have no reason to anticipate much success when dealing with organic affections of the infinitely more delicate, complex, and vulnerable brain-tissues.\textsuperscript{136}

\textsuperscript{132} Christchurch [Anglican] Diocesan Synod reported in Press, 21 October 1944.

\textsuperscript{133} Busfield, p. 260.


\textsuperscript{135} AJHR, 1910, H-7, p. 5.

\textsuperscript{136} Medical Superintendent’s report, Seaciff, AJHR, 1910, H-7, p. 16.
Until there was some breakthrough, Hay committed himself to
treatment directed with all the understanding which the present
state of science gives. This may not be much, but it is all.\textsuperscript{137}

Hay envisaged that reception houses should provide intensive therapy. Only people
who were obviously unfit, such as cases of acute mania, acute melancholia,
epileptics, and those with active suicidal tendencies, went elsewhere immediately.\textsuperscript{138}
To the fullest extent possible within staffing and budgetary limitations, proper care for
acute patients meant intensive care. Hay wanted reception houses to be places where
patients would be tended by a specially trained nursing staff
and where their physical and mental condition would be cared
for by medical experts having access to all therapeutic agencies
for dealing with incipient psychoses and neuroses. This special
institution would need to be self-contained. The necessary
resources for recreation appealing to each special case,
matters just as important in their case as the massage,
hydrotherapy or what not applied in bed cases .... For patients
for whom bed-treatment is deemed advisable, there will, be a
tendency to try a number of therapeutic agencies, and in any
estimate the cost of these must be kept in mind. I refer to
Massage, Electricity, Special baths, Suggestion \&c., and even
psycho-analysis may be demanded in the future.\textsuperscript{139}

Newly admitted patients were given ‘rest-in-bed’ treatment like a general hospital for
a few days for observation and diagnosis prior to transfer to another ward as
necessary.\textsuperscript{140} The forms of treatment contemplated by Hay developed very slowly.
Only in the 1930s, did Porirua reports refer to the provision of physiotherapy, light
therapy, radiant heat, exercise and recreation for recent and recoverable
cases.\textsuperscript{141} Such techniques did not feature in Sir Truby King’s prescription. He was wont to cite
an older authority, Sir Clifford Albutt, on the importance of the ‘intimate personal
relationship’ between sympathetic staff and individual patients that would open the
patient to all the influences of exercise in the fresh air and many of the ‘pleasures

\textsuperscript{137} AJHR, 1910, H-7, p. 5.
\textsuperscript{138} Inspector-General to Medical Administrator of Pensions, 26 August 1924, HMH 8/848.
\textsuperscript{139} Inspector-General to Chairman, Hospitals Commission, 23 May 1921, HMH 4/4/2.
\textsuperscript{140} AJHR, 1909, H-7, p. 6. For a description of admission procedures, see Kennedy, pp. 70, 73,
79; Frame, Faces, pp. 62 ff., 118.
\textsuperscript{141} Medical Superintendent’s report, Porirua, AJHR, 1936, H-7, p. 7; Kennedy, p. 80.
and diversions of life.' In King's mind, these principles largely subsumed ultra-violet treatment, psychoanalysis or psychopathy.\textsuperscript{142}

Newly admitted patients certainly received more individual care and attention. In 1927, Gray ordered that every newly admitted patient in a reception home was to be visited by a medical officer, examined, diagnosed, registered and, where appropriate, sent to another ward. Patients in admission wards were to be weighed weekly, given a regular routine, fed with special diet and fruit, vegetables and cream in abundance, allowed to wear their own clothes, and generally placed under as few restrictions as possible.\textsuperscript{143} Gray implemented elsewhere the routine set by Truby King in the female admission ward at Seacliff, and summarized in the notice King had displayed prominently on the mantelpiece of the Cottage: 'Breakfast may be taken if wished, but an early morning walk, before breakfast, is absolutely essential.'\textsuperscript{144} At the Cottage (and elsewhere under Gray's directive), patients were expected to rise at 6:30 a.m., go for a brisk walk before breakfast at 7:45 a.m., and engage in 'necessary work for the institution' between 9 a.m. and noon. After a half hour walk, dinner was served at 12:30. Patients helped with dishes, then rested until 2 p.m. Then there was another walk or a picnic before the patients returned for tea at 4:45 p.m. Patients had the evenings free for leisure activities before retiring at 9 p.m. Male and female patients shared a picnic on Sundays.\textsuperscript{145} Iris Wilkinson (Robin Hyde), was encouraged to keep a journal and to use the attic of the Lodge, Auckland, as her study when she was a patient in 1933. Other patients whiled away the hours knitting or listening to the radio.\textsuperscript{146} Newly admitted patients were also given occupational therapy as part of their intensive care.\textsuperscript{147}

Pharmacology had a limited role. Potassium bromide, chloral hydrate and paraaldehyde were to be found on dispensary shelves along with an array of tinctures. Opiates were used in the nineteenth century until their addictive properties became known. Phencyclidine and tridione became available in the 1930s to treat epilepsy.

\textsuperscript{142} AJHR, 1925, H-7, pp. 6-7, citing Albutt's evidence to a London County Council committee, c. 1890. 
\textsuperscript{143} Director-General, Circular, 7 November 1927, HMH 4/4/1; Hyde, p. 18. 
\textsuperscript{144} Mary King, \textit{Truby King The Man}, London, 1948, p. 89. 
\textsuperscript{145} Medical Superintendent's Report, Nelson, AJHR, 1922, H-7, p. 9; Notice of Wolfe Home Routine, 12 October 1925, YCAA 1079/5j, File 5/6/0; King, pp. 88-89. 
\textsuperscript{146} Hyde, pp. ix-x, 18. 
\textsuperscript{147} Kennedy, pp. 242-3; Frame, \textit{Faces}, pp. 198-9.
CHANGES IN THE LIVING ENVIRONMENT – DORMITORIES

Female admission ward [?], Sunnyside Mental Hospital, 1908. The photo shows that the ward was lit by electricity. Wooden bedsteads were provided. Pictures and pot plants abound. (Author’s collection.)

Efforts to hospitalize the mental hospital environment were most apparent in admission wards and reception homes. This photograph of a small ward at Wolfe Home, Auckland, c. 1925. The ward is smaller than that shown in the previous picture. (Author’s collection.)
Female admission ward, Rauta block, Porirua Hospital (1956). The ward is very crowded, just like it was in the 1940s, with perhaps only 18 inches between the beds. The ward atmosphere is more clinical, and emphasizes the hospital image of rest-in-bed treatment. (Wendy Hunter Williams, 'Out of Mind Out of Sight: The Story of Porirua Hospital', Porirua, 1987, p. 206.)
A dormitory at Porirua Asylum (1895) full of iron bedsteads and white counterpanes. The lack of decorations in the ward suggests that it was probably a male ward. (Author's collection.)

Dormitory for faulty patients, Hokitika Mental Hospital (1921). (Author's collection, from an original photograph by Dr H.M. Buchanan.)
Reception houses and neuropathic units were well furnished and homely environments, designed to facilitate the early treatment of mental and nervous disorders. These photographs, taken c. 1925, are of a lounge and dining room at the Wolfe Home, Auckland Mental Hospital. (Author's collection.)
Braemar Lodge, Nelson (1923) was typical of the well-appointed reception houses of that period. Staff, and probably some patients, watch a game of tennis, c.1925.

(Author's collection)
These were followed by dilantin in 1941. Mental health administrators, however, were wary about using medication widely, as is obvious from references to psychopharmacology as 'chemical restraint', 'powerful and poisonous drugs', or 'doping'. Such was Gray's concern that he introduced drug registers to record and control the use of sedatives. This had the desired effect. Such attitudes largely limited pharmaceutical treatment to house medicines, stimulants and a few sedatives.

Treatment policies followed from the psychiatric theories held by mental hospital administrators. Their views reflected the general development of psychiatry and rival somatic and dynamic explanations of mental disorder. In the latter half of the nineteenth century, psychiatric theory moved from a blend of somatic principles and psychological exploration to a new somaticism. Theories of mental disorders were reformulated in line with concepts that transformed general medical thought and practice, such as the localization of disease. The new somaticism was manifest in organic neuropsychiatry, theories of heredity and degeneration, and brain pathology. Anatomy, physiology, and the quest for toxic agents were all used to explain the aetiology of mental diseases. In the first half of the twentieth century, the functional school of thought offered an alternative view of psychiatry. Functionalists looked to the significance of life history and prior experiences to explain insanity, particularly in its milder forms. 'Dynamic psychiatry' built upon a nineteenth century therapeutic tradition that included hypnotism, mesmerism, and the rest cure. Freud's psychoanalytic reorientation lay within the dynamic tradition. Tensions between the somatic and functional schools of thought made psychiatry a 'divided and ambivalent specialty' in Grob's opinion. Freudian techniques, however, helped reconceptualize the neuroses as minor mental disorders and to establish them as an important focus of therapeutic interest. Psychoanalysis also created hope for the treatment of neuroses and generated public demand for special services.

148 Reed, pp. 51-52, 89-90.
149 AJHR, 1887, H-9, p. 10. MacGregor's views are also set out in Inspector-General's reports on Nelson, 16 October 1893, AJHR, 1894, H-7, p. 5, and Ashburn Hall, 5 May 1901, AJHR, 1901, H-7, p. 5.
150 R.M. Beattie, 'Lecture Given to Auckland Trained Nurses', Kai Tiaki, 1, 4 (1912), pp. 797-8.
151 Director-General, Circular, 29 June 1931, YCAA 1079/6n, File 5/45/-.  
152 Director-General, Circulars, 29 June 1931 and 18 June 1932, YCAA 1079/6n, File 5/45/-.  
154 Grob, Grob, p. 203.
professionals and treatment to be adopted, particularly for war neuroses. This pattern was most notable in the United States between the 1930s and 1950s where psychodynamic thinking took root more firmly than in somatic oriented European psychiatry.

Key mental health administrators in New Zealand were firmly in the somatic camp. MacGregor espoused hereditarian views and degeneracy theory from the 1870s. Hay believed that heredity and stress existed in inverse ratio as causes of insanity. Sir Truby King propounded that:

“The sooner the public understands that mental disease is for the most part a symptom and expression of bodily disease the better.”

Gray accepted ‘the soundest opinions among psychiatrists’, which held that all so called mental disease had a physical basis, however obscure.

Valenstein considers that somatism led to physical interventions, especially if they offered the prospect of treatment with minimal resources. The absence of major somatic breakthrough created the impression that mental hospital care was custodial. In 1935, E.J. Howard (Labour, Christchurch South) asked rhetorically what treatment was available in the country’s mental hospitals other than Epsom salts? In retirement, Gray recalled how mental hospital doctors used to face a barrage of questions that indicated that no pathology or treatment had been found for mental disorders. In such an atmosphere, any development could be construed as a long-awaited therapeutic breakthrough. Valenstein suggests that the popular press
exaggerated claims of the effectiveness of somatic interventions and created the climate for their widespread use, even though the techniques had not been subjected to rigorous or effective scrutiny within psychiatry.\textsuperscript{164} In New Zealand, suggestive therapeutics gained ‘extraordinary credulity’ and the expectation of widespread application from their success with “shock” cases.\textsuperscript{165} Media reports about later somatic interventions were optimistic. ‘A movement has been started which may go a long way,’\textsuperscript{166} wrote Wellington’s \textit{Dominion} newspaper in 1943. These were welcomed as offering ‘new hope for the mentally afflicted’.\textsuperscript{167} Some psychiatrists, too, were apt to exaggerate the potential of some treatments; but not R.W. Medlicott, then an enterprising medical officer at Porirua. He noted the ‘usual phases’ of medical discoveries: a sequence of cure-all or ideal short-cut, discrediting the treatment as a panacea when complications were found, then the realization of its true value and limitations, and its integration with other forms of treatment.\textsuperscript{168}

Four main somatic treatments were developed in the first half of the twentieth century. Each was tried in New Zealand and each of these treatments helped to raise the level of official optimism. By 1945, when all four somatic interventions were available, 40 per cent of the resident patient population were deemed to be curable, as shown in Table 9.

Three of the four somatic interventions became available during Gray’s administration. As departmental head, his attitude was critical to the adoption of these and other treatments. Records show that before and during his directorate, Gray was very guarded in his response to any new form of treatment. He questioned the lasting benefits of malarial treatment,\textsuperscript{169} and saw little place for pharmacology. When absolutely necessary, he wrote, ‘a wisely prescribed sedative or the good old-fashioned mist. alba. will nine times out of ten win the day against the whole host of high priced pluriglandular concoctions’.\textsuperscript{170} In marked contrast to Buchanan, in 1930 Gray ridiculed occupational therapy as ‘eyewash’; ‘basket-making, raffia-work and other occupations’ were of far lower therapeutic and economic value than ‘real

\begin{itemize}
\item \textsuperscript{164} Valenstein, p. 52.
\item \textsuperscript{165} AJHR, 1925, pp. 3-4.
\item \textsuperscript{166} \textit{Dominion}, 19 October 1943. Cf. Auckland Star, 21 October 1943.
\item \textsuperscript{167} \textit{New Zealand Truth}, 14 March 1945.
\item \textsuperscript{168} R.W. Medlicott to Medical Superintendent, Porirua, May 1945, HMH 4/7/0.
\item \textsuperscript{169} Director-General to C.A.L. Treadwell, 9 May 1932, HMH 4/7/1.
\item \textsuperscript{170} Director-General, Circular, 29 June 1931, YCAA 1079/6n, File 5/45/-.  
\end{itemize}
purposive work carried out in the fresh air’ by men and women.\textsuperscript{171} He adopted a ‘proper attitude’ of caution\textsuperscript{172} towards key therapeutic developments of the 1930s and 1940s, and ensured that somatic interventions were properly trialled before they were generally adopted.\textsuperscript{173} Only in retirement did he acknowledge the full potential of the wave of somatic treatments as ‘the dawn of a new era in psychiatry’.\textsuperscript{174}

The first of the twentieth century somatic interventions was malarial treatment for General Paralysis of the Insane (G.P.I.), which was developed in 1917 by the Viennese psychiatrist Wagner-Jauregg.\textsuperscript{175} The technique was widely adopted in Europe and North America and was still used in the 1940s. Attempts to treat schizophrenia achieved little, in spite of some unsubstantiated claims of improvement.\textsuperscript{176} Malarial treatment for G.P.I. was first tried at Seacliff in October 1924 and then elsewhere. A 25 per cent improvement rate was reported.\textsuperscript{177} The number of mental hospital patients with G.P.I., however, was small with 3.9 per cent (143 patients) in 1921.\textsuperscript{178}

Sleep therapy, or prolonged narcosis, was based on the expectation that sleep would return the stressed and exhausted nervous systems of those with manic-depressive states (bi-polar disorder) and schizophrenia to a more normal state. The treatment is attributed to the German psychiatrist Klaeski in the early 1920s.\textsuperscript{179} Closely linked were two European treatments developed in the early 1930s: insulin-coma\textsuperscript{180} and

\textsuperscript{171} Director-General to C.A. Corban and to Medical Superintendent, Tokanui, 28 November 1930, HMH 2/7/10. Cf. Director-General to Mrs D. Nathan, 16 May 1934, YCAA 1079/6c, File 5/9/1.

\textsuperscript{172} Director-General to F.J. Watson, 26 August 1937, HMH 4/7/2.

\textsuperscript{173} Director-General Circular, 14 April 1939 and Director-General to Minister, 16 May 1939, HMH 4/7/3; Director-General to F.J. Watson, 22 June and 26 August 1937, HMH 4/7/2; AJHR, 1938, H-7, p. 3; Director-General to Medical Superintendent, Sunnyside to Director-General, 3 August 1943, Medical Superintendent, Sunnyside to Director-General, 5 August 1943 and 21 March 1944, L.S. Johns to Medical Superintendent, Sunnyside, 9 December 1943, Sunnyside Hospital administrative file, 140a, formerly held at the Hospital but current whereabouts unknown.

\textsuperscript{174} Gray, Psychiatry, p. 85. With today’s knowledge of the long-term effects of some of these treatments, Gray’s caution was well founded.

\textsuperscript{175} The procedure involved injecting malaria-infected blood into the patient. It was found to remit some of the effects of untreated syphilis on the nervous system.

\textsuperscript{176} Valenstein, p. 31.

\textsuperscript{177} Medical Superintendent, Seacliff to Inspector-General, 16 October 1924, HMH 4/7/1; Medical Superintendent’s report, Seacliff, AJHR, 1925, H-7, p. 13; Deputy Inspector-General to Director-General of Health, 6 October 1926, HMH 4/7/1; J.U. Williams and P.P. Lynch, ‘A Note on the Treatment of General Paralysis by Inoculation with Benign Tertiary Malaria’, \textit{New Zealand Medical Journal}, 24 (1925), p. 67; Director-General, Circular, 24 October 1929, HMH Institutional Circulars.

\textsuperscript{178} AJHR, 1922, H-31A, p. 10.

\textsuperscript{179} Valenstein, pp. 34-35.

\textsuperscript{180} Insulin coma therapy was developed for treating schizophrenia by the Viennese physician Sakel, as an extension of his treatment programme for drug addicts. Patients were given a course of daily injections of insulin to induce states, which ranged from mild hypoglycaemia to deep coma. The
metrazol-convulsion (or cardiazol) therapy. These treatments were publicized and used extensively in the English-speaking world after 1938. The intensive medical and nursing care required to avert risks from coma subsequently led to the procedure being abandoned.

Insulin coma therapy was introduced at Seaciff for selected psychotic conditions in June 1938, and was closely monitored throughout the coma, which might last up to one week. When followed up with intensive activation, nursing care, and the provision of decent clothing, promising initial results warranted cautious optimism.

Cardiazol was first used at Porirua in 1939, apparently with a success not always replicated elsewhere. R.W. Medlicott pioneered a variant of insulin coma treatment in the form of electro-narcosis, which he regarded as safer and less time-consuming than insulin in managing schizophrenia.

Another treatment, electro-convulsive therapy (E.C.T.), was pioneered by Cerletti in Italy. It was soon preferred over cardiazol because it was easier to administer. E.C.T. was first used to treat schizophrenia but, like cardiazol, was later found to be a most effective response to depression. E.C.T. had the advantage of convenience over earlier shock treatments.

E.C.T. was first tried in New Zealand at Sunnyside Mental Hospital in 1943. E.C.T. was said to work best with involuntary melancholia and manic-depression, treatment extended from 40-60 comas and was used for a range of conditions apart from the functional psychoses.

Cardiazol therapy, as it was known in this country, involved injecting a synthetic camphor preparation into the patient to induce convulsions in the treatment of schizophrenia or depression. The experience was by no means comfortable for patients and engendered considerable apprehension.

Valenstein, pp. 46-48; Busfield, p. 333.

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Valenstein, pp. 46-48; Busfield, p. 333.


Medical Superintendent's report, Seaciff, AJHR, 1939, H-7, p. 12; Evening Star, Dunedin, 22 November 1938.

Medical Superintendents' reports, Porirua and Seaview, AJHR, 1940, H-7, pp. 7-8. For a description of cardiazol treatment, see Kennedy, pp. 99-102.

Medical Superintendent, Porirua to Director-General, 26 June 1945, HMH 4/7/8.

Valenstein, pp. 50-51; Busfield, p. 334.

A Christchurch engineer and doctor made the first machine in 1943 as a contribution to the war effort. Once its effectiveness had been demonstrated, there was a public squabble to claim credit. Medical Superintendent, Sunnyside to Director-General, 9 June 1943, and W.S. Johns to Medical Superintendent, Sunnyside, 9 December 1943, Sunnyside Hospital Records, Christchurch,
Circuit diagram of the electronarcosis machine and a patient being restrained during the tonic spasm phase of treatment. Similar procedures were needed during the administration of electro-convulsive therapy until muscle relaxants were used. (R.W. Medlicott, 'Electronarcosis treatment of Schizophrenia', New Zealand Medical Journal, 46, 1947, pp. 283-4.)
This diagram, taken from the first published New Zealand report on pre-frontal leucotomy operations, shows the effect of this drastic psychosurgical procedure. A special instrument, called a leucotome, was inserted through the skull and cut nerve fibres in a wide arc, as shown in the shaded portions of the diagram. (R.W. Medlicott, 'Prefrontal Leucotomy', New Zealand Medical Journal, 42, 1943, p. 113.)
and was least satisfactory with schizophrenia. Relatives appreciated the attempt at active treatment even if no improvement was recorded. Following the trial, Gray recommended that 7 machines be purchased. The treatment was administered directly to the head with a team of nurses holding down the patient against spasm. Muscle relaxants were introduced in 1944, although this did not dispel patients' apprehension, as noted by Frame. Treatment could be administered repeatedly over a prolonged period. By 1948, E.C.T. for new admissions was commonplace, and the treatment was extended to long-standing cases, with gratifying results.

The fourth somatic treatment was the drastic psychosurgical procedure of prefrontal leucotomy (lobotomy). According to Valenstein, this procedure was based on the flimsiest of evidence by Moniz, a Portuguese neurologist, and brought to international attention in 1936. The spread of prefrontal leucotomy after 1942 owes much to the refinement of the technique by Freeman and Watts in the United States.

R.W. Medlicott was impressed by the procedure, having observed the first such operations in New Zealand, which were performed by a visiting American neurosurgeon in 1942. The psychiatrist D.G. McLachlan and the neurosurgeon M.A. Falconer, who teamed up to select and operate on patients later that decade, shared Medlicott's enthusiasm. The Dominion newspaper reported that neurosurgery was generally used as a last resort for hopeless schizophrenics who were destructive and

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Administration File 140a; Medical Superintendent, Sunnyside to Director-General and reply, 22 March 1944, HMH 4/7/6(2); Press, 7 June 1944; Director-General, letter to Press, 14 June 1944.

Medical Superintendent, Sunnyside to Director-General, 20 March 1944, HMH 4/7/6(2); Press, 15 May 1944. See also Medical Superintendent's report, Auckland, AJHR, 1946, H-7, p. 5; Medical Superintendent's report, Kingseat, AJHR 1947, H-7, p.6; R.W. Medlicott, 'Convulsive Therapy: Results and Complications in Four Hundred Cases', New Zealand Medical Journal, 47 (1948), pp. 338-48.

Actually, 8 were ordered. An offer to donate a machine to Kingseat was politely declined. P.H. Dale to Medical Superintendent, Kingseat, 24 August 1944 and Director-General to Medical Superintendent, Kingseat, 31 August 1944, HMH 4/7/6(2).

D.G. McLachlan to P.P.E. Savage, 23 February 1966 [copy from original in addressee's possession].

