

Mental Health and Legal Landscapes

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When it was established early in the twentieth century, Tokanui became part of a network of mental hospitals that were responsible for the care and confinement of the insane and the mentally deficient. At the time of its construction Tokanui was the first new mental hospital commissioned in over 20 years and the first to be built in the central North Island. Of those mental hospitals operating in 1912 all, except Ashburn Hall (the country's only private institution), were government controlled and funded. State dominance in the management of mental abnormality was the result of an unofficial policy which followed English precedent, favouring government intervention in the belief that it produced beneficial results and which endorsed the conviction that government responsibility for such matters could not be divested to a third party. This position was strengthened by the paucity of a prosperous philanthropic class who would otherwise have bridged the gulf between demand and supply under the auspices of charity. The essence of this philosophy was reflected in the early nineteenth and twentieth-century legislation which governed the development and management of New Zealand's mental hospitals.

Centred on institutional care for the disturbed and confinement of the dangerous and unpredictable, this legislation shaped the course of Tokanui's existence by determining who fell under its jurisdiction and what procedures would be followed with regard to admission, treatment and discharge. In turn, Tokanui helped to create and maintain specific ideas about mental health for a local and a broader national context. With the aid of published government documents and two existing historical overviews, this chapter considers the relevance of legislative developments to Tokanui's story and, in turn, Tokanui's place in the wider narrative of mental health in New Zealand.

Legislative Background

Despite lofty ideals of a model society free from vice, crime, deviance and abnormality, the existence of insanity lent an early and particularly unpleasant taint to the social landscape of New Zealand. 'The

very presence of Pakeha misery in the new colony', observes Waltraud Ernst, 'constituted a challenge to the colonial dream, and to the growing myth of a better life, and of a future "ideal society" far from home'.

As early as 1841, only one year after New Zealand became a Crown Colony, the Supreme Court was given jurisdiction over 'idiots, lunatics and those of unsound mind who were unable to care for themselves or their estate'. A year later, following his apprehension by Auckland's chief constable for 'idly wandering about the town with no visible means of support', and for being 'apt' to 'pilfer' while he wandered, JH became the first officially recorded case of insanity in New Zealand. His arrest is significant not because it accurately pinpoints the advent of insanity in the dominion (almost certainly there were cases prior to JH's that went unrecorded), but because it marked a turning point in official responses to lunacy that reflected a growing concern over the threat which the mentally afflicted posed to the country's social equilibrium.

The first piece of legislation to directly address the issue of insanity in New Zealand was the Lunatics Ordinance of 1846. Closely modelled on corresponding law in New South Wales and South Australia and with roots in Georgian and early Victorian English statutes, its core tenets have become the foundation on which all subsequent legislation rests. The most significant of the Ordinance's provisions was allowing for the detention of persons exhibiting a 'derangement of the mind and a purpose of committing suicide or any crime'.

Once apprehended such individuals were brought before two justices of the peace who, calling on the opinion of two legally qualified medical practitioners, passed judgement on the sanity of the suspected lunatic. Foremost in their considerations would have been the threat which these individuals posed to public safety and, if their verdict was one of insanity, the justices were able to commit the lunatic to a gaol, house of correction, or public hospital. There they remained until they were removed to a public colonial lunatic asylum, or until they were either released into the custody of relatives, guardians or friends who were willing to assume responsibility for their care and control, or discharged, presumably on a verdict of sanity or public safety. However, in practice, legal provisions for lunatic asylums were more than a decade ahead of the supporting infrastructure and until the 1860s the majority of detained lunatics were inadequately confined in prisons or, less commonly, hospital wards.

Similarly, the requisite legal and medical sanctions for insanity of two justices of the peace and two medical practitioners proved difficult outside of the main settlements where a paucity of doctors, magistrates and secure facilities led to long, expensive journeys and only the most obvious and dangerous cases of insanity being certified. Provision for the care and maintenance of persons insane, but not dangerously so, was at the governor's discretion following an application from relatives, guardians or friends that had been sanctioned by a judge of the Supreme Court and was supported by two medical certificates. Although demand for private applications was, according to Brunton, steady, perhaps motivated by financial hardship or familial strain, in practice, non-dangerous lunatics were a low priority, only being catered for if space allowed once the dangerous had been secured.

Mainly concerned with admission procedures, in essence, Brunton observes, the Lunatics Ordinance served to legitimise existing practice.

The enactment of the Lunatics Ordinance a mere six years after the Treaty of Waitangi established New Zealand as a Crown Colony begs the question, according to Waltraud Ernst, why such measures were believed necessary given a relatively small European population that had ostensibly been deliberately selected for their good character and sound constitutions. Influenced by British reports of insanity as a colossus and those of other colonies which portrayed lunacy as a growing problem, one possible explanation for the early adoption of legislation by the colonial government was an exaggerated perception of issue, with insanity, in reality, being far less prevalent than was supposed. Of equal merit is the argument that lunacy laws were disseminated as a matter of course along with other British and colonial legislation as part of the colonising process, rather than out of necessity. One further explanation is that the legislation was adopted early in order to suppress lunacy and the challenge which it presented to the racial superiority which underpinned and legitimised the colonising directive.

Two amendments to the Lunatics Ordinance followed in 1858 and 1866 before the Lunatics Act (1868) consolidated the existing legislation into what was a considerably more lengthy and comprehensive document than its 1846 predecessor. Whereas the Ordinance was primarily concerned with the process for detaining dangerous lunatics, the 1868 Act paid greater attention to the sites where these lunatics were to be confined and to the care they were therein to receive. It prescribed greater and more uniform documentation and reporting which included standard forms for the certification, detention and release of lunatics, and registers, case books and journals that recorded largely statistical information, but also pertinent medical information. Further, the Act allowed for the setting up of licensed houses (private residences), made medical management a requirement for all asylums, whether public or private, set out inspection procedures and drew distinction between lunatics and lunatic patients, the latter referring to sufferers already under care in an asylum. It also paid considerable attention to the careful management of all lunatics' estates, especially with regard to how they could be used for their benefit, or in other words how they could be used to cover the cost of their care. The final part of the Act sought to avoid miscarriages of justice by outlining penalties for various offences, including the wrongful detention of an individual, falsification of documentation and applications, and the ill treatment of a lunatic or failing to keep them securely confined. Although the priority for committal remained with dangerous lunatics and the criminally insane, the Act also gave consideration to unsupervised, neglected and ill-treated lunatics and allowed for the curative treatment of drunkards. These changes reflected, if not direct concern for the plight of the mentally afflicted, then at least concern for public expectation. Essentially the 1868 Act was aimed at greater regulation of what had, up until that point, been the ad hoc provision of care. It shifted the focus away from the classification of lunacy towards procedures for confinement in an