Frame, Faces, pp. 18-24; Frame, Angel, p. 98; King, p. 97.


Moniz believed that the frontal lobes of the brain were the seat of psychic activity and that thoughts and ideas were stored in the nerve-fibre connections between brain cells. Moniz also believed that serious mental disorders arose from pathologically fixed thoughts in the nerve pathways. Surgical destruction of the pathways would therefore reduce fear, anxiety and obsessionial behaviour. Valenstein, pp. 63, 84; Busfield, p. 334.

Valenstein, pp. 172-3, 178.

troublesome.\textsuperscript{197} As with other physical treatments, the initial success of prefrontal leucotomy was not destined to last.\textsuperscript{198}

Sir Truby King and Gray were highly critical of psychoanalysis and psychotherapy. Their attitudes ranged between scepticism and invective. Citing an old authority in 1925, King deemed that psychoanalysis, like ultra-violet therapy, was largely implied or provided for, not artificially, but naturally [in mental hospitals], in the personal interest and intimacy needed to bring the doctors and staff into close touch and sympathy with the patients as individuals, and the open-air country life, which provides the most natural, healthful, and enjoyable forms of occupation and recreation - besides being the best of sedatives for restoring rest and sleep.\textsuperscript{199}

King dismissed psychoanalysis as ‘the latest professional shibboleth’.\textsuperscript{200} While it might benefit ‘merely functional nervous and mental disturbances, due to “shock”’, it had no place in treating the ‘ordinary insane person’ who, of course, would be in a mental hospital.\textsuperscript{201} Gray attacked ‘armchair psychologists and wiseacre professors’\textsuperscript{202} and their ‘high falutin’ theories’.\textsuperscript{203} Gray’s reservations about psychoanalysis would only be overcome when practitioners were thoroughly competent and when level headed physicians specialized in the field.\textsuperscript{204} In his opinion, the Diploma in Psychological Medicine curriculum contained enough psychology to be useful without leading to extreme views.\textsuperscript{205}

Partly because of this professional and official antipathy, intensive psychoanalytical and psychotherapeutic techniques were rarely used in state mental hospitals. Psychotherapy was too time-consuming and demanded too much of the few psychiatrists for more than a few patients to benefit.\textsuperscript{206} Frame, too, suggests that

\begin{thebibliography}{9}
\bibitem{197} *Dominion*, 23 April 1946.
\bibitem{199} AJHR, 1925, H-7, p. 7.
\bibitem{200} AJHR, 1925, H-7, p. 3.
\bibitem{201} AJHR, 1925, H-7, p. 4.
\bibitem{202} Inspector-General to Rev. J. Calder (confidential), 15 August 1928, HMH 8/854.
\bibitem{203} Director-General to Professor D’Ath (confidential), 19 April 1945, H 30/5 (34271).
\bibitem{204} Director-General to Secretary, British Medical Association, 15 December 1937, HMH 26/75.
\bibitem{205} Director-General to Inspector-General of the Insane, Victoria, 1 October 1928, HMH 8/854.
\bibitem{206} These reasons were given as late as 1961. Department of Health, *Mental Breakdown*, Wellington, 1961, pp. 21-22.
\end{thebibliography}
somatic interventions were an ally for overworked doctors.207 Psychoanalytic and psychotherapeutic techniques were practised in New Zealand, but largely outside the public mental hospital system.208 The ‘talking cure’ was used to treat war neurosis cases at Hanmer Springs in the early 1920s, though the practitioners involved stopped short of endorsing Freud’s sexual theory.209 Early that decade, the Dunedin physician, Stuart Moore, treated some mild forms of mental disorder with psychoanalysis and this forestalled admission to a mental hospital.210 I.M. Allan, a Wellington neurologist, also supported the use of psychotherapy (but not psychoanalysis) in the treatment of neurasthenia.211 A psychiatrist colleague said that if things got difficult he promptly "unloaded" cases on to Porirua Hospital.212

QUALITY OF THE PHYSICAL ENVIRONMENT

Departmental heads were well aware of the impact of living conditions on the physical health of their patients. With an eye to hygiene and comfort, they expected buildings to be clean,213 well ventilated,214 properly drained,215 well lit,216 warm,217 and supplied with an ample water supply of good quality.218 The psychological

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212 D.G. McLachian to P.P.E. Savage, 23 February 1966 [copy from original held by addressee].
214 E.g., Inspector-General’s reports, Wellington, November 1876, Christchurch, December 1876, and Hokitika, 18-20 December 1876, AJHR, 1877, H-8, pp. 14, 16-17; Inspector-General’s report, Auckland, 28 April 1886, AJHR, 1887, H-9, p. 11; Inspector-General’s reports, Auckland, 9 February 1907, and Christchurch, 16 February 1907, AJHR, 1907, H-7, pp. 23, 32.
impact of the institutional environment was also important to inspectors-general. They knew that patients reacted to the quality of their physical environment.\footnote{E.g., Inspector-General’s report, Wellington, November 1876, AJHR 1877, H-8, p. 15.}

The point was made many times. Skae reckoned that the disgusting back wards and oppressive airing courts for refractory patients at Wellington were built according to the ‘wild-beast theory of insanity’.\footnote{Inspector-General’s report, Wellington, November 1876, AJHR, 1877, H-8, p. 14. Skae said that the place was badly lit, barred cells furnished with nothing but a fixed privy and straw bag, and with a sloping floor and drain to clear the urine. Food was pushed through the inspection hole in the bolted door. Patients took their exercise in a paved yard enclosed by iron 10 or 12 feet high. Inspector-General’s report, Wellington, November 1876, AJHR, 1877, H-8, pp. 14-15. These were the notorious back wards that were the subject of the public inquiry in 1881. } Constant confinement there would only confirm degraded patients in their offensive habits. Pacing up and down depressing yards must foster ‘pent-up excitement, and have a positively injurious effect on the patients, instead of any tendency to cure them’, Skae said.\footnote{Inspector-General’s report, Wellington, November 1876, AJHR, 1877, H-8, p. 16. Cf. Inspector-General’s reports, Sunnyside, 18 January 1883, and Dunedin, 26-7 January 1883, AJHR, 1883, H-3, pp. 7-8. } Skae also commented how many patients had lapsed into ‘hopeless dementia’ under confinement at Dunedin.\footnote{Inspector-General’s report, Sunnyside, December 1876, AJHR, 1877, H-8, p. 16. Cf. Inspector-General’s reports, Sunnyside, 18 January 1883, and Dunedin, 26-7 January 1883, AJHR, 1883, H-3, pp. 7-8. }

The environment, Hay argued, had a ‘sentimental’ effect on people. Even attendants tended to live ‘up to or down to their surroundings’.\footnote{Inspector-General’s report, Auckland, January-February 1877, AJHR 1877, H-8, p. 23, and August 1880, AJHR, 1881, H-13, p. 5. } At the other extreme, Gray never forgot how well patients responded to the de luxe hotel conditions at The Chateau and Wairakei when some Porirua patients were evacuated there in 1942. Admittedly these patients were of the best type\footnote{Director-General to Medical Superintendent, Porirua, 5 August 1942 cit. Williams, p. 186. } but the experience confirmed for Gray that patients behaved themselves like ‘normal’ people when given decent conditions and freedom.\footnote{Theodore G. Gray, \textit{The Very Error of the Moon}, Ilfracombe, 1958, p. 91. Cf. former nurse interviewed in Williams, p. 192. } This was well known. Skae saw how patients ate their meals in a ‘civilized manner’ when they were given knives and forks instead of being expected to eat with a spoon or their fingers.\footnote{Inspector-General’s reports, Auckland, January-February 1877, AJHR 1877, H-8, p. 23, and August 1880, AJHR, 1881, H-13, p. 5. }

Because material conditions made a difference, policy-makers aimed to give patients capable of appreciating it as homely an environment as possible.\footnote{Inspector-General’s reports, Auckland, 18 July 1907, AJHR, 1907, H-7, p. 19. } MacGregor believed that ‘cheerfulness is essential for counteracting the depressing influences of
asylum life'. This was particularly so for those seeking early treatment. Hay thought that homeliness certainly 'softened' the institutional feeling. Departmental heads, therefore, looked for signs in the colour of the décor, provision of plenty of comfortable furniture, and no Spartan benches or forms. 'Bare and comfortless' environments should be tastefully relieved by plenty of ornaments, pictures, floor coverings, and pot plants. The grounds of an institution should be attractive, and the patients should be able to see the outside world from park-like exercise yards.

Improvements that accorded with recognized standards slowly trickled from front to back wards, and from new to old buildings. Grabham was struck immediately by the contrast between front and back wards the first time he inspected Wellington Asylum in 1883. He found the front wards clean and cheerful and presenting 'all the comforts and appliances' needed. The back wards, however, were even worse than anything he had imagined. As befitted MacGregor's original intention to use Porirua as a national chronic asylum, the standard of comfort was not ostentatious. It lacked the

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226 AJHR, 1886, H-6, p. 8.
232 E.g., Inspector-General's report, Wellington, November 1876, Hokitika, 18-20 December 1876, Dunedin, December 1876-January 1877, AJHR, 1877, H-8, pp. 13, 17, 19, 22.
233 AJHR, 1877, H-8, pp. 2-3; Inspector-General's report, Auckland, January-February 1877, AJHR, 1877, H-8, p. 22.
Contrasting appearances between the south wing corridor of Seacliff Asylum in 1891 (left), and A Ward corridor, Hokitika Mental Hospital (1921) (right). The corridor was not modified when Hokitika Gaol was taken over as part of the mental hospital in 1910. (Author’s collection. The original of the Seacliff photograph was found in Medical Superintendent, Seacliff to Minister of Native Affairs, 29 August 1891, MH 1891/2511, Appendix V, formerly in the Health Department head office, but current whereabouts unknown. The Hokitika picture was copied from an original in the possession of the late Dr H.M. Buchanan.)
The more formal atmosphere of the corridor used as a female dining room at Sunnyside Asylum, c. 1880 (top), contrasts with the dining room of a villa at Cherry Farm Hospital, c. 1952. The lower photograph shows some of the improvements made under the furnishings revolution of 1947. (Author's collection. The top photograph is a Burton Brothers photograph, Number 1441, held at Canterbury Museum, Christchurch.)
Billiard room, Seacliff Asylum, 1891. Dr Truby King took this photograph to refute allegations made against his administration. (Author’s collection. Original in Medical Superintendent to Minister of Native Affairs, 29 August 1891, MH 1891/2511, Appendix I, formerly held in the Department of Health head office but current whereabouts unknown.)

Dayroom in a male villa, Cherry Farm, Hospital, c. 1953, showing the sorts of improvements made under the furnishings revolution instituted in 1947. (Author’s collection.)
Northern bathroom, M-7 ward, Auckland Mental Hospital. The photograph was taken in September 1963, just prior to modernization. The conditions set for mass bathing without privacy were typical of those described by Frame and Kennedy of an earlier period. (Author's collection.)

Wash basins in M-7 Ward, Auckland Mental Hospital, September 1963. (Author's collection.)
THE PATTERN OF DAILY LIFE – TOILETING

Toilet facilities in M-7 Ward, Auckland Mental Hospital, in September 1963. The conditions are reminiscent of those described by Frame. (Author's collection.)

Toilet and washroom facilities in M-8 ward, Auckland Mental Hospital main building, prior to modernization, c. 1960. (Author's collection.)
'luxurious fittings and decorative appliances' that he said were almost universal in British asylums.\textsuperscript{238}

Material improvements invariably took second place to the constant need for additional accommodation. Once sufficient bed-space had been found, Hay said, 'comfort can be added at a negligible cost'.\textsuperscript{239} He longed for the time when all the needs of patients able to appreciate their environment being supplied, one will be in a position to turn to the better housing of those who react negatively to their surroundings. This is, of course, the common-sense order, and one cannot recommend otherwise.

Consciously or unconsciously, priorities must have been influenced by official attitudes conveyed in platitudes about the lack of mental awareness of back ward patients:

"They're happy in their own way." "They're so far gone they don't really suffer." "They're used to it, they don't realize any more." "Nothing makes any different to them."\textsuperscript{240}

Photographs of the run-down buildings at Hokitika Mental Hospital in 1921 make the point tellingly. Neither in 'design nor detail' did the original buildings (including the old gaol) conform to professional expectation of a mental hospital, but Hay thought they served 'very well' for mentally infirm patients.\textsuperscript{241} These conditions were tolerated throughout the 1910s as priority was given to building reception houses at Porirua and Christchurch. The reception-hospital block was the first new villa to be built in the resurrected West Coast institution.\textsuperscript{242} When this hospital was rebuilt, as with other new hospitals built on villa lines, chronic patients benefited from an improved living environment.\textsuperscript{243} Nevertheless, very basic and primitive conditions lingered long after 1947 in a few wards within the mental hospital system. These were wards where the most difficult patients were kept, people whose mental state and behaviour were more feral than human, people 'so negative in their animalism as

\begin{footnotes}
\footnotetext[238]{Inspector-General's reports, Porirua, 19 May 1898, AJHR, 1899, H-7, p. 11, and 21 September 1902, AJHR, 1903, H-7, p. 6.}
\footnotetext[239]{AJHR, 1913, H-7, p. 7.}
\footnotetext[240]{Frame, Faces, p. 42.}
\footnotetext[241]{AJHR, 1912, H-7, p. 13.}
\footnotetext[242]{AJHR, 1922, H-7, p. 6. See also Warwick Brunton, Sitivation 125: A History of Seaview Hospital, Hokitika and West Coast Mental Health Services, 1872-1997, Hokitika, 1997, pp. 28-31, 34.}
\footnotetext[243]{Kennedy, pp. 235-7.}
\end{footnotes}
to be almost vegetable'.\textsuperscript{244} For instance, a Porirua attendant, describing the ramshackle collection of "Lower Buildings"\textsuperscript{245} that served as the male disturbed wards in the early 1950s, remembered how the dayroom of Ward 7 was still hosed out twice weekly to wash away the urine and faeces\textsuperscript{246} of people whose behaviour was impossible to manage until the pharmacological revolution of the 1950s.\textsuperscript{247}

Real reform of patients' living conditions was possible in new facilities, but 'very little' was done with the badly designed and ill-equipped nineteenth century asylum buildings until the fundamental need for accommodation had been met.\textsuperscript{248} Overcrowding obliged the Department to make do with these facilities, however bad.\textsuperscript{249} While the amenities were maintained and smartened up from time to time,\textsuperscript{250} they became more outmoded over the years. Solidly built older furniture was made to last and so it did. The Governor-General was sufficiently distressed after visiting the Auckland Mental Hospital in 1926 that he formally protested to the Prime Minister about the gloomy state of the buildings, their inadequate kitchens and laundry, and poor staff quarters. The problem was blamed on the previous medical superintendent's 'grave monastic dinginess'.\textsuperscript{251} In 1947, the Department reported that older buildings were 'all capable of brightening up and of increased comfort'.\textsuperscript{252} When change came in 1947 (Frame called it the "new" attitude\textsuperscript{253}), it was so dramatic that a former Seacliff employee called part of the general improvement the 'furnishings revolution'. Outmoded and uncomfortable couches were progressively replaced by vinyl covered upholstered armchairs, white counterpanes by coloured

\textsuperscript{244} Kennedy, pp. 157-8.
\textsuperscript{245} These were erected in 1910 to house patients transferred when Wellington Asylum was closed. Medical Superintendent's report, Porirua, AJHR, 1911, H-7, p. 17.
\textsuperscript{246} Williams, pp. 204-5.
\textsuperscript{247} Anonymous nurse quoted in Williams, p. 179. A male attendant gave a similar account, dating from the early 1950s, in Williams, p. 208.
\textsuperscript{248} Inspector-General to Minister, 21 November 1913, HMH 4/4/8.
\textsuperscript{249} Inspector-General to Minister, 2 August 1914, HMH 1913/372.
\textsuperscript{250} For example, Truby King publicized the improvements he made at Seacliff within a few years of his appointment. Instead of the 'sombre green and strong blue' that prevailed throughout, the interior of each ward was repainted in light, pleasant colours. He decorated the wards with pictures, flowers, ferns and singing birds, all of them thought to be 'elevating, refining and soothing influences.' The principal male day room was transformed. This 'bare, barn-like place' was furnished with 'wooden tables, forms, and a few sofas in black American cloth'. It was brightened with linoleum and hearthrugs, pictures, and tables for games, reading, and billiards. Medical Superintendent, Seacliff to Inspector-General, 29 August 1891, AJHR, 1891, H-29, p. 7.
\textsuperscript{251} Governor-General to Prime Minister, 19 April 1926, and Inspector-General's undated draft reply, HMH 7/1/1. I am grateful to the late Lord Ballantrae for trying to trace any entry in his father's diary about this visit. The Governor-General was also moved to call for greater public interest in mental hospitals. 'Hopeful', letter to Auckland Star, 6 May 1926.
\textsuperscript{252} AJHR, 1947, H-7, p. 3.
\textsuperscript{253} Frame, Faces, pp. 121, 162.
bedspreads, iron bedsteads by wooden beds, cream casement cloth curtains by floral curtains, and haircord runner carpet by floor rugs.\textsuperscript{254} An incredulous charge attendant at Sunnyside needed the Director's personal reassurance that he could requisition furnishings to the unbelievable figure of £50, ten times more than he was used to.\textsuperscript{255}

**PERSONAL AND INDIVIDUAL ATTENTION**

From their awareness of the psychological impact of inactivity and dull surroundings upon patients, administrators obviously had some insight into the psychological phenomenon we now know as "institutionalization". Institutionalization also covers two adaptive responses that Goffman's classic sociological analysis called "situational withdrawal" and "colonization". Goffman described how inmates in residential institutions might respond by retreating or regressing to a state of psychological isolation. Colonization referred to the way in which an inmate's world shrinks to the sample provided by the institution. The patient then cultivates a stable, relatively contented existence out of the maximum satisfactions procurable in the institution.\textsuperscript{256} For Jones and Fowles, institutionalization epitomized a loss of liberty and personal autonomy, social stigma, depersonalization, and low material standards experienced by people in long-term residential care.\textsuperscript{257} Frame gave a patient's perspective:

There was a personal, geographical, even linguistic exclusiveness in this community of the insane who yet had no legal or personal external identity – no clothes of their own to wear, no handbags, no purses, no possessions but a temporary bed to sleep in with a locker beside it, and a room to sit in and stare, called the *dayroom*. Many patients confined in other wards of Seaciff had no name, only a nickname, no past, no future, only an imprisoned Now ...\textsuperscript{258}

\textsuperscript{254} Personal communication, Mr J.O. Mackie, 20 March 2000.
\textsuperscript{255} Personal communication, the late Dr S.W.P. Mirams. As an assistant medical officer at Sunnyside at the time, Mirams' support was needed before the requisition order was placed. Mirams used this example to show how staff were conditioned by the tight limits of expenditure control.
\textsuperscript{258} Frame, *Angel*, pp. 72-73. Emphasis in original.
In an institutional atmosphere of professional relationships and emotional sterility, cuddle "therapy" for mentally defective children under the medical superintendence of J.U. Williams at Nelson (1934-64)\(^{259}\) was virtually unheard of.

Although mindful of the insidious effects of institutionalization upon patients' personality and individual self-esteem, these were less tangible than the prevailing general condition of an institution. Inspectors-general looked to see that patients were kept clean, suitably clothed, well fed, and tidy.\(^{260}\) They examined patients' clothing and bedding for adequacy and warmth.\(^{261}\) Inspectors-general sometimes tasted patients' meals to ensure that they were abundant, well cooked, and neatly presented. They expected food to be consumed in an orderly way.\(^{262}\) Generally speaking, these qualities of care left 'little or nothing to be desired', as MacGregor found.\(^{263}\) Whether or not a 'personal touch' of care\(^{264}\) was provided in readiness for an official inspection is hard to say, but there is some evidence that this occurred. It did not escape Gray's attention that last-minute provision of toilet paper, soap and bedspreads was made ahead of his visits.\(^{265}\)

To help ensure that chronic patients were not forgotten as individuals, various procedures were instituted in the 1910s. Departmental rulebooks reminded staff how they should show proper consideration for patients' individuality in the way they addressed, observed and related to patients, as shown in the staff rules in appendix 6. In small institutions, medical superintendents could know their patients


\(^{259}\) E.g., Inspector-General's report, Sunnyside, December 1876, AJHR, 1877, H-8, p. 16; Inspector-General's report, Napier, 17 April 1883, AJHR, 1883, H-3, p. 9; Inspector-General's reports, Wellington, 7 August 1886, and Nelson, 31 August 1886, AJHR, 1887, H-9, pp. 10, 12.


\(^{262}\) AJHR, 1887, H-9, p. 6.

\(^{263}\) Frame, *Faces*, p. 105. Frame describes as a 'panic' the ward's preparation for the visit.

individually. Such personal knowledge was esteemed but difficult to expect when institutions expanded and medical superintendents became absorbed with demanding administrative duties. As a check on possible clinical forgetfulness, after 1911 the law required every committed patient to be reviewed annually. Individual patient files replaced the large casebooks (1915) in the hope that a less cumbersome system would help doctors keep better clinical records of their care of chronic patients.

As a recoverable patient, Frame considered herself ‘treated as a person of some worth, a human being’. As one of the ‘forgotten people’ in a typical back ward, Frame likened the state to ‘forced submission to custodial capture.’ Mass treatment was virtually unavoidable for most patients, that is, chronic patients who were largely or fully supported by the state in a system constrained by therapeutic pessimism, inadequate budgets, overcrowded accommodation, constant staff shortages and many outdated facilities. Frame told how each day began when:

... all patients from the dormitories and rooms were crowded into the tiny wash room to be dressed; there was little hope of washing, and as one entered the room one was bulldozed, as it were, by the smell of stale bodies. We stood there naked, packed tightly like cattle at the saleyards, and awaiting the random distribution of our clothes, which usually arrived with one or two articles missing. I was shocked once to find myself without pants.

At Hokitika, chronic male patients were shaved twice a week. Little attention was paid to cosmetics or hairdressing for women before 1947. A privileged few and trusted patients might be allowed a daily shower or bath, but for most continent

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266 AJHR, 1910, H-7, p. 4, and 1911, H-7, p. 4; Mental Defectives Act 1911, s. 15(1). The late Dr S.W.P. Mirams, Director, 1964-79, told the author that he and his predecessors had little faith in this process. However well intentioned, the idea was little more than a bureaucratic formality. The lengthy lists submitted to the head office were simply filed without action.
267 Inspector-General, Circular, 23 August 1915, YCAA 1079/1q, File 21/30 (2).
268 Frame Angel, p. 112.
269 Frame, Angel, p. 109.
270 Frame, Faces, p. 83. Cf., unidentified attendant quoted in Williams, p. 205.
271 Personal communication, Messrs J.P. Atkinson and F.B. Thomas.
272 Frame, Faces, p. 163. Women hairdressers were appointed in 1938. An official visitor at Seaciff thought it of great benefit from a psychological point of view AJHR, 1938, H-7, p. 8; Official Visitor’s report, Seaciff, 7 July 1939, DAHI D 264/6.
patients, speedy, supervised and unscreened bathing was a weekly ward event.\textsuperscript{274} One nurse, remembering her work at Porirua c. 1940, described bathing day procedure:

... You went on a list for bathing day. This would be practically all day – we bathed about 400 people a day .... You had a dressing room outside and the patients would all be undressed out there, then the door would open and they'd all come through – all these naked bodies would be pushed through. We always, even in those days, had fresh water in the baths, you never put anyone into someone else's water. We bathed these people with bar soap – there was no such thing as toilet soap – washed their hair with soap ... But what else were we to do?\textsuperscript{275} 

Skae found that it was fairly common practice to bathe several patients in the same water.\textsuperscript{276} In 1889, King improved bathing facilities so that two men would not have to share the same bath at once nor for the same water to serve five to ten patients.\textsuperscript{277} Gray issued an instruction that fresh bath water was to be used for every patient.\textsuperscript{278} In 1945, immigrant nurses were so shocked at the mass bathing and toileting that they wrote to Gray about it. They described Porirua patients as barefooted and barely clad, all congregated in a corridor, and sent to a lavatory where there was no toilet paper. Gray remonstrated with the Medical Superintendent about such practices.\textsuperscript{279} 

Dressing operations followed a similar pattern of mass treatment according to Frame. Visiting days began when two nurses opened a sheeted bundle of:

... "best "clothes, anybody's clothes as long as they nearly fitted ... The waiting patients were already being stripped of their high-waisted, faded, floral smocks and being subjected to a swift curry-combing process with a damp flannel and a ward

\textsuperscript{274} Mental Hospitals Department, \textit{Rules and Regulations for Nurses}, Wellington, 1928, pp. 14-15; Mental Hospitals Department, \textit{Mental Hospitals; Rules for Staff}, Wellington, 1940, pp. 13-14; Frame, \textit{Faces}, p. 38.
\textsuperscript{275} Cited in Williams, p. 182.
\textsuperscript{276} Inspector-General's reports, Wellington, November 1876, Hokitika, December 1876, Dunedin, December 1876-January 1877, and Auckland, January-February 1877, AJHR, 1877, H-8, pp. 15, 18-9, 22. The bath was refilled for each female patient at Auckland but not for men.
\textsuperscript{277} Medical Superintendent, Seacliff to Inspector-General, 10 September 1889, AJHR, 1891, H-29, p. 15. In 1897, however, an official visitor at the asylum upheld a complaint by a patient that the same bathwater was used to bathe several patients. Official Visitor's report, Seacliff, 25 October 1897, DAHI D 264/47.
\textsuperscript{278} Inspector-General, Circular, 8 November 1927, HMH 4/4/1.
\textsuperscript{279} Director-General to Medical Superintendent, Porirua, 20 December 1946, Porirua Hospital Records, Porirua Hospital, File 44/36. For a description of mass toileting, see Frame, \textit{Faces}, p. 135.
comb. Shoes were put on, ward shoes, black lace-ups with a dusty shine on them, and there were high-spirited clumpings up and down and attempts at skating and kicking. A pillow-case of garters was emptied on the floor and distributed with earnest persuasions not to ping them but to wear them for keeping up stockings. Some patients had gray ward-socks; others, whose relatives had remembered that mentally sick people, at least on gala occasions like visiting day, may sometimes wear the kind of clothes worn in the outside world, had their own real nylons.

280 A royal commission found a similar everyday situation at Sunnyside in 1913. When 400 patients had to be outfitted with clean and warm clothes, it was impossible to ensure that everybody's clothes fitted properly.281 The minor repairs needed compounded the problem. In 1940, Gray's sharp eye noticed that too many patients had holes in their socks, missing buttons and ill-fitting clothes.282

With an eye and taste for detail, inspectors-general responded to the quantity, wholesomeness and presentation of patients' meals as well as the orderliness of meal times. Skae looked for white tablecloths, earthenware and proper cutlery.283 When provided, as was not always the case, behaviour improved greatly.284 These standards were applied systematically, but Auckland lagged well behind other institutions in this and other standards of daily living, a factor that undoubtedly sparked the formation of the Auckland Mental Hospital Reform Association.285 In 1918, the medical superintendent, R.M. Beattie, defended the general use of enamel...

281 Epitome of the report of the Royal Commission of Inquiry into Sunnyside Mental Hospital, 1 November 1913, HMH 1913/961, re complaint of W.A. Tribe.
282 Director-General, Circular, 27 June 1940, MH Institutional Circulars, 1940-42. Buttons seem to have been an ongoing concern. Skae said that shabbily dressed men at Dunedin were permitted to 'show a contempt for buttons which is quite behind the age.' Inspector-General's report, Dunedin, 14-20 January 1880, AJHR, 1880, H-6, p.8. Buttons also went missing because clothes were washed so frequently. Epitome of the report of the Royal Commission of Inquiry into Sunnyside Mental Hospital, 1 November 1913, HMH 1913/961, evidence of W.B. Gow, Medical Superintendent, p. 246. Some chronic patients also finely shredded their clothes or picked away constantly at their skin. Kennedy, p. 172.
283 Dunedin and Auckland patients used iron or horn spoons; too many at Auckland ate with their fingers. Inspector-General reports, Dunedin, December 1876-January 1877, and Auckland, January-February 1877, AJHR 1877, H-8, pp. 19, 23; Inspector-General's reports, Auckland, 15-6 April 1878, AJHR, 1878, H-10, p. 8, 11 April 1879, AJHR, 1879, H-4, p. 6.
285 J. Armstead, letter to Auckland Star, 22 May 1925.
mugs on the grounds of price, danger, and availability. Of course, not all patients could use a knife and fork: some had to be spoon-fed and others could not be trusted. Nor was it possible in some back wards to maintain any standard of decorum at mealtimes. According to Frame, meals could become 'a bedlam of grabbing and throwing and almost delirious excitement'.

Inspection reports sometimes mentioned the monotonous meals, but this seemed to have been secondary to wholesomeness and presentation. The repetitiveness of mental hospital meals occasionally prompted public or political criticism from the late 1920s. Frame's division of the week by the pattern of main meals also suggests undue predictability for those on ordinary rations. After 1930, breakfast invariably consisted of porridge, large slabs of bread thinly spread with butter and served with mugs of tea. An official visitor complained that bread was served in slices an inch thick at Auckland in 1918. The economical medical superintendent retorted that with 1,100 patients to feed, it would be far too difficult to halve the thickness of the slices. The extra cost of buttering twice as many slices of bread also had to be considered. The same superintendent was accused of boiling all the strength out of the tea leaves to save money. In one institution, butter was evidently melted down and applied with a black lead brush. The main midday meal was a hot meal served with vegetables - corned beef, roast, pie, stew or fish. Sago, rice or tapioca was served afterwards as pudding. The standard evening tea was similar to breakfast, with mugs of tea, bread and butter served with 'flycatcher' (treacle), jam or medical Superintendent, Auckland to Inspector-General, 28 August 1918, YCAA 1079/5n, File 5/45. Hay confided that Beattie's administration was very economical, 'too much so at times'. Inspector-General to Secretary, Public Service Commissioner, 19 February 1924, MH 3/1/7.

286 Medical Superintendent, Auckland to Inspector-General, 28 August 1918, YCAA 1079/5n, File 5/45. Hay confided that Beattie's administration was very economical, 'too much so at times'.

287 Inspector-General to Minister, 5 July 1921, YCAA 1079/5n, File 5/45.

288 Frame, Faces, p. 82; Kennedy, pp. 197-8.

289 E.g., Inspector-General's report, Auckland, August 1880, AJHR, 1881, H-13, p. 5; Inspector-General's reports, 21 November 1882, Wellington, AJHR, 1883, H-3, p. 11, and 10 June 1885, AJHR, 1885, H-10, p. 15; Inspector-General's reports, Auckland, 28 April 1886, and Nelson, 31 August 1886, AJHR, 1887, H-9, pp. 11-12. At Auckland, Skae reported that women had roast or baked meat three or four days each week in 1880, but male patients were invariably served boiled meat.

290 Sick or feeble patients received special diets that included cream and eggs.

291 Medical Superintendent, Auckland to Inspector-General, 28 August 1918, YCAA 1079/6n, File 5/45.

292 Official Visitor, Auckland to Inspector-General, 1 July 1923, YCAA 1079/6n, File 5/45.

293 Personal communication, Mr F.B. Thomas.
cheese. At the Minister's direction, fresh fruit was ordered for all patients in 1947 in an effort to increase the variety and appeal of the food.

Grabham's reports suggest that patients at some asylums were allowed to wear their own clothes, but how widespread this practice was is hard to gauge. Sources much later in the period suggest that the practice quietly disappeared. In 1913, it was simply not practicable for patients to wear their own clothes at Sunnyside. The clothes would inevitably get mixed up in the laundry with those from other wards. After repeated washing, the clothes could not be properly identified and might be returned to another ward. In 1927, Gray directed that patients in admission wards should be encouraged to wear their own clothes regularly and not just on special occasions. Personal hygiene determined the common sense of this policy. In back wards, very few patients wore their own clothes, though Kennedy says that a few patients started to do so in the new villas at Porirua. In 1945, several years after maintenance charges were abolished, families and hospitals still expected hospitals to outfit patients. Patients maintained at public expense only knew institutional clothing.

Because patients' clothing required frequent washing, particularly in back wards, it had to be hard wearing, like the virtually indestructible hats provided for the general run of male patients. Moleskin trousers, too, could be washed repeatedly as required for dirty patients or those involved in outside work. Kennedy surmised that refractory women patients were issued with boots so they could not tear them

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295 Director-General to Minister, 15 September 1930, HMH 8/975; Mr F.B. Thomas to Dietitian, Department of Health, 4 August 1971 and in personal communication to author; Kennedy, p. 34.
296 Personal communications, the late Dr G.M. Tothill, 11 August 1970, and the late Dr S.W.P. Mirams.
297 Inspector-General's reports, Sunnyside, 18 January 1883, and Dunedin / Seaciff, 26-7 January 1883, AJHR, 1883, H-3, pp. 7-8.
298 Medical Superintendent, Sunnyside in evidence to Royal Commission of Inquiry into Sunnyside Mental Hospital, p. 244, and Epitome of the Report of the Royal Commission, 1 November 1913, HMH 1913/961, re complaint of W.A. Tribe.
299 Inspector-General, Circular, 8 November 1927, HMH 4/4/1.
300 Kennedy, p. 91.
301 Kennedy, p. 162.
302 Kennedy, p. 237.
303 Acting Director-General, Circular, 8 August 1945, Mental Hospitals Department File MH 2/8/4, formerly held in Health Department head office records storage but current whereabouts unknown.
304 Inspector-General to Minister, 5 July 1921, YCAA 1079/6n, File 5/45. Cf. Epitome of the report of the Royal Commission of Inquiry into Sunnyside Mental Hospital, 1 November 1913, HMH 1913/961, re complaint of W.A. Tribe.
305 Epitome of report of the Royal Commission of Inquiry into Sunnyside Mental Hospital, 1 November 1913, HMH 1913/961, evidence of W.B. Gow, Medical Superintendent, p. 243.
There were clearly practical and economic reasons why wearability and uniform standards were sought in bulk-purchased institutional garb rather than variety and individual appeal of style, fit and appearance. Thus a press reporter found ‘little refinement' in patients' clothing at Auckland in 1911. Men were dressed in ‘somewhat rough attire', he claimed. Clothes had a ‘penitential aspect' as one complainant said in 1937, 60 years after Skae made similar complaints about the men's attire at Auckland and Wellington. By 1945, clothing standards fell far short of the desirable, especially for women. When invited to suggest improvements, medical superintendents enthusiastically called for greater colour, attractiveness and variety. Drabness, uniformity and outmoded fashion were clearly not new problems.

In 1945, long after they were generally fashionable, patients still wore calico combinations. Interlock underclothes and lingerie were virtually unknown, as were sanitary towels. Women wore "mother hubbards" made of hard-wearing material, jerseys, and colour-coded long socks. Army surplus provided bulk supplies of flannel shirts and dyed greatcoats for men, and used footwear.

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306 Kennedy, p. 125.
307 *New Zealand Herald*, 3 August 1911.
308 Secretary, Women's Service Guild to Minister, 21 April 1937, HMH 4/4/0.
310 Acting Director-General, Circular, 8 August 1945, Mental Hospitals Department File MH 2/8/4, formerly held in Health Department head office records storage but current whereabouts unknown.
311 Inspector-General, Circular, 8 November 1927, HMH 4/4/1; Deputy Medical Superintendent, Auckland to Director-General, 23 January 1936, YCAA 1079/91, File 7/4; Director-General to Medical Superintendent, Kingsseat, 17 May 1938, MH 2/8/4.
313 Medical Superintendent, Seacliff to Director-General, 28 August 1945, Medical Superintendent, Kingseat to Director-General, 18 September 1945, Medical Superintendent, Sunnyside to Director-General, 19 September 1945, Medical Superintendent, Hokitika to Director-General, 16 October 1945, and Medical Superintendent, Auckland to Director-General, 23 November 1945, MH 2/8/4.
314 Williams, p. 180. Sanitary towels were expensive and not common in New Zealand at that time.
315 Kennedy, pp. 162-3.
316 Medical Superintendent, Seacliff to Director-General, 28 August 1945, Medical Superintendent, Porirua to Director-General, 14 September 1945, Medical Superintendent, Sunnyside to Director-General, 19 September 1945, Medical Superintendent, Kingseat to Director-General, 18 September 1945, MH 2/8/4.
317 Medical Superintendent Seaciff to Director-General, 28 August 1945, Medical Superintendent, Sunnyside to Director-General, 19 September 1945, Medical Superintendent, Kingseat to Director-General, 18 September 1945, MH 2/8/4; Kennedy, p. 163; Frame, *Faces*, pp. 19, 212; personal communication Mr F.B. Thomas.
318 Inspector-General to Minister, 13 October 1917, HMH 8/367; Clerk, Auckland to Director of Equipment and Ordnance Store, 19 September 1919, YCAA 1079/10c, File 7/10/2; Medical
Suits, dresses and hob-nailed boots made in gaols helped boost prison industry and cut costs. The need for greater variety of types and styles of footwear was recognized.

Medical superintendents also criticized uniform features of men’s apparel in 1945. What Auckland’s medical superintendent called ‘objectionable looking’ moleskins were still issued to male patients in 1936, nine years after they were supposed to have been phased out. The drabness of these uniforms was relieved here and there by yellow or turkey-red neckerchiefs worn to signify epileptic or escapee patients. Some medical superintendents called for the provision of hats instead of caps, for dress shirts, braces, ties or sports coats. It is little wonder that another part of the sweeping Howard-Russell reforms of 1947 was termed the ‘clothing revolution’. The impact of the extent of change left Nurse Kennedy simply incredulous.

CONCLUSION

Mental hospitals looked after a small number of acute (or recoverable) and a much greater number of chronic patients. As institutions diversified their services from the core of Victorian asylum buildings, patients who were given some hope of recovery

Superintendent, Nelson to Director-General, 17 September 1945, and Medical Superintendent, Kingsseat to Director-General, 18 September 1945, MH 2/8/4.
319 Medical Superintendent, Seaciff to Director-General, 28 August 1945, MH 2/8/4.
320 Minister of Justice to Minister, 14 May 1917 and Controller-General of Prisons to Minister, 24 October 1917, HMH 8/367; Inspector-General to Secretary, Public Service Commissioner, 26 April 1921, HMH 3/6/8.
321 Acting Medical Superintendent, The Chateau to Director-General, 20 August 1945, Medical Superintendent, Nelson to Director-General, 17 September 1945, Medical Superintendent, Kingsseat to Director-General, 18 September 1945, Medical Superintendent, Sunnyside to Director-General, 19 September 1945, Medical Superintendent, Auckland to Director-General, 23 November 1945, MH 2/8/4. Cf. Kennedy, p. 236.
322 Medical Superintendent, Seaciff to Director-General, 28 August 1945, Acting Medical Superintendent, The Chateau to Director-General, 20 August 1945, Medical Superintendent, Kingsseat to Director-General, 18 September 1945, MH 2/8/4.
323 Medical Superintendent, Auckland to Director-General, 23 September 1936, YCAA 1079/91, File 7/4.
324 Inspector-General, Circular, 8 November 1927, HMH 4/4/1.
325 Personal communication, Mr F.B. Thomas.
326 Medical Superintendent, Seaciff to Director-General, 28 August 1945, Medical Superintendent, Kingsseat to Director-General, 18 September 1945, Medical Superintendent, Auckland to Director-General, 23 November 1945, MH 2/8/4.
327 Personal communication, Mr J.O. Mackie, 20 February 2000.
328 Kennedy, p. 236.
or full rehabilitation could expect priority attention, intensive treatment, more individual consideration, and a superior standard of living in “front” wards. Limitations of medical and scientific knowledge necessitated different goals for patients suffering from mental states that required lengthy or even life-long care in “back” wards. Ideally, chronic patients could be assured of the basic necessities of survival, protection from physical harm, functional participation in a sheltered community, attempts to prevent psychological or personality deterioration through activation and routines, and second-class priority for material improvements in their living conditions.

The official or avowed ideals of care and treatment stand in sharp contrast to the detailed realities criticized in inspection reports, revealed by photographs, and recounted by Frame and Kennedy in the 1940s. Between the two lie many paradoxes. The physical environment ranged from the homely to the decidedly institutional. Individual autonomy and self-esteem existed along with mass treatment. “I” got lost in “themness”. Activation and mental stimulation coexisted with a predictable and monotonous daily routine. Some aspects of treatment could be confused with custodial care.

These paradoxes can be explained. Some first-order ideals applied to all patients. The professional and social values espoused by top officials emphasized qualities of care like cleanliness, order, neatness, decency, comfort, liberty, legality, and occupation, to name a few. Without doubt the overall standard of care improved for all patients over time in response to these considerations. Second-order ideals were less obvious. These were values like individuality, fashion, variety, privacy, dignity, and sensitivity. Many constraints, however, precluded the translation of second order values into first order ideals for everyone. Somatically oriented officials had no panacea, although the makings of a therapeutic revolution were evident in the last decade of my study period. There is some evidence that chronic patients may be thought to have been incapable of appreciating their surroundings. Constant shortages of specialized staff and overcrowded facilities made conditions ripe for treatment in the mass. Accommodation shortfalls were the first claim on capital expenditure. Frustrating and ongoing problems with the building programme delayed the system-wide provision of adequate facilities and a modern environment. The durable and very solid Victorian asylums, which still contained more than half of the
country's patients in 1947, were hard to adapt to changing views on care and treatment. Large numbers of patients were maintained wholly or significantly at state expense. Efficient and economical management under centralized administration made conditions ripe for uniformity. Public interest in mental hospital reform was fickle. All of these factors contributed to prioritized care and a trickle-down improvement from "front" wards to "back" wards, and from new hospitals to old institutions.

From Skae to Gray, ideological continuity was provided by a somatic view of psychiatry. A casual observer would have recognized many familiar elements to programmes at any time throughout the period 1876-1947 because of the importance in care and treatment that was given to physiological principles, classification, high standards of nursing care, and institutionally ordered routines. Mental care was predicated on notions of appropriate safety, parole, work, and recreation. The cornerstone was work. The observer in the 1940s would have noticed that programmes of craftwork were starting to complement the established forms of 'occupational' therapy. Many aspects of care and treatment were gradually regulated by statute, professional standards, and administrative memoranda in line with experience from tragedies, and from changing professional and social expectations.

Until the 1920s there was little clinical innovation that might benefit the great majority of patients who passed through the country's mental hospital system. Only when various somatic treatments, described by Valenstein in the title of his book as 'great and desperate remedies' were adopted, followed by psychotropic drugs in the 1950s, did therapeutic optimism return. After some top-level wariness, the Department tried and adopted those somatic treatments and extended their use from acute to chronic patients. By 1947, there were signs that a new era was beginning in the country's mental health services as the combined impact of therapeutic, furnishing and clothing revolutions made their mark. I leave the last word to Kennedy:

There was no longer one-way traffic ... The doors that had once clocked shut with horrible finality behind the new admission now swung both ways, letting in the sunshine and fresh air of normality as they did so.\textsuperscript{329}

\textsuperscript{329} Kennedy, p. 261.
CONCLUSIONS

In recent decades, mental health services have been the subject of considerable historical interest and controversy internationally. For some years, too, historians and writers have told aspects of the story of New Zealand's mental health services, using a variety of methodologies, the rich clinical archives of some of the country's older mental hospitals, and the more limited administrative records that have survived. The fruits of this research and scholarship are to be found in the growing number of academic studies and institutional histories. At times, however, local and even national studies have overlooked or understated the importance of the national policy and organizational framework within which developments occurred, particularly after 1876. By studying New Zealand's national mental health policy and the overall system that resulted from that policy, a common context and continuous thread can connect other studies and perspectives. I consider that a top-down view of national policy and public policy-making processes can inform other research of a local, social, or professional nature. I have endeavoured to provide that context and that thread in this work, bringing to the task my experience and previous career in health policy-making at national level.

In health policy literature, the word "policy" commonly refers to the intentions and outcomes of sets of decisions. Throughout the period I studied, mental health was a domain of public policy because it fitted the main functions of government in society. National governments alone had the power to make and enforce laws that bound everyone in New Zealand, to provide socially beneficial goods and services that were unlikely to be provided by individual effort, philanthropy or by the market place, and to promote access to those services.
Government mental health policy aimed to protect the community from harm by mentally disordered individuals, and to care and treat those mentally disordered individuals, if necessary by detaining them until they were well enough to resume a place in society. The human rights of mentally disordered individuals and the public were to be respected. The mental health system was to be publicly accountable for providing humane care and treating mentally disordered people using contemporary medical knowledge, progressive practices, and competent staff. The estates of mentally disordered people were to be protected.

Public policy aims were achieved primarily through regulation, funding, ownership, and occasionally through investigation. Regulation defined the scope and boundaries of the mental health system, established the rights, responsibilities and relationships of participants, and mandated the organization. The broad social intent of policy was enshrined in special mental health legislation, which was amended from time to time in the light of changing needs and experience. Secondary legislation, government and ministerial decisions and memoranda, staff rulebooks, departmental circular memoranda, and local rules for staff and patients supplemented statute law. Governments raised general revenue to achieve their intentions and allocated funds annually for designated departmental expenditure. Some funds were channelled through other government departments or agencies such as public works, public hospitals, police, education and defence. Governments expected their agencies to achieve policies efficiently and economically, that is, to produce the desired results with minimum effort or energy according to administrative rules and within budgetary limits.

At the outset of this work, I asked whether New Zealand's mental hospital system happened by deliberate choice or whether it was it the product of layers of decisions taken over many years. This scattered, sizeable and complex system was 107 years in the making. It could hardly have been planned that way in any sense of the purely rationalist view of policy-making. Formal policy advice to the minister or government was presented as a single course of action to address a particular policy problem rather than as a carefully appraised range of options. Nor were the
technical and pragmatic solutions mooted detached from the real world. The political environment, economic situation, state of medical and scientific knowledge, social values, public attitudes, and the conflicting social purposes of mental hospitals all constrained or bounded policy options. Policy-makers who were committed to patient welfare were hardly likely to have designed a system with serious shortcomings evoked by the title of Sainsbury’s 1946 pamphlet *Misery Mansion,*¹ and by the conditions of daily life in “back” wards later exposed by Frame’s *Faces in the Water* (1961) and Kennedy’s *The Wrong Side of the Door* (1963). True, departmental policy-makers put up with these conditions and were to some extent inured to them, but that is different from deliberately planning a system with intractable problems.

I consider that the mental health system of 1947 was the accumulated compound of choices and decisions, problems and solutions. Necessities, planned intentions and unexpected results also entered the equation. Many decisions were personal, like the 64,000 decisions by or about individuals who wanted or needed psychiatric help between 1876-1947. Clinical decisions were important too because of their policy implications. Politicians and public administrators made decisions on systemic policy, priorities, resources and rules. The personality, power and views of individual ministers, departmental heads and medical or lay superintendents influenced policy decisions.

Three foundational policies set in the early years of the colony - institutional care, state management, and functional separatism - still formed the core of New Zealand’s mental health policy in 1947. When problems arose, the core policies were adjusted incrementally in the light of overseas trends, new medical knowledge, changes in the population, social attitudes, political ideology, economic circumstances and government administration.

The lunatic asylum was fundamental to the provision of specialized psychiatric care and treatment in New Zealand. Decisions to establish lunatic asylums can be called the first foundational policy. Progressive and humanitarian colonial opinion upheld

the asylum as the enlightened and proper venue of treatment under the system of moral management, as was the case in early Victorian England. It was also efficient to collect people where there were specialized facilities and skilled staff. Based on fashionable ideas in the United Kingdom, governments could have chosen the English residential model of care or the Scottish varied model of boarding out (or grant-aided family care) and institutional care at almost any time during the Crown colony and provincial eras. Boarding out was certainly used in very a limited way, but as early as 1846, the concept of the lunatic asylum was embedded in legislation. The concept was confirmed by proposals for a central lunatic asylum but it was actually realized when provincial governments decided to build their own asylums (1853-76). Post-provincial census data confirm that New Zealand embraced the institutional model so strongly that the label lunatic really only applied to someone in an asylum.

The second foundational policy involved government decisions to run asylums directly. Governments did so within the state's police and welfare functions and to the extent that it could or would not shift responsibility elsewhere. State intervention was more centrist than in England or Scotland as is shown by the functions of the post-provincial Department. These were adapted from the prevailing English and Scottish inspectorates but, unlike those models, retained in the same national organization combined responsibilities for policy development and the oversight and management of institutions. At no time before 1947 did governments decide to run public mental hospitals indirectly through an accountable local board, like public hospitals or schools.

Mental health policy fell within the steady spread of central government into most aspects of social and economic life in New Zealand society. Bassett calls this a social tide of 'idealistic collectivism' that amounted to a passion for state activity, based on a popular feeling that government intervention seemed likely to produce worthwhile results. Direct state intervention was almost inevitable. The colony

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lacked a wealthy philanthropic class capable of or interested in endowing asylums in the manner of voluntary or subscription hospitals. Parliamentary debate on the role of the marketplace in mental health stirred up memories and myths of the English madhouse tradition. When, despite the opposition, legal provision was made for licensed institutions in 1868, it took 14 years for the one and only such institution to be set up, and even it struggled to remain viable at times. As late as 1945, governments were reluctant to test the market, although some small nursing homes, private hospitals and very few private psychiatrists met a limited demand. With voluntary and private funds insufficient to meet national needs, the state was the only institution in society capable of stepping in.

The third foundational policy stemmed from the recognition of mental disorder as an entity separate from disease and other social problems. This policy was embodied in separate mental health legislation, separate administration, separate facilities, and distinct admission and discharge procedures. Committal, with its associated checks and balances, was the kernel of comprehensive legislation.

The policies of institutional care, direct central government intervention, and mental health separatism were interrelated. Moreover, the accrued effects of those policies, intended and unintended, and the way subsequent policies were built upon the original foundations, show how the original policies cramped future possibilities for radical change.

After colonial and provincial policy-makers adopted the asylum-only model, prospects for introducing the Scottish varied system were slowly sidelined. However valid the rationales of social intolerance or lack of economic opportunity may have been in late nineteenth century New Zealand, the loss of this general policy option deprived institutions of relief from overcrowding. Colonial aversion to British poor law institutions like workhouses or infirmaries removed another form of relief for asylums. Without such alternatives, the available accommodation quickly filled up to overflowing. Overcrowding remained a constant problem, as it was in other countries similar to New Zealand.
Changing interpretations of the requirements for committal, which was the sole means of entry to a mental hospital before 1911 and the predominant means thereafter, can explain the pressure on institutional accommodation. In the colony's early years, statutory criteria were initially applied in a way that corresponded to crisis care for the most obvious lunatics, those who presented the greatest social or personal risk. Personal decision-makers involved in committal proceedings liberally interpreted procedures for lawful state intervention in the life or affairs of a mentally disordered person. In 1881, Inspector-General F.W.A. Skae (1876-81) said that committal provided 'a strong inducement to allow the elastic term "insanity" to be applied with the utmost latitude'. A liberal interpretation helped New Zealand cope with two major demographic changes in Pakeha society in the late nineteenth century. Firstly, the distorted age and sex structure of frontier society exposed the need to care for single men and people with no known relatives in New Zealand. Some became physically or mentally infirm through age. Others were mentally weak or impaired, eccentric or loners. Others suffered the mental consequences of alcohol abuse or syphilis. Asylum officials blamed hospital and charitable aid authorities for committing harmless elderly persons who did not need asylum care. Mental infirmity remained a policy problem for mental hospitals.

A second demographic change brought other mental health problems to light. As New Zealand's population structure started to stabilize through natural increase, families under strain sought help from asylums for disabled offspring or relatives who suffered from mental deficiency and / or epilepsy. These people came to official attention during or after compulsory primary schooling, or when the personal resources of those who cared for them at home were depleted. Some carers simply sought respite; others thought that institutional care was superior to home care, and some, no doubt, wished to avoid further personal expense. Decisions were also influenced by a powerful but vague colonial ideology of egalitarianism.

Expanded social definitions and contemporary medical thinking about the classification of mental disorders were duly incorporated into policy on who was a

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3 Appendixes to the Journals of the House of Representatives (AJHR), 1881, H-13, p. 2.
mentally disordered person. Mental infirmity was clearly established through the backlash that aborted MacGregor's attempts to test the legal and political waters in 1888-90. The new statutory definition of mental defective, adopted in 1911, divided mental deficiency into three classes of idiocy, imbecility and feeblemindedness. Epilepsy and mental infirmity were also included. Habitual inebriates were removed from the scope of mental health law. In 1928, social defect was added.

Having widened the legal doorway into asylums, as it were, further institution-based policies had to be devised. Lacking alternative solutions for managing the influx, institutions simply expanded, like inflated 'India-rubber balloons'. Declaratory policies about the upper limit acceptable for individual attention, sound classification, and a homely community grew accordingly until they reached a maximum of 1,000 beds. A policy on statutory airspace standards was soon shown to be both unenforceable and unworkable.

A Sisyphean struggle against overcrowding led to many policies for short-term relief. Mass transfers of patients and improvised accommodation in recycled buildings can be seen in this light. Meanwhile, a policy of planned capital development attempted to overtake the arrears of accommodation. Unfortunately, decisions to build major asylums of the Victorian era in permanent materials exacerbated the problems. When architectural grandeur was found to be no substitute for quick construction or alteration, the Department embarked upon various attempts to build special facilities for particular groups of patients. Ambitious plans for a national chronic asylum at Porirua or Tokanui were fantastic and overtaken by further accommodation needs even as they were being built. Apart from special colonies promoted to provide segregated residential care and rudimentary training for mentally deficient children, most schemes either faded after an experimental phase (like the inebriates home and epileptics colony at Waitati) or else they came to nought. Rest homes for senile patients never materialized. A national maximum-security unit was not built before 1947. Classification at the institutional level may have been largely unsuccessful, but local experiments with cottage care of some patients paved the way for the
adoption of the villa system as national policy early in the twentieth century. The villa system was eminently successful as a means of restoring the benefits of small-scale units for patients of similar needs. New mental hospitals and additional accommodation in older hospitals were built on villa lines.

Other policies that overlaid the core policy emerged as a reaction to the so-called stigma, or negative public image of mental disorders and places for their treatment. The daily press, feeding off overseas trends, which were imported via the telegraph, Home journals and popular novels, was as much responsible for cultivating popular stereotypes of insane persons as violent, and for conveying a sense of what might be called "nimbyism" that both alienated and insulated the system from mainstream society. The roots of that insulation can be found in the policy of rural development. Policy-makers decided to build Seacliff and Porirua and subsequently other institutions in remote rural areas, some several miles and others up to 30 miles away from the centres of population they were supposed to serve. This policy had mixed results. Isolated institutions were a major, if not the major source of employment in small towns and provided an important venue for social activities. Photographs suggest that staff sports and social clubs thrived. The rustic seclusion of the more isolated mental hospitals encouraged greater self-sufficiency for foodstuffs and laundry services, but the distance from the centres of population undoubtedly added to the cost of personnel, supplies, and transport. Distance made it difficult for relatives to visit patients in far-away institutions. Isolation added to staffing problems in an unattractive service because a staff accommodation policy would prove unnecessary to attract and retain staff on or near the campus.

Other policies sought to mitigate the negative public perception of institutions. They can all be linked to MacGregor's aim of transforming 'asylums for the safe-keeping of lunatics ... into hospitals, whose main object must be by early treatment to prevent

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5 A term coined from the common New Zealand expression "not in my back yard". The word was used by M.J. Cullen (Labour, St Kilda) in *New Zealand Parliamentary Debates (NZPD)*, 12 March 1992, 522, p. 6872.
mental diseases from becoming chronic and inveterate’, as he put it in 1887. National policies intended to meet that aim included the relaxation of traditional committal procedures (e.g., voluntary boarders, emergency admissions, and procedures for minors), and the development of reception houses and neuropathic hospitals (including Hornby Lodge) for newly admitted and convalescent patients. These new facilities set out to mirror the active therapeutic perception of the general hospital with their superior and clinical environments, concentrated levels of care, and higher staff ratios. From the 1890s, staffing policy, too, emulated general hospital ideals by seeking to transform into professions those occupations involved in direct patient care. The Department initiated fledgling efforts to form a New Zealand branch of the Medico-Psychological Association, but had greater success with its staff of attendants. By elevating the status of female attendants to that of hospital nurses, MacGregor hoped to create a sentiment about ‘the honourable though arduous duties of asylum nurses’ as would ‘raise the ideal of their duty, and remove the prejudice which at present exists against this as affording a career for educated young women.’ MacGregor was less enthusiastic about “warders”, as he called them, though the system could not dispense with them in favour of female nurses under male medical control. Professional training and registration schemes were set up for all attendants. Some female mental nurses were later employed in paramedical professions like occupational therapy or social work.

The formal switches of name from lunatic asylum to “mental hospital”, until the word “mental” was dropped in 1946, were also symbols of the policy of ‘hospitalization of the institutions’. From the time of the First World War, policies were made for handling war and other neuroses. New Zealand society was reluctant to accept the full treatment implications of these conditions once they were clinically recognized as forms of mental disorder. Thus they occupied a blurred therapeutic and jurisdictional borderland at the edge of the formal mental health system. This was shown by the decision to transfer Queen Mary Hospital to Health Department control, not that of

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6 AJHR, 1887, H-9, pp. 1-2.
7 AJHR, 1890, H-12, pp. 2-3.
8 AJHR, 1923, H-7, p. 5.
the Mental Hospitals Department, in 1922. Three years later, a policy of institutional outreach saw outpatient clinics established to manage minor mental disorders, psychoneuroses, and incipient insanity where and when local hospital boards were prepared to allow that. Public hospitals, rather than gaols and lockups, were officially encouraged to provide transit care. By the late 1930s, the most progressive hospital boards had their own policies to treat patients in local psychiatric wards. General hospital psychiatry was delayed as a policy option because psychiatric expertise was firmly locked into the mental hospital system.

State intervention, the second foundational policy, also posed policy difficulties. The tide of idealistic collectivism, to use Bassett's reference to central government intervention once more, extended well beyond public institutions and outpatient clinics. The central government's role in mental health became multifaceted. Institutions were public buildings paid for by the taxpayer and programmed among other public works. Departmental employees were civil servants who, after 1913, were employed under the centralized personnel policies of the Public Service. Since 1872, the government's Public Trust Office (and later the Maori Trustee) managed nearly every patient's estate, because every committed patient lost the right to control his or her affairs. Until maintenance charges were abolished in 1939, the state fully met or subsidized the upkeep of nearly 60 per cent of all patients whose estates or relatives could not pay. Maintenance of criminal lunatics and armed service patients was a full charge on the state. The government arranged bulk national contracts to feed and clothe its charges and to provide them with medicine. Government subsidies to hospital boards came with stipulations.

The mental health system was almost totally reliant on the government for gross funds. Government always meant the central government except during the provincial interlude. Direct government funding deprived the system of alternative income sources like local rates or philanthropy, such as public hospitals enjoyed for many years. Mental hospitals rarely benefited from significant bequests, possibly because they were identified as a government service; small-scale donations for

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9 AJHR, 1975, H-23, p. 197.
recreation, yes, but not large-scale bequests. Local community fund-raising was largely confined to providing comforts. Because mental health policies were so dependent upon public revenue from taxation, the system was set among the vagaries and vicissitudes of provincial and national politics. Balancing the interests of patients, staff, and taxpayers was never easy in such an environment, so the ideal inevitably got caught between fiscal and social objectives of public policy. Policy solutions had to be affordable, not necessarily ideal from a professional viewpoint. This helps to explain why some values, like dignity, individuality, privacy, variety, fashion, or homeliness were subordinated in the mass treatment of some groups of patients. First-order social and professional values, like order, neatness, cleanliness, or any form of work (however tedious), were generally honoured.

Politicians generally responded to the vacillating public views about mental health policies. They shared the humanitarian sentiment for public asylums until public and press attitudes became more ambivalent soon after asylums were set up. After that, MacGregor felt trapped between general public indifference interspersed with 'very exacting' but 'spasmodic demands for the proper treatment of the insane', excited by some crisis or other. Mental health held nothing like the same electoral appeal as state investment in opening up the country for settlement, transport, public utilities, education or hospitals. There was no solid, united or continuous constituency for mental health outside the bureaucracy. Committed patients were disenfranchised. The patchy progress of capital development to deal with the persistent overcrowding showed well enough the lowly place of mental health at the pork barrel. Mental health expenditure was too small a part of government expenditure to warrant high priority. Mental hospitals were incidental to the social security debate of 1936-8.

Mental health was a minor policy domain within the overall scope of state activity. Low to middle ranked ministers usually held the portfolio once it was detached from the ubiquitous responsibilities of the Colonial Secretary. Some ministers certainly made a good personal contribution to policy but many were cautious. Most ministers relied on their expert departmental advisers who knew the technical complexities and the day-to-day requirements of the system they ran. Politicians rested content with

10 AJHR, 1898, H-7, p. 3.
the general course of the nation's policy, as shown by the rarity of general policy reviews through public inquiries, the long intervals between revisions of mental health legislation, and the intermittent bursts of overdue reform. Thus, the policy foundations remained intact.

Officials gained considerable influence in the formulation stage of policy-making because of the general political environment outlined above. Provincial and central governments needed dedicated officials to develop ideas and to respond to problems. Ministers generally trusted the technical and professional know-how of these officials and delegated to them much of the responsibility for day-to-day policy-making. This pattern was consistent with transitions of government power from the legislature to the executive branch and from ministers to officials. Ministers, individually or collectively, made major decisions and retained responsibility for the carriage of significant policy proposals before Cabinet, the legislature and sometimes the media. Ministers relied on their expert officials, however, to formulate proposals within general government policy. The conventions of Westminster style government kept much of the debate within the confines of free and frank advice to ministers who were protected from political embarrassment as much as possible by their departmental advisers.

Once the Lunatic Asylums Department was set up as a national bureaucracy, the influence of officials increased. That department (and its successors) was durable and its leaders survived the frequent turnover of ministers. Technical expertise, and a national overview of mental health were all concentrated there. Command over resources and statutory authority for implementing policy, gave the organization further levers. Head office based professional and administrative officers gave the bureaucracy its own institutional memory, precedents, traditions and ethos. Direct access between the head office and institutions provided first-hand knowledge of the problems and a two-way conduit for information and consultation with street level bureaucrats, as Lipsky once called them.¹¹ The departmental records system ensured a long-term view.

Policy-making and resource allocation were largely centralized in the Department's head office or shared with the control departments of government. Strong-minded and/or long-serving departmental heads could make a major impact. The early inspectors-general, particularly the stern MacGregor, devised management policies to consolidate the disparate assortment of provincial lunatic asylums into one national system. Policies of medical pre-eminence and occupational hierarchy (including staff and patients), with their associated power relationships were implemented. Job ladders arranged the staff needed for the growing complexity of institutional functions and acknowledged trends in both hospitals and the wider labour market. Twelve skill-sets needed in 1876 had grown to 38 by 1947. MacGregor instituted a policy of tough discipline. Hierarchical arrangements were also secured through staff rules, institutional custom, traditions and professional loyalty. Career progression in the Department allowed for thorough acculturation into an institutional ethos, respect for hierarchical authority, rules and precedent.

The third foundational policy of separatism found diverse expression. Separatism was born from the idea that mental disorder was a distinct entity or social problem. Conceptual separatism lingered throughout in the legal nomenclature of "lunacy" and later of "mental defect". Admission procedures were distinct: "committal" meant compulsory detention and care in an asylum or mental hospital, nowhere else. "Voluntary boarders" were unique to the mental hospital system.

"Lunatic asylums" or "mental hospitals" were also administered separately. The distinct management arrangements of the original asylums left them largely independent of hospital and other services at local level. A national asylums and hospitals inspectorate was combined between 1881-1906, but this did not affect the governance of separate systems when general hospitals were placed under the control of local boards. Mental hospitals had "district inspectors" and "official visitors" as their public watchdogs. When the dual inspectorate ended, the Department: lay outside the reorganization of government health departments in 1909 and 1920. In 1947, the merger of the Mental Hospitals and Health Departments had to be facilitated, if not imposed, to make it happen.
The large workforce of male and female "attendants" and their respective gender-based hierarchies were also separate features of mental hospitals. Male attendants were the largest single group of departmental employees and an unusual feature in the profession of nursing. Neither the dual management system nor the presence of a large workforce of male attendants was dislodged in spite of a number of policy initiatives to favour the advancement and influence of female nurses throughout the system. Departmental administrators contended that women brought special qualities to patient care and to the ward environment that most male attendants did not. Nurses were also cheaper to employ than men and they were thought to be more accepting of medical authority. Between 1907-1945, mental nurses were registered under a different system from state registered general nurses.

Men like MacGregor, Hay and Gray carefully maintained the separatism of the mental hospital system when they appealed to general hospital models for some of their policies. Various distinctions showed that the policy of hospitalization did not fully embrace the evolving general hospital model. These policies reflected, perhaps, a corporate dimension of the insulated way of life in mental hospitals.

I contend from the foregoing that New Zealand's mental health policy was a compound of the three foundational policies of institutional care, direct state management, and separatism. These policies were adjusted incrementally as new problems emerged, and as previous policies led to unexpected results. Rochefort's cyclical explanation of mental health policy as alternating crests of high policy activity and injections of resources, with troughs of stagnation or indifference and, I might add, otherwise quiet policy adjustments, is consistent with New Zealand experience. The diffuse administrative arrangements prior to 1876 makes it difficult to identify particular national policy crests, although 1846 (Lunatics Ordinance and the establishment of colonial hospitals), 1858 (Select Committee on the Central Lunatic Asylum), 1868 (Lunatics Act) and 1871-6 (establishment of the national inspectorate) stand out. In the post-provincial era, particular occasional bursts of policy development can be identified more readily. These include the years 1877-80 (rural development, medical management), 1907-11 (mental nurse training, new villa

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institution, Mental Defectives Act, reception houses), 1925-8 (general hospital psychiatry, mental deficiency colonies), and 1947 (major upgrading of conditions, proposed new legislation). When examined further, those dates coincided with the early period of a departmental head's administration, most often through a solid partnership between innovative or receptive ministers and fresh departmental heads, like Hay-Fowlds, Truby King-Pomare, Young-Gray, and Howard-Russell. A departmental head's most productive years were invariably those when he was new to the job and before he grew stale, tired, ill, or trapped at the top of his public service career.

To be successful though, major policy initiatives had to coincide with the right political climate and loose purse strings. Minor bursts were sometimes activated when personal (or, one may add, institutional) 'troubles' blew up into issues. In colonial and provincial times, the plight of lunatics like J.H. (1842), E.E. (1843), or S.C. (1855) inclined local decision-makers towards an institutional policy. Much later, the escapes and perceived menace of Terry and Matthews helped shape the policy of maximum secure care. Politically embarrassing institutional troubles were also catalysts sometimes. The Royal Commission of Inquiry into Wellington Asylum (1881) accelerated progress towards the policy of medical management. The 1946 staffing inquiry catapulted policies to remedy the accumulated grievances of departmental nursing staff.

Between the high points, core policies were added to at the margins, which bears out Polaschek's contention that:

Government is not a series of startling innovations. Rather, it is a process of gradual and minor adaptations to changing conditions. This fairly smooth progression is broken at rare intervals by a flood of important legislation, brought about because, with the passage of time, the marginal adjustments that have been made tend to fall short of what the people feel they need.\(^{13}\)

\(^{13}\) R.J. Polaschek, Government Administration in New Zealand, Wellington, 1958, p. 212.
Changes in the key mechanisms of government intervention in mental health make the point. Core mental health legislation was reviewed on average once a generation, in 1846, 1868, 1882, and 1911. New statutes grafted innovations onto a large core of precedents so much that elsewhere I have likened legislation to a coral tree with a living fringe built upon ancestral foundations.\textsuperscript{14} Departmental appropriations were annualized, with adjustments up or down for fiscal retrenchment or the cost of ad hoc policy approvals. Institutional outreach programmes moved from main buildings to the periphery of mental hospital estates, then to satellite campuses and general hospital psychiatry, but always in a manner that retained overall institutional influence. Public inquiries into the nation's mental health policy were held very rarely: the Parliamentary select / joint committees of 1858 and 1871 and a ministerial committee of enquiry in 1924-5 being the only examples. The infrequency of such policy-oriented inquiries suggests that politicians usually preferred not to disturb the general foundations of mental health policy.

Budgetary, bureaucratic and political constraints led Inspector-General MacGregor to sum up his predicament as a departmental policy-maker cum manager as 'a choice of difficulties'.\textsuperscript{15} His predecessors and his successors, who operated under similar limitations, might just as easily have coined that expression. The phrase is so apt that I have borrowed it as the title of my thesis. The history of New Zealand's mental health policy shows how the foundational policies and their consequences made for this choice of difficulties.

First, capital development was a Hobson's choice policy because of circumstances in the late nineteenth century. Boarding out had been excluded as unfeasible. Inadequate welfare services were managed by unwilling charitable aid authorities. There were no poor law institutions. At that time, general hospital authorities were unwilling to treat mental disorders and had no specialist staff to do so. Politicians were very reluctant to upset local government agencies like hospital and / or charitable aid boards.

\textsuperscript{14} Warwick Brunton, 'Mental Health Law in New Zealand: Some Sources and Traditions', \textit{Community Mental Health in New Zealand}, 2, 1 (1985), p. 80.
\textsuperscript{15} AJHR, 1938, H-7, p. 3.
Psychiatrist-administrators who worked in a state-run system were burdened by the second choice of difficulty: how to reconcile the clinical ideal of the best care for the individual patient with bureaucratic notions of efficient and economical administration. Seen at this distance from the period under review, one can sympathize with the officials. They felt bound by convention to work within the political environment of public service for change whilst having to help their ministers defend the limitations of the system. They had to work within the budgetary limits they could negotiate with their ministers and within the limits those ministers were able to negotiate in Cabinet. Meanwhile, officials lived with constant reminders of the restrictions of therapeutic knowledge, insufficient staff of the quality they sought, great variability in institutional living conditions, and the monotony of daily life for back ward patients. Capricious public and professional attitudes to the difficulties administrators faced were a constant backdrop. Centralized management allowed them to foster a fair application of new policies and resources, not necessarily all at once, but certainly in a way that eventually ensured nation-wide consistency. At the same time, and as the system expanded, uniformity sometimes came at the price of monotony, as seen in the diet, clothing, and daily activities of chronic patients. Occasionally departmental heads found different equivalents of the confessional to pour out their frustration. Skae and Grabham relied on their annual reports, but never as strongly as MacGregor, who eventually stopped after venting his concerns publicly against the Liberal government for some years. Hay conveyed his disquiet in personal or confidential memoranda to ministers. Truby King could dispose of allegations angrily and emphatically. Gray reacted hypersensitively to external criticism, particularly in the latter years of his administration.

Administrators faced a third choice of difficulty in the way they defined the relationship of their system to medicine and the evolving health care system. The difficulty they faced was to obtain the benefits of closer alignment with health care without sacrificing administrative autonomy or the loss of interesting clinical work. As we have seen, the moves towards recognition of psychiatry as a medical specialty, and attendants and other staff involved in patient care as professionals were motivated by a desire to improve the standing of mental health within the health
system. That professional standing was not always reciprocated. Departmental doctors were different from those in private practice: medical colleagues regarded them as accountable to their employer and not to their patients. Mental nurses did not have the same state registration as general nurses until 1945. The medical and nursing professions embraced these professional "cousins" dutifully but distantly.

A repeated pattern of policy cause-effect-adjustment stands alongside Kingdon's garbage can theory of the process of policy development. He considers that policy is drawn from a cauldron of problems, ideas (and ideals), participants, and political opportunity. According to Kingdon, policy is made when a problem or solution captures the attention of people in and around government, has the support of other interest groups, and the political environment is favourable. Those processes converged at critical times and shaped decisions about the foundational policies.

No one theory of interest groups can fully explain the changing and relative roles of different parties in mental health policy-making over a century or so. At different times, a pluralist perspective can be discerned in the impact of negotiated consensuses on aspects of national policies like state-run institutions, or the official frame of insanity. At a later stage of the period under review, well-organized national associations or lobby groups give credence to corporatist theories. On the other hand, periodic alignment of interested parties and the political process around particular policy issues of mental health concern resembled an issue network. These networks shared an "outer" circle of interested parties and an "inner" circle of parties within government administration. In my view, the degree of influence was relative to continuity of association with the problems and proximity to the machinery of government. The inner circle influence was doubtless enhanced, as I have indicated, by the presence and growth of a permanent specialized bureaucracy. The idea of an issue network rather than a policy community reflects the fluidity of policy-making process and the policy-making environment of the period. Even though well-organized national associations or lobby groups articulated their own policy ideas,

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they hardly constituted a stable and continuous policy community that was consulted and that matched the scheme of public administration of the day. Outside of the Department, mental health really lacked its own dedicated national lobby group or patient voice.

The mental health system that evolved in New Zealand by 1947 and that was centred upon mental hospitals was not dissimilar from the systems of other comparable countries or, indeed, from the first technical advice of the World Health Organization in 1952 to ‘countries which are at an early stage of economic development’. Imperialism, technology, social ties and emigration transported the same fashionable ideas wherever British settlers went around the globe, including New Zealand. Sentimental, professional, constitutional and cultural ties sustained the link so that Britain remained the primary reference point for New Zealand throughout the period. The mid-Victorian Scottish psychiatrist W. Lauder Lindsay astutely observed, that colonists had an inordinate penchant for adopting home models. They acted, he said, upon the adage "'There's no place like home", in a mischievous and absurd way. The British link was maintained through the spread of ideas, knowledge and intellectual currents in professional journals subscribed to here. Psychiatrists tried to keep some links with the Medico-Psychological Association as their specialist body and in 1946, a number joined the Australasian Association of Psychiatrists when it was formed. Despite some attempts, New Zealand had no specialist professional association of its own, either for psychiatrists or psychiatric nurses. Their numbers were probably too small and practitioners were too isolated, although psychiatric nurses and departmental medical officers had started to band together for industrial purposes by 1947.

The British connection was maintained in many ways. Every departmental head received his medical education in Britain. New Zealand administrators always kept up with British developments on their overseas study tours and through their personal networks. Departmental doctors could become qualified psychiatrists through the policy of study leave in British hospitals. A steady stream of immigrant psychiatrists


over the years brought further infusions of current British ideas and practice. Australian and American developments were sometimes of interest, but never as influential as ideas from the United Kingdom.

Some adaptation of British models to frontier conditions and the needs of a maturing colonial society were inevitable. Settler views alone framed official decision-making throughout the period. Maori views obviously featured in decisions about the care of individuals, but notions of mental health (te taha hinengaro) did not feature in public policy decisions. The ideological and racial underpinnings of mental health policies in British India or African colonies were not formalized here.

The British nation-state had started to play a much wider role in social policies to tackle the social effects of urbanization, industrialization, and transportation about the time New Zealand became a colony. Reform of the institutions of government and public administration was an important part of the process. Residential solutions were an attractive solution to social problems like crime, poverty and illness. Mental health policy was swept up among these changes. In England, the 1840s were a decade of intense activity initiated by the central government. New Zealand retained the essence of these English (and Scottish and Irish developments too), but their form and emphasis sometimes differed. For instance, the New Zealand system differed from English and Scottish provision of care because the government directly funded and managed state institutions. Private services had a very limited role. Mental health legislation also shows a degree of local adaptation. The home-grown, simple and pragmatic Lunatics Ordinance 1846, kept the essential principles and procedures of prevailing English law, but was a far cry from the complex corpus of the English statutes that were incorporated in 1868 and thereafter. New Zealand did not opt for parallel streams of legislation for persons of unsound mind and for mental deficiency. Voluntary boarders were first admitted to a public mental hospital in New Zealand in 1911, but not in England until 1930. Responsibility for the training and registration of attendants in New Zealand differed slightly from the United Kingdom, although both schemes aspired to give these staff professional status. The Department and not the Medico-Psychological Association set the standards, conducted the programme, and kept the national register until 1945. Finally, the
English and Scottish models of a permanent national inspectorate comprising specialist medical and legal expertise were simplified. The colonial variant of an inspector-general represented psychiatry only.

The multiple effects and interaction of the country's triangular foundational policies obliged decision-makers to make adjustments at the margins rather than to completely recast the foundations. Lindsay, that astute Scottish observer of New Zealand's mental health system, noted prophetically in 1872, that the foundational policies were deterministic:

*after* money has been sunk and laws have taken hold, it is not easy to undo and substitute, however desirable progress or reform may be.¹⁹

How true that statement was to prove.

---

¹⁹ Lindsay, pp. 811. Emphasis in original.
## APPENDIX 1

### CABINET MINISTERS WITH RESPONSIBILITY FOR MENTAL HOSPITALS, 1876-1947

<table>
<thead>
<tr>
<th>Name</th>
<th>Dates of Office</th>
<th>Cabinet Ranking</th>
<th>Previous Cabinet Experience</th>
<th>Departmental Head</th>
</tr>
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<tbody>
<tr>
<td><strong>'Continuous' Ministry</strong></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>D. Pollen</td>
<td>1876-77</td>
<td>2/7</td>
<td>Colonial Secretary</td>
<td>F.W.A. Skae (1876-1881)</td>
</tr>
<tr>
<td>G. Grey</td>
<td>1877</td>
<td>1/5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>G.W.S. Whitmore</td>
<td>1877-79</td>
<td>2/6</td>
<td></td>
<td></td>
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<tr>
<td>J. Hall</td>
<td>1879-80</td>
<td>1/6</td>
<td>Colonial Secretary</td>
<td></td>
</tr>
<tr>
<td>T. Dick</td>
<td>1880-82</td>
<td>2/7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>T. Dick</td>
<td>1882-83</td>
<td>3/7</td>
<td></td>
<td>G.W. Grabham (1882-86)</td>
</tr>
<tr>
<td>T. Dick</td>
<td>1883-84</td>
<td>2/7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>W. Montgomery</td>
<td>1884</td>
<td>5/8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E. Wakefield</td>
<td>1884</td>
<td>4/6</td>
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<td></td>
</tr>
<tr>
<td>P.A. Buckley</td>
<td>1884-87</td>
<td>6/7</td>
<td></td>
<td>D. Macgregor (1886-1906)</td>
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<td>T.W. Hislop</td>
<td>1887-89</td>
<td>2/5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>W.R. Russell</td>
<td>1889-91</td>
<td>3/8</td>
<td>Postmaster-General Telegraphs</td>
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<tr>
<td><strong>Liberal</strong></td>
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<tr>
<td>A.J. Cadman</td>
<td>1891-92</td>
<td>6/7</td>
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<tr>
<td>W.P. Reeves</td>
<td>1892-96</td>
<td>3/8</td>
<td>Education</td>
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<td>W.C. Walker</td>
<td>1896-1903</td>
<td>5/7</td>
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<tr>
<td>W. Hall-Jones</td>
<td>1903-06</td>
<td>4/8</td>
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<td>W. Hall-Jones</td>
<td>1906</td>
<td>8/8</td>
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<td>G. Fowlds</td>
<td>1906-11</td>
<td>8/10</td>
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<tr>
<td>D. Buddo</td>
<td>1911-12</td>
<td>8/10</td>
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<tr>
<td>G.W. Russell</td>
<td>1912</td>
<td>6/10</td>
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<td><strong>Reform</strong></td>
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<td>R.H. Rhodes</td>
<td>1912-15</td>
<td>8/9</td>
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<tr>
<td>G.W. Russell</td>
<td>1915-16</td>
<td>8/13</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Name</td>
<td>Dates of Office</td>
<td>Cabinet Ranking</td>
<td>Previous Cabinet Experience</td>
<td>Departmental Head</td>
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<td>-------------</td>
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<tr>
<td>National</td>
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<tr>
<td>G.W. Russell</td>
<td>1916-19</td>
<td>8/13</td>
<td>...</td>
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<tr>
<td>Reform</td>
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<tr>
<td>F.H.D. Bell</td>
<td>1919-20</td>
<td>5/10</td>
<td>Internal Affairs</td>
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<td></td>
<td>Immigration</td>
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<td>Attorney-General</td>
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</tr>
<tr>
<td>C.J. Parr</td>
<td>1920-23</td>
<td>9/12</td>
<td>Without Portfolio</td>
<td>Sir Truby King</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Cook Islands</td>
<td>(1924-27)</td>
</tr>
<tr>
<td>M. Pomare</td>
<td>1923-26</td>
<td>10/11</td>
<td></td>
<td>T.G. Gray</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(1927-47)</td>
</tr>
<tr>
<td>J.A. Young</td>
<td>1926-28</td>
<td>13/15</td>
<td></td>
<td></td>
</tr>
<tr>
<td>United</td>
<td></td>
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<tr>
<td>A.J. Stallworthy</td>
<td>1928-30</td>
<td>12/13</td>
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<tr>
<td>Coalition</td>
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<tr>
<td>J.A. Young</td>
<td>1931-35</td>
<td>6/10</td>
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<tr>
<td>Labour</td>
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<tr>
<td>P. Fraser</td>
<td>1936-40</td>
<td>2/13</td>
<td>Labour</td>
<td>J. Russell</td>
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<tr>
<td>H.T. Armstrong</td>
<td>1940-41</td>
<td>5/13</td>
<td>Immigration</td>
<td>(1947-50)</td>
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<tr>
<td>A.H. Nordmeyer</td>
<td>1941-47</td>
<td>13/14; 10/15</td>
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<tr>
<td>M.H. Howard</td>
<td>1947-49</td>
<td>13/15</td>
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</table>

Note:

Ministerial responsibility was entrusted to the Colonial Secretary (1876-91), Native Minister (1891-2), Minister of Education (1892-1903), Minister-in-Charge of Hospitals and Lunatic Asylums (1903-07) and to the Minister-in Charge of Mental Hospitals (1907-47).

APPENDIX 2

CAREER PATHWAYS
OF SENIOR MENTAL HOSPITALS DEPARTMENT STAFF,
1876-1947

Note: Subsequent career details are shown in italics.
Details of war service are not included.

Inspector / Director-General

F.W.A. Skae¹ (1876-1881)

Medical Superintendent, Stirling District Lunatic Asylum (1869)
Assistant Medical Officer, Royal Edinburgh Asylum (1865)
M.D. (St Andrews) (1862), M.S., L. (1865) / F.R.C.S.E. (1868)

G.W. Grabham² (1882-86)

Private practice, Witham, Essex, England
Visiting Physician, Bradford Borough Fever Hospital
Resident Physician and Superintendent, Royal Earlswood Asylum for Idiots, Radhill, Surrey (1868)
Senior Assistant Medical Officer, Surrey County Lunatic Asylum
House Surgeon / Resident Accoucheur, St Thomas' Hospital, London
Physician, Bradford Infirmary and Dispensary

D. MacGregor (1886-1906)³


Medical Officer, Dunedin Asylum (1876)
Inspector, Dunedin Asylum (1873)
Professor of Moral and Mental Philosophy, University of Otago (1870)
M.A., M.B. (1870), Hon. Litt. D.

J.F.S. Hay^4 (1907-1925)

Deputy Inspector-General (1904)
Medical Superintendent, Ashburn Hall (1897)
Assistant Medical Officer, James Murray Royal Asylum, Perthshire (1890)
M.B., C.M. (Aberdeen) (1890), M-P.C. (1890)

Sir Truby King^6 (1924-27)

Director of Child Welfare, Health Department (1921)
Medical Superintendent, Seacliff Asylum (1889)
Resident Medical Officer, Wellington Hospital (1888)
M.B., C.M., B.Sc. (Public Health) (Edinburgh) (1888), M-P.C. (1894)

T.G. Gray^6 (1927-'947)

Deputy Inspector-General (1928)
Medical Superintendent, Auckland (1925)
Medical Superintendent, Nelson (1920)
Senior Assistant Medical Officer, Seacliff (1915)
Senior Assistant Medical Officer, Auckland (1913)
Junior Assistant Medical Officer, Porirua (1911)
Junior Medical Officer, Kingscot Mental Hospital, Aberdeenshire (1906)
M.B., Ch.B. (Aberdeen) (1905), M-P.C. (1911)

J. Russell^7 (1947-50)

Deputy Director-General (1928)
Senior Assistant Medical Officer, Sunnyside (1928)
Assistant Medical Officer, Sunnyside (1926)
Maudsley Clinic, London (1923-5)
Assistant Medical Officer, Horton Mental Hospital, Epsom, England
B.A. (Cantab.), M.B., Ch.B. (1923), D.P.M. (1925)

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5 Barbara Brookes, 'King, Frederic Truby', DNZB, Vol. 2, Wellington, pp. 257-8; King to wife, 10 July 1894, Sir Truby King Papers, Alexander Turnbull Library, MS-1004.


Deputy Inspector / Director-General

J.F.S. Hay (1904-07)

[see above]

St L. H. Gribben⁸ (1911-1916)

Private Practice (1929)
Medical Superintendent, Seacliff (1924?)
Medical Superintendent, Tokanui (1919)
Medical Superintendent, Sunnyside (1916)
Assistant Medical Officer, Sunnyside (1905)
Assistant Medical Officer, London County Asylum, Cane Hill, England
Assistant Medical Officer, Norfolk County Lunatic Asylum, England
House Surgeon, Royal Infirmary, Stirling, Scotland
Dresser / Surgeon, Edinburgh Field Hospital, South Africa
M.D. (1904), M.S. (1899) (Edinburgh)

W.B. Gow⁹ (1916-1923)

Medical Superintendent, Sunnyside (1905)
Medical Superintendent, Mount View (1900)
Senior Assistant Medical Officer, Auckland (1899)
Assistant Medical Officer, Country Asylum, Prestwich, Manchester, England
Junior House Surgeon, Bury Dispensary and Hospital, England
M.D. (1899), M.S. (1892) (Edinburgh)

T.G. Gray (1926-7)

[see above]

J. Russell (1927-47)

[see above]

Assistant Inspector [Nursing]

G. Neill¹⁰ (1895-1906)

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⁹ Medical Directory for 1897, London, 1897, p. 752; Departmental Reports, AJHR, 1900-23; PSCL, supplements to New Zealand Gazette, 1913-23.
Inspector, Labour Department (1894)
Lady Superintendent, Pendlebury Children’s Hospital (1876)
King’s College and Charing Cross Hospitals (1873)

H. Maclean (1907-20)
Sister-in-Charge, District Nursing Association, Sydney (1906)
Matron, Bay View Asylum (1905)
Matron, Melbourne Children’s Hospital (1900)
Matron, Queen Victoria Hospital for Women and Children (1899)
Sister, Women’s Hospital, Melbourne (1897)
Matron, Koganah Hospital, New South Wales (1894)
Private Nursing (1893)
Royal Prince Alfred Hospital [Nursing] Certificate (1893)

E. Hanna (1920-1927 ?)
Matron, Sunnyside (<1907)
(1902)

**Director of Clinical Services**

R.G.T. Lewis (1945-48)

*Deputy Director-General of Health (1960)*
*Director, Mental Hygiene Division (1950)*
*Medical Superintendent, Kingseat (1948)*
*Senior Assistant Medical Officer, Porirua (1936)*
*Assistant Medical Officer, Sunnyside (1930??)*
*M.B. Ch.B. (Otago) (1927)*

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Chief Clerks

W.L. Loveday\(^{13}\) (1876-?)

- Private Sector (1873)
- Clerk, Junior Civil Commissioners (1871)
- Clerk, Thames Warden's Court (1867)
- Military Service

D. Souter\(^{14}\) (?1905-1920)

- Clerk, Asylums Department (1890)
- Private Sector
- Postal Department (1872)

J.E. Russell\(^{15}\) (1920)

- Clerk [and Storekeeper], Sunnyside Asylum (1887)
- Clerk, Mount View Asylum (1878)

G.C. Holder\(^{16}\) (1921-1935)

- Clerk, Porirua Asylum (1899)
- Clerk, Mount View Asylum (1898)
- Clerk, Auckland Asylum (1894)
- ?? Lunatic Asylums Department (1893)

A. Sinclair\(^{17}\) (1935-)

- Building Coordinator/Development Officer (1947-50 [?])
- Clerk / Storekeeper, Auckland (1925)
- Clerk / Storekeeper, Nelson (1924 ?)
- Clerk, Nelson (1915 ?)
- Cadet, Seacliff (1911)

I.M. Lilly\(^{18}\) (1947-1958)

- Chief Clerk, Mental Hygiene Division (>1958)
- Accountant and Inspector, Head Office (1942)
- Chief Clerk, Auckland (1939)

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\(^{12}\) Designated Clerk and Accountant in 1897.

\(^{13}\) Cyclopaedia of New Zealand, Volume 1, p. 355.

\(^{14}\) Cyclopaedia of New Zealand, Volume 1, p. 171; PSCL, 1913-21; AJHR, 1920, H-7, p. 5.

\(^{15}\) Cyclopaedia of New Zealand, Volume 3, p. 158; PSCL, 1913-20; AJHR, 1920, H-7, p. 5.

\(^{16}\) PSCL, 1913-35; New Zealand Gazette, 4 October 1894, p. 1512, 5 May 1898, p. 761, and 22 June 1899, p. 1167.

\(^{17}\) PSCL, 1913-47.

\(^{18}\) PSCL, 1913-47; Personal communication, Mr I.M. Lilly, 22 December 1970.
Clark / Storekeeper, Tokanui (1932)
Assistant Clerk and Storekeeper, Seacliff (1931)
Assistant Clerk and Storekeeper, Auckland (1924)
Cadet, Porirua (1923)
APPENDIX 3

DEPARTMENTAL ORGANIZATION, 1876-1947

The following organization charts show changes in the structure of the Lunatic Asylums / Mental Hospitals Department at decennial intervals.

1 Lunatic Asylums Department 1877
2 Lunatic Asylums Department 1886
3 Lunatic Asylums Department 1896
4 Mental Hospitals Department 1906
5 Mental Hospitals Department 1916
6 Mental Hospitals Department 1926
7 Mental Hospitals Department 1936
8 Mental Hospitals Department 1946
9 Mental Hospitals Department 1947
LUNATIC ASYLUMS DEPARTMENT
1877

INSPECTOR-GENERAL

RECORD CLERK AND ACCOUNTANT

RESIDENT SURGEON, AUCKLAND
KEEPERS:
• NEW PLYMOUTH
• WELLINGTON
• NAPIER
• NELSON
• HOKITIKA
• CHRISTCHURCH
SUPERINTENDENT, DUNEDIN

Source: AJHR, 1877, B-28, p. 15 ff.
LUNATIC ASYLUMS DEPARTMENT
1886

INSPECTOR-GENERAL

HOSPITALS & CHARITABLE DEPARTMENT

CHIEF CLERK & ACCOUNTANT

RESIDENT MEDICAL SUPERINTENDENTS
• AUCKLAND
• WELLINGTON
• CHRISTCHURCH
• SEACLIFF
SUPERINTENDENTS
• NAPIER
• NELSON
• HOKITIKA

Source: AJHR, 1886, B-1A, pp. 17-18.
Source: AJHR, 1896, B-7, p. 46.
MENTAL HOSPITALS DEPARTMENT
1906

INSPECTOR-GENERAL

HOSPITALS & CHARITABLE DEPARTMENT

ASSISTANT INSPECTOR

DEPUTY INSPECTOR-GENERAL

CLERK

MESSENGER

MEDICAL SUPERINTENDENTS

- AUCKLAND
- WELLINGTON
- PORIRUA
- CHRISTCHURCH
- SEACLIFF

SUPERINTENDENTS

- NELSON
- HOKITIKA
- THE CAMP

MENTAL HOSPITALS DEPARTMENT
1916

INSPECTOR-GENERAL

DEPUTY INSPECTOR-GENERAL  CHIEF CLERK  RECEIVER  MEDICAL SUPERINTENDENTS

- AUCKLAND
- TOKANUI
- PORIRUA
- NELSON
- CHRISTCHURCH
- SEACLIFF
SUPERINTENDENT
- HOKITIKA
MATRON
- RICHMOND HOME FOR DEFECTIVES

MENTAL HOSPITALS DEPARTMENT
1926

INSPECTOR-GENERAL

DEPUTY INSPECTOR-GENERAL

CHIEF CLERK

ASSISTANT INSPECTOR

RELIEVING MATRON

RECEIVER

ACCOUNTANT

4 CLERKS

1 OFFICE ASSISTANT

MEDICAL SUPERINTENDENTS

- AUCKLAND
- TOKANUI
- PORIRUA
- NELSON
- CHRISTCHURCH
- HOKITIKA
- SEA CLIFF

MENTAL HOSPITALS DEPARTMENT
1936

DIRECTOR-GENERAL

DEPUTY DIRECTOR-GENERAL

CHIEF CLERK

MEDICAL SUPERINTENDENTS
• AUCKLAND
• TOKANUI
• PORIRUA
• NELSON
• CHRISTCHURCH
• HOKITIKA
• SEACLIFF

RECEIVER

ACCOUNTANT

8 CLERKS/CADET

Sources: New Zealand Gazette, 11 January 1937, pp. 155-6; AJHR, 1936, B-7, p. 211.
MENTAL HOSPITALS DEPARTMENT
1946

DIRECTOR-GENERAL

DEPUTY DIRECTOR-GENERAL
DIRECTOR OF CLINICAL SERVICES
CHIEF CLERK
MEDICAL SUPERINTENDENT
- AUCKLAND
- KINGSEAT
- RAVENTHORPE
- TOKANUI
- PORIRUA
- NELSON
- HOKITIKA (SEAVIEW)
- CHRISTCHURCH (SUNNYSIDE)
- SEA Cliff

ACCOUNTANT
8 CLERKS
TYPIST
ASSISTANT ACCOUNTANT
RECORDS CLERK

MENTAL HOSPITALS DEPARTMENT
1947

DIRECTOR-GENERAL
(vacant)

DEPUTY DIRECTOR-GENERAL (ACTING DIRECTOR-GENERAL)

DIRECTOR OF CLINICAL SERVICES

CHIEF CLERK

DEVELOPMENT OFFICER

ACCOUNTANT

6 CLERKS

1 SHORTHAND TYPIST

ASSISTANT ACCOUNTANT

1 RECORD CLERK

MEDICAL SUPERINTENDENTS

• AUCKLAND
• KINGSEAT
• TOKANUI
• PORIRUA
• NELSON
• HOKITIKA (SEAVIEW)
• CHRISTCHURCH (SUNNYSIDE)
• SEACLIFF

APPENDIX 4

A NOTE ON THE TEACHING OF UNDERGRADUATE PSYCHIATRY IN NEW ZEALAND

The earliest medical undergraduate teaching in insanity took place as part of lectures on the practice of medicine and on medical jurisprudence. In 1888-9, a clinical course was held at Seaciff Asylum. This was the forerunner of a residential programme, which was integral to the clinical instruction of generations of New Zealand medical students. As the cornerstone of teaching in the subject, the Seaciff programme acquainted students with the more florid forms of insanity (personified by Lionel Terry whose case impressed generations of medical students). Teaching did not really get underway until a lectureship in mental diseases was first held along with the medical superintendence of Seaciff Asylum in 1889. Insanity became a compulsory subject in 1914. In 1930, two students criticised the teaching for the lack of depth, relevance to general practice and other fields of medicine, and breadth. No changes were made to the course which other

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1 University of Otago, Calendar for the Year 1889, Dunedin, 1889, pp. 61-2, 146.
2 D.W. Carmalt-Jones, Annals of the University of Otago Medical School, 1875-1939, Dunedin, 1945, pp. 117, 188; Director-General to Minister, 19 July 1946, Health Department, Mental Health Division Archives, National Archives, Wellington, File HMH 26/75.
4 Carmalt-Jones, pp. 95, 99. The course outline for 1890 shows the changes instituted by King. The content included a preliminary outline of anatomy, physiology and pathology of the nervous system in regard to insanity; development and critical periods of life; special temperaments and heredity in regard to neuroses and insanity; chief forms of insanity – causes, diagnosis, treatment, etc.; examination of the insane and care taking; ordinary medical and medico-legal bearings of insanity; filling out statutory forms; and opinions as to testamentary capacity. The residential component was termed 'asylum practice'. The same synopsis was given in 1928. University of Otago, Calendar for the Year 1890, Dunedin, 1890, pp. 60, 67; University of Otago, Calendar for the Year 1928, Dunedin, 1928, p. 270.
5 Inspector-General to Minister, 26 June 1914, HMH 4/4/3.
6 W.A. Fitzherbert, 'The Prevention of Mental Diseases in New Zealand', Preventive Medicine Dissertation, University of Otago, 1930, [p.2], Appendix III. The existing curriculum was said to deny medical practitioners the advantage of a modern knowledge of psychology and psychopathology. Only six lectures were given on the main mental diseases and one lecture each on hysteria and neurasthenia as part of general medicine. Medical students were given also two and one-half days of
Faculty staff thought was demanding enough for students who were too immature to handle the topic.\(^7\)

By 1945, Gray (Director-General, 1927-47) thought that the teaching of psychiatry had improved\(^8\) but he may not have fully considered the negative impression conveyed by the teaching approach. On the one hand, he thought that medical men [sic] were not attracted to work in mental hospitals because psychiatry was not emphasised at university training and because or because they did not like to admit refer people to mental hospitals.\(^9\) Paradoxically Gray remained firmly wedded to the institutional approach as became evident in discussions on the establishment of a chair of psychiatry at Otago University.\(^10\) Rather than an outside appointment to the chair, Gray hoped the Edinburgh arrangement would be copied and lectures given by the medical superintendent of the local mental hospital.\(^11\) A 'practical teacher of practical psychiatry' was needed, not the exponent of 'all the high falutin' theories which seem to obscure commonsense in our special branch.\(^12\) Gray's strong views reflected his concern about psychanalytic techniques.\(^13\) As it happened, Harold Palmer was appointed to a senior lectureship and not as a professor in April 1946. Palmer rearranged the course, intending to scrap the fifth year lectures in favour of a

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8. Director-General to Professor D'Ath (confidential), 19 April 1945, Health Department Archives, National Archives, Wellington, File H 30/5 (34271).
10. The substantial bequest to establish a chair, in 1939, by one of the residual beneficiaries of the Hume family interest in Ashburn Hall opened the door for further debate on the nature of teaching. *Otago Daily Times*, 18 October 1939, H 209/2/8 (30407). Gray's attitude was probably conditioned by his wish to keep teaching within the organic tradition of psychiatry. Similarly, the Department met half the salary of a part-time academic-service appointment in neurosurgery in 1945. M.A. Falconer to Dean, Medical School, 23 March 1945 and Director-General to Dean, Otago Medical School, 18 April 1945, H 30/5 (34271).
11. This remained the custom from Truby King's time. The course synopsis for 1947 provided by M. Brown in his capacity as a part-time Lecturer in Mental Diseases included fifth year lectures on neuroses, psychoneuroses and psychoses – diagnosis and treatment, certification and some other legal aspects of psychiatry. Clinical instruction continued to be provided at Seaciff. University of Otago, *Calendar for the Year 1947*, Dunedin, 1947, pp. 252, 267. Ernest Beaglehole's monograph, *Mental Health in New Zealand*, Wellington, 1950, p. 103, was highly critical of the depth and content of the curriculum as shown by the continued reference to asylums in the course prescription.
12. Director-General to Professor D’Ath (confidential), 19 April 1945, H 30/5 (34271). M. Brown, the Medical Superintendent, agreed with his superior. Medical Superintendent Seaciff to Director-General, [7] March 1945, H 30/35/35 (34286).
sixth year course and a fortnight's experience at a major mental hospital. Such moves coincided with Gray's hope that mental hospitals might be included as training posts for house surgeons.
APPENDIX 5

INTERNATIONAL STATISTICAL CLASSIFICATION OF
FORMS OF INSANITY

1901

Class III – Dietetic Diseases

3(a) Chronic Alcoholism
(b) Delirium tremens

Class VI - Local Diseases, Order I: Diseases of the Nervous System

7 Insanity. General Paralysis of the Insane
9 Epilepsy

1908

Class I – General Diseases

56 Acute and Chronic Alcoholism

Class II - Diseases of the Nervous System and Organs of Special Sense

67 General Paralysis [of the Insane]
68 Other forms of Mental Alienation
69 Epilepsy
74A Hysteria

Class XII – Old Age

154 Senile Debility

1920

Class I – General Diseases

56 Alcoholism

1 Statistics of the Colony of New Zealand 1901, Wellington, 1902, p. 78 ff.
3 Statistics of the Dominion of New Zealand 1920, Volume I, Wellington, 1921, p. 157 ff. This assumes that the third revision was adopted by that year.
Class II - Diseases of the Nervous System and Organs of Special Sense

67 General Paralysis of the Insane
68 Insanity
68 Mania
68 Dementia
68 Melancholia
68 Paranoia
68 Mental Cases
69 Epilepsy
74 Neurasthenia
74 Neurosis

Class VII – Puerperal State

140 Puerperal Insanity
141 Puerperal Melancholia

Class XII – Old Age

154 Senility

1930

Class V – Chronic Poisonings and Intoxication

75 Alcoholism
76 Morphinism
76 Veronal Addict
76 Cocaine Addict
76 Drug Addict (drug not stated)

Class VI - Diseases of the Nervous System and Organs of Special Sense

83 General Paralysis of the Insane
84A Dementia praecox
84B Dementia
84B Mania
84B Delusional Insanity
84B Melancholia
84B Psychasthenia
84B Other and Undefined Forms of Insanity
85 Epilepsy
87E Hysteria
87E Neurasthenia
87E Neurosis

4 This was the first use made of the fourth revision of the international list. The overall scheme was arranged under 18 class headings with 200 orders instead of the 15 classes and 205 orders of the previous revision. Department of Census and Statistics, Vital Statistics of New Zealand 1930, Wellington, 1931, pp. xv, 17 ff.
Nervous Debility

Class XVI – Senility

162 Senility

1940

Class I – Infectious and Parasitic Diseases

30B General Paralysis of the Insane

Class V – Chronic Poisoning and Intoxication

77 Alcoholism

Class VI - Diseases of the Nervous System and Organs of Special Sense

83 General Paralysis of the Insane
84A Mental Deficiency
84B Schizophrenia (Dementia Praecox)
84C Manic-Depressive psychosis
84D Dementia
84D Mania
84D Delusional Insanity
84D Melancholia
84D Neurosis
84D Neurasthenia
84D Anorexia Nervosa
84D Psychasthenia
84D Hysteria
84D Nervous Debility
84D Other and undefined Mental Diseases

1948

Class I – Infective and Parasitic Diseases

263 General paresis and other syphilitic psychoses

Class V – Chronic Poisoning and Intoxication

270 Alcoholism
278 Chronic poisoning by habit-forming drugs

Class VI - Diseases of the Nervous System and Sense Organs, including Mental Disorders

320 Schizophrenia
321 Manic-depressive psychosis
322 Involutional psychosis


323  Paranoia and paranoid conditions  
324  Senile psychosis  
325  Psychosis with cerebral arteriosclerosis  
326  Alcoholic psychosis  
328  Psychosis due to other diseases, poisons or injuries  
329  Other psychoses  
330  Psychoneurosis  
334  Psychopathic personality  
335  Mental deficiency  
336  Epilepsy  
339  Other mental and nervous diseases  

Class XVI – Other and Ill-defined Diseases  

781  Senility
APPENDIX 6

THE DIVISION OF LABOUR IN MENTAL HOSPITALS

This appendix describes some of the main changes that occurred in the clusters of jobs within the Lunatic Asylums / Mental Hospitals Department through specialization, growth of the Department, and institutional support functions. The explanatory notes accompany Table 19 that shows the breakdown of staff categories employed in the Department in 1876, 1900, 1925 and 1947.¹

MANAGEMENT AND ADMINISTRATION

When the Department was formed in 1876, lay keepers or superintendents managed all asylums except Auckland. Several of these superintendents had extensive experience as attendants before being given overall charge of an asylum. This pattern began to change under pressure from F.W.A. Skae, Inspector-General (1876-1881), who saw the treatment function as the basis of a medical claim that clinical responsibilities extended to overall management authority.

Mental health legislation empowered the government to specify duties for the principal officers of an asylum,² but job descriptions were scarcely evident for senior officers.³ Some of the functions and powers of the office of medical superintendent were set out in the 1940 rulebook (as shown in the Table below) but the absence of a clear-cut job description reflects the high discretion accorded professional staff. Mary King's recollections give a glimpse of her father's workload at Seacliff, about 1912. His working day

¹ The table is sourced from AJHR, 1876-1900, Estimates of Expenditure; Public Service Classification Lists, supplements to New Zealand Gazette, 1925-47.
² Lunatics Act 1868, s. 23; Lunatics Act 1882, s. 51; Mental Defectives Act 1911, s. 44 (5).
³ Assistant Inspector-General to C.C. Kettle, S.M., [Commission of Inquiry into Auckland Mental Hospital], 24 July 1912, Exhibit 45, HMH Bundle 55.
began at 7 or 8 a.m. with an inspection of the byres, piggeries, poultry houses, and a distant ward block. After breakfast at home, King generally inspected the wards and airing courts and discussed cases with attendants. After lunch and a nap, he plunged into the afternoon’s (presumably office) work and often did not return home for dinner until 8 p.m. He would visit sick staff or their family members. Once a week, he visited the Waitati branch establishment. The outwards letter books of Seaciff and Seaview Asylums show that until c. 1913, the medical / superintendent wrote and did not simply sign an amazing range of routine administrative correspondence. He wrote personally to inquiring relatives about patients, to the head office about staff and personnel matters, farm management, buildings and maintenance, justifying expenditure, furnishing information sought by circular memoranda, and he briefed the Inspector-General about special incidents.

According to the eminent Victorian physician Sir Clifford Albutt, whom King was fond of quoting, ‘your Superintendent [is] everything and, subject to him, makes your staff everything also’. Hands-on management of King’s generation was not easily sustained by succeeding generations of medical superintendents. The balance between statutory, administrative, clinical, and supervisory components of medical management duties undoubtedly varied according to the size of the institution. But that was not the only factor. Personal management style, individual enthusiasm and energy, the personal interest or knowledge of the detailed operations of different aspects of institutional support, and the need for a medical superintendent to provide clinical back-up, all played a part. Further, the medical superintendent was involved in bureaucratic processes because he was the local controlling officer. Implicit or explicit delegation thus became essential for good management and personal well being, hence the increasing reliance of

5 Quoted in Medical Superintendent, Seaciff to Medical Superintendent, Sunnyside, 13 March 1894, Plunket Society Archives 88-098-25, Hocken Library, Dunedin; AJHR, 1925, H-7, p. 7.
medical superintendents upon daily reports and meeting with senior staff to remain abreast of the main aspects of institutional life.⁶

**MEDICAL TREATMENT**

Treatment was primarily a medical function that was documented in various statutory medical records. These included the medical journal,⁷ casebooks,⁸ reports on the physical and mental examination of new patients, prescriptions, restraint and seclusion registers, and post-mortem records.⁹ The treatment function included daily medical observation of the patients during ward rounds, reviews of physical and mental progress, response to medical emergencies, prescribing medicines and tonics, and performing minor surgery.

In the early years, a visiting medical officer or medical superintendent treated the patients single-handedly but the administrative side of a medical superintendent's duties gradually limited the amount of clinical work they could do. Duncan MacGregor, Inspector-General (1886-1906), complimented the medical superintendents at Seaciff and Sunnyside, Truby King and E.G. Levinge respectively, for their knowledge of individual patients. Disaffected staff, however, claimed that the claims of managing a large and continually expanding institution took priority over patient care.¹⁰ W. Hall-Jones, the Minister in 1903, thought that medical superintendents spent too much of their time on farms.¹¹ A.H. Crosby, the Medical Superintendent of Sunnyside, told

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⁶ F. Truby King, Evidence, R. v. Maxwell, 31 August 1893, MH 1891/2511, pp. 22-23; Medical Superintendent's evidence to Inglis Commission of Inquiry, Auckland Mental Hospital, 25 July 1912, HMH Bundle 55, p. 32.
⁷ Later known as the weekly report.
⁸ In 1915, a clinical file on each patient superseded these cumbersome tomes.
⁹ Lunatics Act 1868, s. 25; Mental Defectives Act 1911, s. 65.
¹⁰ 'Ex-Attendant No. 3', letter to Globe, Dunedin, 17 April 1893; 'Hoping', letter to Press, Christchurch, 14 October 1904.
¹¹ *New Zealand Parliamentary Debates* (NZPD), 18 September 1903, 125, p. 605.
a Royal Commission held there in 1913 that the farm occupied the greater part of his time and at the expense of clinical matters.\textsuperscript{12}

Medical superintendents did some clinical work depending upon administrative pressures, the size of mental hospitals, and the exigencies of medical staffing. They also provided a second opinion on appropriate treatment.\textsuperscript{13} The medical care of patients, however, was largely deputed to medical officers. MacGregor feared that young, under-paid assistant medical officers (A.M.O's) would be left to treat the patients, while senior, well-paid officers, would absorb themselves in administration.\textsuperscript{14}

From a job description prepared at Auckland in 1912, we know that the A.M.O's made a daily ward round and paid surprise visits to the back wards. The senior assistant medical officer (S.A.M.O.) looked after the front wards. An A.M.O. was expected to visit those patients who worked around the hospital and to pay particular attention to patients who were in bed or who had undergone recent surgery. Wards and staff quarters were to be inspected for cleanliness and tidiness. The quality of patients' food was to be monitored. The A.M.O. was expected to get to know all the patients under his charge and to encourage them to work. He could authorize some restraint.\textsuperscript{15} Depending upon the management style of a medical superintendent, A.M.O's had considerable clinical autonomy. H.M. Buchanan recalled that when he was an A.M.O. at Seacliff in 1913, King largely left him alone.\textsuperscript{16} At the same time, a senior assistant medical officer (S.A.M.O.) supervised Auckland A.M.O's. The A.M.O. accompanied his senior on ward rounds once a week. The S.A.M.O.

\textsuperscript{12} Royal Commission of Inquiry into Sunnyside Mental Hospital, Health Department, Mental Health Division Archives, National Archives, Wellington, File HMH 1913/961, Minutes of evidence, p. 286.


\textsuperscript{14} \textit{Appendices to the Journals of the House of Representatives (AJHR)}, 1887, H-6, p. 3.

\textsuperscript{15} Medical Superintendent, Auckland, Rules for Assistant Medical Officers, 9 January 1912, HMH Bundle 55, Exhibit 29. The detailed list was probably prompted by the prospect of disciplinary action against an ineffectual A.M.O., Dr Inglis, who was later dismissed. \textit{New Zealand Gazette}, 31 October 1912, p. 3140.

\textsuperscript{16} Personal communication, the late Dr H.M. Buchanan, 21 December 1970.
was required to be present in the main building at Auckland during visiting hours, to dispense medicines\(^\text{17}\) and to undertake post-mortem examinations. Reports on patients were made to the Medical Superintendent through the S.A.M.O. By 1912, too, seniors photographed patients upon arrival (when that process was part of the admission formalities).\(^\text{18}\) They also checked committal papers for accuracy and compliance,\(^\text{19}\) and maintained the casebooks. The Medical Superintendent retained authority over communications to and from patients, and granted access to visitors.\(^\text{20}\)

Further details of the work of A.M.O's were eventually set out in the departmental rulebook. This information is contained in tabular form below.

**ANCILLARY MEDICAL TREATMENT**

Some specialized treatment functions resulted from the expansion of services or from therapeutic developments after the late 1920s. Social work and occupational therapy became the domain of professionals working within the bureaucracy rather than the untrained volunteers of small-scale local groups.

Social workers, known earlier as social service workers or psychiatric social workers, were the first of these new occupations. The diverse origins of professional social work in New Zealand can be found in the work of hospital almoners, charitable aid relieving officers, child welfare officers, and probation...

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\(^{17}\) The assistant medical officer might also dispense medicines, although early in his incumbency at Seaciff, Truby King showed the head attendant how to do so. R. Stewart, Head Attendant, evidence in R. v. Maxwell, Mental Hospitals Department File, MH 1891/2511, p. 189, formerly held at the Health Department head office but current whereabouts unknown.

\(^{18}\) Beattie obviously accepted that taking photographs of patients was part of the duty of an A.M.O. King at Seaciff had taught him this aspect of the job. Beattie, evidence to Inglis Inquiry, Auckland Mental Hospital, 25 July 1912, HMH Bundle 55. The practice was discontinued generally soon afterwards.

\(^{19}\) Eleanor Baker-McLaglan recalled that as an A.M.O. at Seaciff in 1904 it was her job to give advice on veterinary matters, pest control, to censor the patients' newspapers and mail, as well as checking the case notes and committal papers. Eleanor S. Baker McLaglan, *Stethoscope and Saddlebags*, Auckland, 1965, p. 70.

\(^{20}\) Medical Superintendent, Auckland, Rules for A.M.O's, 9 January 1912, HMH Bundle 55, Exhibit 29.
officers. Tennant notes the role of women in these developments. Paid professional social service workers in America impressed Gray during his first overseas study tour in 1927. Based on his observations, Gray envisaged that a social service worker would act as a go-between institution, families, employers and after-care associations in the assessment of trained mental defectives, and in the monitoring of their rehabilitation. Social service workers were also expected to be an advocate for the mentally defective child and to be the 'principal executive officer' of local social service [after-care] associations. A social service worker was attached to each of the Wellington and Auckland psychological clinics, which were set up under the auspices of the Eugenics Board. Social service workers carried out investigations and enquiries 'as may be desired by the examining doctor', visits to a child's home and school, obtaining social and personal history. Comprehensive reports were furnished on children's conditions and environments, including special features that may have influenced upbringing and behaviour. Social service workers gave priority to assessment work with the parents of children with behavioural problems. The field was large, with frequent visiting, making suggestions, watching the general health, and generally shepherding the child through difficulties. Suitable employment might be found for the child and when the child had settled into job, the professional relationship might be ended. The social service worker also took social histories of people seen at psychiatric outpatient clinics or admitted to Wellington Hospital for observation. She also undertook some pre-discharge liaison work with families and employers.

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21 Margaret Tennant, Paupers and Providers: Charitable Aid in New Zealand, Wellington, 1989, pp. 73-74, 143, 199.
23 AJHR, 1930, H-7, p. 3.
Social workers next appeared as part of the far-reaching plans for law reform proposed by J. Russell, acting Director-General in 1947. In November 1947, the Minister announced that a social worker would be appointed to each major mental hospital, as soon happened. If the experience of a pioneer psychiatric social worker at Porirua is indicative, they were left to their own devices to establish a role that generally followed their own interests. Hospital staff were not briefed in advance about the role. Lacking medical referrals from within the hospital, the Porirua social worker decided to work with the outpatient clinic at Wellington Hospital. Some joint family interviews were also held. Other social workers helped find jobs for patients on leaving hospital. These tasks matched the envisaged official role. The appointment of 'social service workers' (social workers) to the Auckland and Wellington child guidance clinics was so successful that Gray sought views on extending the concept to rehabilitation of patients.

Like social work, professional occupational therapy was not unique to mental health services. Its origins can be traced to the rehabilitation of physically and mentally disabled servicemen during and after World War I. Like psychiatric social work, too, professional occupational therapy was introduced to mental hospitals as ancillary treatment under medical sponsorship. Gray, it seems, had not originally looked beyond New Zealand for someone to lead this development, but he changed his mind, probably upon Buchanan's

26 Acting Director-General to Minister, 13 August 1947, HMH 8/50/0.
28 Acting Director-General to Secretary, Public Service Commission, 27 March 1947, HMH 8/50/0.
29 Director to Minister, 19 March 1954, HMH 8/54/0.
30 Wendy Hunter Williams, Out of Mind out of Sight: The Story of Porirua Hospital, Porirua, 1987, pp. 219-20.
31 Director to Minister, 2 July 1948, Health Department Archives, National Archives, Wellington, File H 30/38 (30451).
32 Acting Director-General to Secretary, Public Service Commission, 27 March 1947, HMH 8/50/0.
33 Director-General to Medical Superintendent Auckland, 2 July 1935 and reply, 8 August 1935, Carrington Hospital Archives, National Archives, Auckland, YCAA 1079/7C, file 5/57/1.
34 Unpublished notes on Occupational Therapy in New Zealand, c. 1956, pp. 2-3. A copy [source unknown] is held among the author's papers.
recommendation. Miss M. Inman, who was a qualified nurse and graduate of the School, was appointed Supervisor of Occupational Therapy and arrived in 1940 to establish a role for the discipline in mental hospitals by training nurses. A pioneer occupational therapist at Porirua described her work in 1945. She held craft work classes in the admission, refractory and long-stay wards several times a week. Patients might unravel condemned woollen clothing, do simple knitting, sewing, weaving, or rug making, according to their mental and physical capacities. Games sessions were run, including team games, action songs, basketball, and simple country dancing. From time to time, social evenings were held with party games, novelty dances and competitions. The O.T. was storyteller to mentally defective children.

Dentistry was another area of specialized professional treatment. Little is known about policy in this field but it seems reasonable to suppose that specialized dental treatment may have been provided privately to patients with means. Otherwise simple emergency dental treatment was probably undertaken by medical staff; complicated procedures by referral to a dental practitioner. This pattern is suggested by the small amounts spent on dental treatment once expenditure was isolated in departmental reports from 1923. A qualified dentist was attached to the staff at Sunnyside Mental Hospital about 1939. The history of Porirua Hospital suggests that this dentist had a department-wide responsibility to provide dental care to patients and to promote dental hygiene. Clinics were held during extended visits to each hospital. In 1947, a second appointment was made and the work reassigned on a regional basis.

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37 AJHR, 1923, H-7, p. 24. For example, the amount of £3.3s.0d. spent at Porirua is consistent with a scale of professional fees. The total expenditure that year was £64.19s.0d. Auckland and Nelson recorded no expenditure on this item at all.

38 Public Service Classification List, *New Zealand Gazette*, 13 November 1940, p. 3282. The date is derived from details of public service.

39 Williams, pp. 265-7.
CUSTODY AND CARE

As their title implies, attendants were responsible for the safe-custody of patients and for attending to their daily needs and personal care. The likely model was the comprehensive set of revised regulations for Sunnyside Asylum (1883), which, in turn, was probably drawn from English precedents. Job expectations were codified in highly prescriptive national rulebooks and institutional orders. General civil service rules were complemented by particular expectations of persons working with the insane. Legal obligations were specified, and situations of particular risk to patients were anticipated. Rules about obvious dangers were spelt out in great detail, as can be gauged from the summary of staff rules contained at the end of this appendix.

A dual role was acknowledged in the rulebook's constant exhortation that attendants were not 'keepers only, but companions and nurses'. Staff were reminded to employ and amuse the patients as much as possible, because 'idleness and listlessness among patients often indicates indifference on the part of attendants', which MacGregor loathed. Attendants were expected to set an example to the patients of obedience, cleanliness, honesty, intelligence, diligence, sobriety, work, service, tact and courteous official

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40 Christchurch Lunatic Asylum, Regulations for the Guidance of Attendants, Wellington, 1883. The format is very different from the previous local Regulations of 1875 that were published in the New Zealand Gazette, 1875, pp. 123-8. The similarity between many of the rules of 1883 and those of the West Riding Pauper Lunatic Asylum (1873) suggests them as a possible source. J. Sheehan, 'The role and rewards of asylum attendants in Victorian England', International History of Nursing Journal, 3, 4, 1998, pp. 25-31.

41 Nelson Lunatic Asylum, Rules and Instructions for the Guidance of Attendants, Wellington, 1886, p. 6; Auckland Lunatic Asylum Rules, August 1900, No. 26, Carrington Hospital Archives, National Archives, Auckland Office; Mental Hospitals Department, General Rules and Instructions for the Guidance of the Nursing Staff and Other Workers, Wellington, 1910, p. 9; Mental Hospitals Department, Rules and Regulations for Nurses, Wellington, 1928, p. 11; Mental Hospitals Department, Mental Hospitals: Rules for Staff, Wellington, 1940, p. 7.

42 Christchurch Lunatic Asylum, pp. 2-3.

43 The exemplar role was also set out in the locally produced "Aphorisms for Attendants" at Sunnyside, which included the following:

A want of occupation, gives no rest.
A mind quite vacant is a mind distressed...
relationships. They were expected to be agents of medical staff by observing and reporting changes in the bodily or mental condition or behaviour of the patients, or unusual incidents in the ward. Attendants were also charged with maintaining an orderly and hygienic ward environment. The attendant was a general factotum.  

J. Green recalled that at Seaview male attendants did all the work, domestic, cooking - the male nurses would work on the grounds, butchers [sic] shop, van driving, cleaning drains, cleaning all the old coal ranges, cooking in the main kitchen and work with the patients on the painting gangs.  

**ADMINISTRATION**

Clerical support functions grew from the record keeping required by lunacy law. They also grew from the differentiation between administration and medical management, when the lay superintendents of Christchurch and Dunedin Asylums became house stewards. At Sunnyside, the change left Seager to manage the store, kitchen, and farm departments under the direction of the Medical Superintendent. Later titles of clerk or clerk and storekeeper imply that the dignified designation 'House Steward' was chosen to soften the blow to those superintendents whose jobs had been

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Look upon them as children, try and teach them self-control and self-respect by a good example.

Consider the various trusts with which you are invested, in a manner as nothing as compared with the sacred duty of protecting those who are visited with madness, it is as much a Disease as any with which it pleases GOD to affect mankind.

Physician-Superintendent, Sunnyside to Mayor, Christchurch, 7 October 1884, L. 476/84, Christchurch City Council Archives, National Archives, Christchurch.

44 See, for example, Seaview School of Nursing Reunion Committee, *Memories*, Hokitika, 1992, pp. 3-4, 13, 14-16; Williams, quoting former nurses at Porirua, c. 1940, pp. 178-84.

45 Seaview School of Nursing Reunion Committee, p. 15. Cf. Williams, pp. 194-5.

46 Lunatics Act 1868, ss.23- 24, 26-7; Lunatics Act 1882, s. 51 and Part III.

47 In contemporary British nomenclature, the steward was analogous to a storekeeper and subordinate to the Clerk. In some asylums these offices were combined. H.C. Burdett, *Hospitals and Asylums of the World*, Volume I, London, 1891, p. 202.

downgraded. Specialization even within those departments assigned to a house steward also occurred to the point that estate management acquired its own organizational structure. A farm manager was appointed to Seacliff in 1887 with clear instructions from MacGregor about efficiency: the estate was to be regarded not as a model farm but a paying one. The farm manager was also enjoined to utilize patient labour to the utmost under the control of the medical superintendent. A farm or estate manager and works overseer was eventually appointed to each institution. If British asylum practice were adopted here, then workshops and artisan staff would have remained the nominal responsibility of clerical staff.

Administrative, clerical, accounting, record-keeping and stores management became the responsibility of a position later identified as the chief clerk, rather than house steward. Other clerks, storekeepers and office assistants helped him. In 1910, they were receivers of maintenance (shortly to be transferred to the head office), attended to correspondence, maintained statutory notices and books, requisitions and checking of supplies, keeping tally of produce consumed and sold, stores issued and received. They were 'very fully occupied'. Staff supervision was gradually dispersed among the various groups of occupations with the medical / superintendent retaining disciplinary powers as part of overall accountability for the running of the institution.

HOUSEHOLD MAINTENANCE AND FARMING

The common element of the work of trades and domestic, transport, farm and garden staff was its contribution to the maintenance of the buildings, plant, equipment, and land. The servicing of heating, lighting, cooking, laundry and ventilation systems and plant required mechanical engineering expertise. Other skilled labour came, at first, from a pool of skilled tradesmen who were

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49 Inspector-General to Farm Manager, Seacliff, 13 August 1887, Internal Affairs Department Archives, National Archives, Wellington, File IA 102/2.
50 Burdett, Volume 1, p. 226.
51 AJHR, 1910, H-7, p. 9.
also employed as attendants. By day, such a butcher, baker, boot maker, upholsterer, bricklayer, painter or carpenter pIed his trade around the institution. He also supervised a small number of worker-patients assigned to him at that workshop. Artisan attendants then assisted with ward duty in the early evenings. A decision to discontinue the position of (male) artisan-attendants was made in 1913 when they complained about their double duties. A decade later, however, little progress had been made as the topic still rated on the medical superintendents’ conference agenda. A new occupational class of artisan was recognized from 1926.

From Victorian times, asylums employed some domestic workers, usually women, who came under the matron’s responsibility for household management. Although, as has been mentioned, attendants were expected to do much of the cooking and cleaning around a mental hospital, these tasks were slowly allocated to cooks and laundry workers and their assistants. Decentralized kitchens were an important feature of the villa system, and contributed to the increase in the number of male and female cooks. Similarly, the category of domestic staff was separated from that of female attendants. The first wards maids were appointed in 1907. They did the housework in matron’s rooms and undertook non-nursing duties in the wards. Wards maids were employed in only very small numbers, so that the bulk of such work fell to trusty ‘pensioner-patient[s].’ The establishment of domestic positions officially freed attendants to concentrate on other aspects of their work, but as Kennedy recalled, little changed:

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52 Burdett, Volume I, pp. 230-1.
53 Medical Superintendent, SeacIiff to Inspector-General, 20 March 1913, HMH 1913/389.
54 Agenda for Medical Superintendents’ Conference, 20 June 1923, HMH 8/94/1.
55 Inspector-General to Medical Superintendent Auckland, 19 May 1925, YCAA 1079/7k, File 6/5/-, and 2 September 1926, YCAA 1079/71, File 6/6/-.
56 AJHR, 1923, H-7, p. 5.
57 Notes on Supplementary Estimates, 18 May 1907 [?], HMH 1907/456.
The nurses did everything, except where patients would help and how we would ever have got on without the patients I really don’t know.\textsuperscript{58}

It must be remembered that the policy of work therapy meant that patient labour was indispensable to the smooth functioning of institutions. Most of this work was menial, acting in kitchens, laundries, sewing rooms, domestic chores in wards, carrying stores and supplies around the campus, as well as working about the farms and gardens.

\textsuperscript{58} Cited in Williams, p. 152.
# Table 19

SPECIALIZATION WITHIN MENTAL HOSPITAL JOB FAMILIES, SELECTED YEARS 1876-1947

<table>
<thead>
<tr>
<th>Year</th>
<th>Management and Administration</th>
</tr>
</thead>
<tbody>
<tr>
<td>1876</td>
<td>Inspector-General</td>
</tr>
<tr>
<td></td>
<td>Assistant Inspector</td>
</tr>
<tr>
<td></td>
<td>Head Keeper / Superintendent</td>
</tr>
<tr>
<td></td>
<td>Medical Superintendents</td>
</tr>
<tr>
<td></td>
<td>Clerk / Storekeepers</td>
</tr>
<tr>
<td></td>
<td>Asst Clerks / Storekeepers</td>
</tr>
<tr>
<td>1900</td>
<td>Inspector-General</td>
</tr>
<tr>
<td></td>
<td>Assistant Inspector</td>
</tr>
<tr>
<td></td>
<td>Medical Superintendents</td>
</tr>
<tr>
<td></td>
<td>Clerk / Storekeepers</td>
</tr>
<tr>
<td></td>
<td>Asst Clerks / Storekeepers</td>
</tr>
<tr>
<td>1925</td>
<td>Inspector-General</td>
</tr>
<tr>
<td></td>
<td>Assistant Inspector</td>
</tr>
<tr>
<td></td>
<td>Medical Superintendents</td>
</tr>
<tr>
<td></td>
<td>Clerk / Storekeepers</td>
</tr>
<tr>
<td></td>
<td>[Maintenance] Receiver</td>
</tr>
<tr>
<td></td>
<td>Asst Clerks / Storekeepers</td>
</tr>
<tr>
<td>1947</td>
<td>Deputy / Director-General</td>
</tr>
<tr>
<td></td>
<td>Director of Clinical Services</td>
</tr>
<tr>
<td></td>
<td>Chief Clerks</td>
</tr>
<tr>
<td></td>
<td>Assistant / Accountant</td>
</tr>
<tr>
<td></td>
<td>Senior Clerks</td>
</tr>
<tr>
<td></td>
<td>Clerks</td>
</tr>
<tr>
<td></td>
<td>Staff Clerks</td>
</tr>
<tr>
<td></td>
<td>Record Clerk</td>
</tr>
<tr>
<td></td>
<td>Clerks</td>
</tr>
<tr>
<td></td>
<td>Clerical Cadet</td>
</tr>
<tr>
<td></td>
<td>Office Assistants</td>
</tr>
<tr>
<td></td>
<td>Clerical Cadet</td>
</tr>
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<td></td>
<td>Office Assistants</td>
</tr>
<tr>
<td></td>
<td>Shorthand-Typists</td>
</tr>
<tr>
<td></td>
<td>Storemen</td>
</tr>
<tr>
<td></td>
<td>Storekeepers (Grades 1-2)</td>
</tr>
<tr>
<td></td>
<td>Senior Storemen</td>
</tr>
<tr>
<td>Year</td>
<td>1876</td>
</tr>
<tr>
<td>------</td>
<td>------</td>
</tr>
<tr>
<td><strong>Resident Surgeon / Medical Officer</strong></td>
<td>-</td>
</tr>
<tr>
<td><strong>Visiting Medical Officer / Surgeon</strong></td>
<td>-</td>
</tr>
<tr>
<td><strong>OTHER TREATMENT</strong></td>
<td>-</td>
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<tr>
<td>Musical Inspector</td>
<td>-</td>
</tr>
<tr>
<td><strong>ATTENDANTS (Male)</strong></td>
<td>Head Keeper / Chief Attendant</td>
</tr>
<tr>
<td>Senior Keeper</td>
<td>-</td>
</tr>
<tr>
<td>Attendants/Night Attendants</td>
<td>Attendants</td>
</tr>
<tr>
<td><strong>ATTENDANTS (Female)</strong></td>
<td>Matrons</td>
</tr>
<tr>
<td>Matrons</td>
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</tr>
<tr>
<td>Year</td>
<td>Female Attendants</td>
</tr>
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<td>-------------------</td>
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<tr>
<td>1875</td>
<td>Female Attendants</td>
</tr>
<tr>
<td>1900</td>
<td>Female Attendants</td>
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<tr>
<td>1925</td>
<td>Nurses</td>
</tr>
<tr>
<td>1947</td>
<td>Nurses</td>
</tr>
</tbody>
</table>

**HOUSEHOLD**

- Kitchen Maid
  - Cook (Female)
  - Assistant Cook
- Cooks (Male)
  - Cooks (Male)
- Kitchen Lad
  - Cooks (Male)

**Laundresses**

- Laundresses
- Assistant Laundress

**Farm / Gardens**

- Farm Managers
- Farm Bailiff / Caretaker
- Estate / Farm Managers
- Farm Overseers
- Farm Managers (Grades 1-3)
- Farm Overseers
<table>
<thead>
<tr>
<th>1876</th>
<th>1900</th>
<th>1925</th>
<th>1947</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Section Hands</td>
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<td></td>
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<td>Farm Hands</td>
</tr>
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<td></td>
<td></td>
<td>Orchard</td>
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<tr>
<td>Farm Hand / Labourer</td>
<td>-</td>
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<td>Head Gardeners (Grades 1-2)</td>
</tr>
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<td></td>
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<tr>
<td></td>
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<td>Poultymen</td>
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<td>BUILDINGS / TRADES</td>
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<tr>
<td>Assistant / Engineers</td>
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<td>Assistant / Engineers</td>
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<td></td>
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</tr>
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<td>Bakers</td>
<td>Bakers</td>
<td>Bakers</td>
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<td></td>
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<td></td>
<td>Blacksmiths</td>
<td>Blacksmiths</td>
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<tr>
<td></td>
<td>Bootmakers</td>
<td>Bootmakers</td>
<td></td>
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<tr>
<td></td>
<td>Bricklayers</td>
<td>Bricklayers</td>
<td></td>
</tr>
<tr>
<td>Butcher</td>
<td>-</td>
<td>-</td>
<td>Butchers (Grades 1-2)</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Carpenter</td>
<td>Carpenters</td>
<td>Carpenters</td>
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<tr>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Electricians</td>
<td>Electricians</td>
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<tr>
<td></td>
<td>Engine-drivers</td>
<td>Engine-drivers</td>
<td></td>
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</tr>
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<td>Firemen</td>
<td>Fitters</td>
<td>Fitters</td>
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<td></td>
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<tr>
<td></td>
<td>Painters</td>
<td>Painters</td>
<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td>Plasterer / Bricklayer</td>
<td>Plumbers</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plumber-Attendant</td>
<td>Plumbers</td>
<td>Plumbers</td>
<td></td>
</tr>
<tr>
<td>Year</td>
<td>Labourers</td>
<td>Skilled Labourers</td>
<td>Motor-drivers</td>
</tr>
<tr>
<td>------</td>
<td>-----------</td>
<td>------------------</td>
<td>---------------</td>
</tr>
<tr>
<td>1876</td>
<td>-</td>
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</tr>
<tr>
<td>1900</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>1925</td>
<td>-</td>
<td>-</td>
<td>Motor-drivers</td>
</tr>
<tr>
<td>1947</td>
<td>Labourers</td>
<td>Skilled Labourers</td>
<td>Motor-drivers / Chauffeurs</td>
</tr>
</tbody>
</table>

Sources: AJHR, 1876-1900, Estimates of Expenditure; Public Service Classification Lists, New Zealand Gazette, 1925-47.
### Table 20: Duties of Attendants and Medical Staff as Outlined in Departmental Rule Books, 1883-1940.

**General Roles and Responsibilities of Nurses / Attendants**

<table>
<thead>
<tr>
<th>Exemplar</th>
<th>1883</th>
<th>1901</th>
<th>1910</th>
<th>1928</th>
<th>1940</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obeys all orders</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Sobriety, Subordinate, Stock control</td>
<td>4</td>
<td>5</td>
<td>5</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Is properly dressed when on duty</td>
<td>7</td>
<td>12</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Remains on duty</td>
<td>8</td>
<td>13</td>
<td>15</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Males do not enter female department (and vice versa) without permission</td>
<td>12</td>
<td>30</td>
<td>34</td>
<td>9</td>
<td>-</td>
</tr>
<tr>
<td>Remains calm but determined with irritated or difficult patients</td>
<td>15</td>
<td>20</td>
<td>22</td>
<td>28-9</td>
<td>23</td>
</tr>
<tr>
<td>Sets an example of work</td>
<td>42</td>
<td>23</td>
<td>26</td>
<td>31</td>
<td>22</td>
</tr>
<tr>
<td>Maintains patient and institutional confidentiality</td>
<td>45</td>
<td>7</td>
<td>8</td>
<td>12</td>
<td>6</td>
</tr>
<tr>
<td>Does not use patient labour or financial transactions for personal gain</td>
<td>47-8</td>
<td>24-5</td>
<td>28</td>
<td>14-15</td>
<td>25</td>
</tr>
<tr>
<td>- without Medical Superintendent's permission</td>
<td>-</td>
<td>-</td>
<td>26</td>
<td>14-15</td>
<td>25</td>
</tr>
<tr>
<td>Is trustworthy with stores</td>
<td>49</td>
<td>26</td>
<td>30</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Receives visitors or strangers only with official permission</td>
<td>51</td>
<td>11</td>
<td>12</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Receives no gratuities or consideration from outsiders</td>
<td>-</td>
<td>9</td>
<td>29</td>
<td>14</td>
<td>25</td>
</tr>
<tr>
<td>Treats all without fear of favouritism</td>
<td>-</td>
<td>22</td>
<td>25</td>
<td>30</td>
<td>-</td>
</tr>
<tr>
<td>Keeps a clean and tidy room with dangerous items locked up</td>
<td>-</td>
<td>-</td>
<td>13</td>
<td>11</td>
<td>10</td>
</tr>
<tr>
<td>Acts in a spirit of teamwork</td>
<td>-</td>
<td>-</td>
<td>14, 21</td>
<td>12</td>
<td>11</td>
</tr>
<tr>
<td>Reports breaches of discipline</td>
<td>-</td>
<td>-</td>
<td>15</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Uses minimal force for restraint with no dangerous holds</td>
<td>-</td>
<td>-</td>
<td>23</td>
<td>29</td>
<td>38</td>
</tr>
<tr>
<td>Does not bring alcohol onto estate without permission</td>
<td>-</td>
<td>-</td>
<td>11</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Remains a full-time officer with no outside work except by permission</td>
<td>-</td>
<td>-</td>
<td>28</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

**Official relationships**

<table>
<thead>
<tr>
<th>Oblong orders</th>
<th>1883</th>
<th>1901</th>
<th>1910</th>
<th>1928</th>
<th>1940</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communicates with [Medical] Superintendent through Matron / Head Attendant</td>
<td>6</td>
<td>6</td>
<td>-</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Remains within male / female division as attendant / nurse</td>
<td>12</td>
<td>30</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Uses formal honorific when addressing other staff</td>
<td>-</td>
<td>-</td>
<td>27</td>
<td>12, 32</td>
<td>11, 20</td>
</tr>
<tr>
<td>Is not familiar when addressing patients</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>12</td>
<td>11</td>
</tr>
<tr>
<td>Wears mufli when with patients outside the estate</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>17</td>
<td>15</td>
</tr>
</tbody>
</table>
Directs inquiries about patient care to medical staff
Does not send / Obtain permission to send patients' correspondence

Safe-Custody
Locks up all medicines
Is responsible for safe-keeping of patients under their care
Prevents violence
Obtains assistance for restraint
Removes razors from wards
Observes all patients, especially the dangerous or possible escapees
Counts patients at meal times
Removes day clothes from patients at night
Counts and locks up knives, and carving fork and knife after meals
Searches for missing knives
Locks attendants' rooms, sculleries, bedrooms, stores, cupboards
Leaves no water in baths and sinks
Keeps brooms, knives and scissors out of reach
Collects all glass fragments from broken windows
and broken crockery
Searches beds, clothing etc. of suicidal patients or rubbish hoarders
Aware of duty in event of fire
and with care of dangerous things; and bathing rules
Always wears keys secured by strap or chain
Accompanies walking parties at front and rear
Frequently and irregularly counts non-parole patients
Stays with patients and distributes attention among them
Knows patient numbers on walking parties
Signs and accounts for constant observation patients
Constantly stays with patients on constant observation

Patient Care
Employs and amuses patients as much as possible
Keeps patients clean

<table>
<thead>
<tr>
<th>1883</th>
<th>1901</th>
<th>1910</th>
<th>1928</th>
<th>1940</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

- 45  9  -  7  7 |
- 51 11 10 37 27 |
Cuts hair properly | 1883 | 1901 | 1910 | 1928 | 1949
---|---|---|---|---|---
Pares nails | 16 | 36 | - | - | -
Assists in shaving patients under medical direction with safety razor. Med Supt can authorise shaving by patients | 17 | 32 | 40 | - | 35
Bathes patient on admission and weekly thereafter | - | - | - | 40 | -
Properly dresses patients | - | - | 40 Bath R. 1 | 41 | -
Maintains order during meals, and help patients who need feeding | - | - | - | - | -
Ensures food is equally distributed to all | - | - | - | - | -
Encourages use of knives and forks whenever safe and possible | - | - | - | - | -
Groups patients at meals according to manners | - | - | - | - | -
Prevents patients leaving meals with food | - | - | - | - | -
Changes patients' clothes on admission and weekly thereafter | - | - | - | - | -
Puts patients to bed at appointed hour | - | - | - | - | -
Uses skills to divert patients' from brooding or delusions | - | - | - | - | -
Corrects bad habits and language or disgusting tendencies | - | - | - | - | -
Ensures that patients wear night attire | - | - | - | - | -
Gives patients opportunity for washing and tidying | - | - | - | - | -
Ensures paper, envelopes and pens available for patients | - | - | - | - | -
Treats individual patients with appropriate liberty / security | - | - | - | - | -
Does not punish patients | - | - | - | - | -

Observation and Reporting
Reports daily on bodily examination for bed sores, etc. | 16 | 36 | - | - | -
Reports illness, examine faeces, diet, delusions | 20 | 17 | 19 | 40 | -
Reports emergency seclusion or restraint | 25 | 21 | 24 | 42 | -
Reports patient deaths to Matron / Head Attendant | 27 | 28 | 32 | 33 | -
Reports escapes, accidents, sudden illness | 28 | 27 | 32 | 33 | 17
Reports changes of condition of patient | - | - | - | 33 | 24
Reports improper or disgusting acts | - | - | - | 20 | 41

Institutional Order and Environmental Hygiene
Removes dirty laundry promptly | 32 | - | - | - | -
Prevents food hoarding by patients | 34 | 34, 39 | - | - | -
<table>
<thead>
<tr>
<th></th>
<th>1883</th>
<th>1901</th>
<th>1910</th>
<th>1928</th>
<th>1940</th>
</tr>
</thead>
<tbody>
<tr>
<td>Keeps closets clean</td>
<td>36</td>
<td>44</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Keeps wards clean and conducted on the lines of a house</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>21</td>
</tr>
<tr>
<td>Keeps bedding and furniture tidy, clean and fumigated</td>
<td>37</td>
<td>44</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Unlocks doors at stated hours</td>
<td>39</td>
<td>-</td>
<td>13</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Opens windows in morning</td>
<td>-</td>
<td>12</td>
<td>13</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Replaces stock monthly</td>
<td>39</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Submits weekly requisitions for stores and supplies</td>
<td>-</td>
<td>41</td>
<td>-</td>
<td>37</td>
<td>-</td>
</tr>
<tr>
<td>Reports mechanical faults affecting security</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
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<tr>
<td>Professional Development</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Studies diligently towards professional registration</td>
<td>-</td>
<td>-</td>
<td>3</td>
<td>4</td>
<td>-</td>
</tr>
<tr>
<td>Knows instructions for dealing with choking</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>36</td>
<td>-</td>
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</table>

**CHARGE ATTENDANTS**

<table>
<thead>
<tr>
<th></th>
<th>1883</th>
<th>1901</th>
<th>1910</th>
<th>1928</th>
<th>1940</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reports and Records</td>
<td>43</td>
<td>40</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Prepares ward daily report</td>
<td>43</td>
<td>40</td>
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</tr>
<tr>
<td>Prepares diet book</td>
<td>43</td>
<td>40</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Prepares laundry list</td>
<td>43</td>
<td>40</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Prepares mending list</td>
<td>43</td>
<td>41</td>
<td>-</td>
<td>20</td>
<td>-</td>
</tr>
<tr>
<td>Prepares stock sheets</td>
<td>43</td>
<td>40</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Prepares monthly returns of bedding and clothing</td>
<td>43</td>
<td>43</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Prepares weekly report</td>
<td>43</td>
<td>43</td>
<td>46</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Prepares condemned sheets</td>
<td>44</td>
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</tr>
<tr>
<td>Prepares money report on value of pellont work</td>
<td>-</td>
<td>-</td>
<td>45</td>
<td>20</td>
<td>43</td>
</tr>
<tr>
<td>Ensures the safe-custody of all ward stock</td>
<td>-</td>
<td>-</td>
<td>47</td>
<td>20</td>
<td>46</td>
</tr>
<tr>
<td>Ward Environment</td>
<td>-</td>
<td>-</td>
<td>48</td>
<td>21</td>
<td>46</td>
</tr>
<tr>
<td>Cleanliness of bedding, furniture etc.</td>
<td>-</td>
<td>-</td>
<td>48</td>
<td>21</td>
<td>46</td>
</tr>
<tr>
<td>Ensures cleanliness and scrubbing of ward, ventilation, temperature</td>
<td>-</td>
<td>-</td>
<td>48</td>
<td>21</td>
<td>46</td>
</tr>
<tr>
<td>Ensures closets odour-free and urinals flushed</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>21</td>
<td>46</td>
</tr>
<tr>
<td>Adequate supplies of soap, towels, toilet paper and sanitary towels</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>46</td>
</tr>
<tr>
<td>Reports broken windows</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>44</td>
<td>-</td>
</tr>
</tbody>
</table>
### Staff Supervision

**Ward level**
- Report breaches of discipline to Matron / Head Attendant
- Formally takes / hands over ward charge each shift

### Patient Care
- Patients tidy and suitably dressed
- Ensures meals served promptly and tastefully

### Training Junior Nurses
- Ensures nurses receive sound training
- Sets example to nurses
- Reports merits and misconduct of staff to head attendant / matron

### Institutional Order
- Senior Attendant says grace before meals

<table>
<thead>
<tr>
<th>Matrons and Head Attendants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ensures staff carry out their duties</td>
</tr>
<tr>
<td>Spends time on wards, villas, workshops, occupational centres etc.</td>
</tr>
<tr>
<td>Reports any allegation of assault to Medical Superintendent</td>
</tr>
<tr>
<td>Attends admission of any patient, Observes bathing to report injuries or disease to medical officer</td>
</tr>
<tr>
<td>Ensures list made of patient's possessions on admission and how disposed of</td>
</tr>
<tr>
<td>Attends all patients' entertainments</td>
</tr>
<tr>
<td>Ensures bathing apparatus operating on bathing days</td>
</tr>
<tr>
<td>Ensures all staff receive first aid for choking within one month</td>
</tr>
<tr>
<td>Ensures Institutional hygiene and sanitation, e.g. rubbish, sanitation</td>
</tr>
<tr>
<td>Reports concerns about quality, quantity and timeliness of meals</td>
</tr>
<tr>
<td>Encourages wearing of private clothes by patients</td>
</tr>
<tr>
<td>Monitors size, fit and suitability of institutional clothes, and draws attention of charges to slackness</td>
</tr>
</tbody>
</table>
Promotes occupation and recreation among patients as part of individual treatment
May inspect quarters occupied by staff

**HOME SISTER**
Ensures discipline and good conduct prevail in nurses' home
Reports discipline matters to Matron

N.B. Standard nursing duties only, not night attendants

**MEDICAL OFFICERS**

| Handle all inquiries from relatives about patients' condition | - | - | - | - | 7 | 7 |
| Acts on reports of changes of condition, accidents, injury, escape, sudden illness or death | - | - | - | - | 19 | 33, 40 | 17 |
| May censor patient's letters | - | - | - | - | - | 37 | 27 |
| Authorises use of single rooms by patient under constant observation | - | - | - | - | - | 36 | 39 |
| May place patients under constant observation notice | - | - | - | - | - | 36 | 39 |
| May issue / renew seclusion or restraint order | - | - | 24 | - | - | 42 | 28 |
| May vary temperature of patients' bath water outside specified range | - | - | - | - | - | Bthg R. 4 | - |
| May issue special bathing instructions if weekly bath not possible | - | - | - | - | - | Bthg R. 5 | - |
| May authorise cold bath | - | - | - | - | - | Bthg R. 10 | - |
| Acts on nursing reports of changes in patient's condition | - | - | - | - | - | 24 | - |
| May vary patient's privileges | - | - | - | - | - | - | 28 |
| May relieve nursing staff from ward duty | - | - | - | - | - | - | 30 |
| Authorises male patients to use safety razors | - | - | - | - | - | - | 35 |
| May authorise individual patients to bathe / shower privately | - | - | - | - | - | - | 41 |
| Undertakes any other duties set by Minister or under Act | Act | Act | Act | Act | Act | Act | Act |
| Keeps weekly report book, case books, prescription books, registers of seclusion and restraint; and post-mortems | Act | Act | Act | Act | Act | Act | Act |
| May recommend / cancel trial leave | Act | Act | Act | Act | Act | Act | Act |
| May recommend discharge of committed patients | Act | Act | Act | Act | Act | Act | Act |

**MEDICAL SUPERINTENDENTS**
May terminate services of staff on probation
Deals with staff discipline matters  
Considers complaints and suggestions by staff  
Sanctions private work done for staff by patients or workshops  
Determines price to be paid for work done by patients for staff  
Authorises alcoholic liquor to be brought onto estate by staff  
May relieve nursing staff from ward duty  
Acts on reports of accidents, injury, escape, sudden illness or death  
Authorises male patients to use safety razors  
May order restrictions on a patient's outward correspondence  
Reviews constant observation notices each month  
May revoke constant observation notices  
Approves visiting arrangements for nurses' homes  
May inspect quarters occupied by staff  
Acts on reports of emergencies  
Ensures that fire safety inspections made twice yearly  
(Determines what lectures staff shall take and when)  
May vary conditions of constant observation  
(May authorise other paid work by staff  
May permit male staff to enter female division and vice versa  
Authorises patients to be shaved  
Ensures statutory registers are kept and maintained  
Notifies Inspector-General of admissions, discharge, transfer, death, escape

<table>
<thead>
<tr>
<th>Source</th>
<th>1883</th>
<th>1901</th>
<th>1910</th>
<th>1928</th>
<th>1940</th>
</tr>
</thead>
<tbody>
<tr>
<td>Christchurch Lunatic Asylum, Regulations for the Guidance of Attendants, Wellington, 1883; Lunatic Asylums Department, Rules and Instructions for the Guidance of Attendants in Lunatic Asylums in New Zealand, Wellington, 1901; Mental Hospitals Department, General Rules and Instructions for the Guidance of the Nursing Staff and other Workers, Wellington, 1910; Mental Hospitals Department, Rules and Regulations for Nurses, Wellington, 1928; Mental Hospitals Department, Mental Hospitals: Rules for Staff, Wellington, 1940.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
BIBLIOGRAPHICAL AND BIOGRAPHICAL NOTE

A. PRIMARY SOURCES

1. Unpublished Records and Archives
   (a) Official
      (i) Archives held at the National Archives, Wellington
      (ii) Archives held at the National Archives, Auckland
      (iii) Archives held at the National Archives, Christchurch
      (iv) Archives held at the National Archives, Dunedin
      (v) Records held at Psychiatric Hospitals
      (vi) Records held in Other Locations
      (vii) Records whose current whereabouts are unknown
   (b) Private Papers
   (c) Unpublished Theses and Dissertations

2. Publications
   (a) Official
      (i) New Zealand National
      (ii) New Zealand Local
      (iii) Overseas
   (b) Journals
   (c) Newspapers
   (d) Books
   (e) Articles

3. Interviews

B. SECONDARY SOURCES

1. Books
   (a) Official
      (i) New Zealand
      (ii) Overseas
   (b) Other

2. Articles

3. Audiovisual

4. Unpublished Theses and Dissertations

5. Unpublished Conference and Miscellaneous Papers
My thesis refers on a number of occasions to files or documents whose current whereabouts are unknown. Much of the research for my thesis was undertaken in the late 1960s and early 1970s, when proper protocols had not been established for access to personal information and patient confidentiality. Many of my primary sources were still stored at mental hospitals run by the Department of Health’s Division of Mental Health. The divisional director, Dr S.W.P. Mirams, kindly granted me full access to those institutional and head office records, including personal files of patients. I shall always remain indebted to him for encouraging me to apply my historical insights to present day problems as a health policy analyst. The temptation was irresistible, so as my 24-year career in the Department / Ministry of Health unfolded, research notes and cards were relegated to the ceiling of my home, always with the intention of returning to the topic one day. That opportunity arose in 1996, well into a period of unprecedented upheaval in the organization of the health and public sectors.

In the years between my initial research and writing up this thesis, psychiatric hospitals were administered by no less than five different organizations – the Department, hospital boards, area health boards, Crown health enterprises and hospital and health services – and subjected to numerous internal health service reorganizations. Under the policies of deinstitutionalization and fiscal pressure, psychiatric hospitals were run down and faced the threat of eventual closure, a fate that some already met, like Carrington (Auckland) and Cherry Farm (Waikouaiti). The Department of Health twice moved its headquarters between 1969-90. Major records storage areas were moved three times.

Major administrative disruptions have inevitably affected the fate of some of my primary sources. In the face of institutional run-down or closure, clinical and administrative records of Carrington, the Seacliff Group of hospitals, Seaview and Sunnyside Hospitals have been safely deposited with the National Archives or else they are in the process of transfer. The active and closed files of the main mental health series (H 30) of the Department’s head office have also been deposited with the National Archives. Those records have been given the appropriate National Archives citation throughout the thesis. Some administrative files of Sunnyside Hospital that date from the 1920s do not appear to have been transferred from Hillmorton, as the hospital is now known. The poorly preserved administrative files of Porirua Hospital are kept at that hospital.

The chequered lines of administrative responsibility for mental health within central government have made for a complex system of record keeping. This is shown in a confusing array of citations. In 1933 and subsequently, hundreds of mental health files of the Colonial Secretary’s Department were transferred from the Department of Internal Affairs to the Mental Hospitals Department, at the latter’s request. Details were carefully annotated in the correspondence registers of the Colonial Secretary’s Department. This correspondence was filed under the annual single number system (e.g., L. 1876/322). Former Mental Hospitals Department head office staff remembered that virtually all of that correspondence was pulped during World War II.
paper shortage. The lack of historical consciousness was evident in the seeming random pattern of the few surviving files that I located as a student. Some files that were current when the Mental Hospitals Department filing system was set up escaped destruction because they were incorporated into that system. Looking at the reverse side of wartime correspondence sometimes shows how other early files were recycled. The miscellany of surviving files has since been reintegrated into the Internal Affairs Department (IA) or Health Department, Mental Health Division (HMH) archives, where I have identified them as such.

The fate of other head office records is less determinable. A few historic records were once stored in a neglected corner of the Department's head office in the McCarthy Trust Building, Wellington, notably the original correspondence pertaining to the Seacliff Asylum Inquiry and Regina (F.T. King) v. Sydney Maxwell (MH 1891/2511), and volume 6 of the Inspector-General's outwards letter book (the only volume extant). These records are prefixed MH throughout the footnotes. I have been unable to trace these records since the Department moved to its present offices in 1989.

The Mental Hospitals Department established its own subject-based filing system from c. 1913. This continued to operate for some years after the amalgamation with the Health Department in 1947. Archived files from those series are prefixed HMH. I have identified those files that were not archived but kept at one of the Department's records storage by the prefix MH. Their present whereabouts is not so easily ascertainable. After discussing the point with former departmental colleagues, I am left with the impression that these records did not survive a move from the Stout Street storage room to the basement of the Bowen State Building some time in the 1970s.

Given its diverse activities, the Health Department's filing system was far more complex than that of the Mental Hospital Department. The Mental Health Division used series 30 of the multiple number classification of the Health Department's higgledy-piggledy system. Some of that series of files duplicated earlier Health Department files on, say, series 1 (nursing) or 37 (occupational therapy). Files about individual psychiatric hospitals were gradually incorporated into other series files concerned with hospital land and buildings or hospital boards. All of these files are identified by the prefix letter "H". As files were closed off for storage or archiving, they were given a closed file number, which is the number given in parentheses in my footnotes (e.g. H 30/4/7 (27465)). In c. 1985-6, series 30 files were closed off and a completely new mental health series (355) opened. In a symbolic gesture of dissociation by the new Ministry of Health (1993) from its departmental predecessor, what remained of the Department's files after appraisal was transferred to the National Archives in its entirety.

These arrangements did not affect the personal file held at one time on every patient at the head office, which was originally the Mental Hospitals Department's series 1. Apart from the files of special patients and a few notable patients, the only use I made of this collection was the file of Reginald Matthews MH 1/6650. I have followed the guidance of the Wellington Ethics Committee on the use of non-identifying clinical material. Particular sensitivity has been necessary in the case of Matthews and his fellow patient, Lionel Terry, where some information is in the public
domain, but much of it is not. I have used the personal and clinical files of each patient extensively. The mix of public and private information meant that it was impossible not to identify these two patients although hopefully in a manner that is not overly judgemental of the individuals concerned, as the Ethics Committee requested. The Department of Health granted me access to this material and permission to use it when the information was part of its records. Under current conditions, that information is no longer accessible. I was also privileged to interview Matthews at Lake Alice Hospital in 1970. Matthews readily agreed to the interview, but the process of obtaining agreement, through the medical superintendent, would not have met present-day consent standards. Access to the Justice or Prisons Department files on Terry and Matthews was kindly and informally arranged by the late Mr D.F. McKenzie, then Director of Research in the Department of Justice, under prevailing conditions for the exchange of information among Public Servants.

Changes in the public sector have affected a few very early records that I consulted in buildings since demolished. Despite my best efforts to trace them, I have been unable to find the fascinating journal of the Wellington Gaol (1849-51), which I found neglected in the basement of the Wellington Magistrate’s Court. It was entrusted to the care of a senior officer of the Justice Department who has since passed away. I consulted the Nelson Gaol diaries (1856-67) and recognized them among records in the custody of the Police Training College at Trentham. Despite the best efforts of the librarian, efforts to locate these unique accounts among the records of the Royal New Zealand Police Training College and Police Museum at Porirua have proved unavailing.
A. PRIMARY SOURCES

1. Unpublished Records and Archives

(a) Official

(i) Archives held at the National Archives, Wellington.

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Series 2 Provincial Superintendent’s Inwards Correspondence
Series 5 Provincial Superintendent’s Miscellaneous Papers

Child Welfare Division Archives [CW]
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Series 44 Oakley Hospital
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Series 47 Seaciff Hospital
Series 43 Seaview Hospital
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ABQU Mental Hospital Weekly Reports

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Series 9 Registers of Colonial Secretary’s Inwards Correspondence
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Hospital File Reginald Matthews (transferred from Lake Alice Hospital)

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3. Interviews

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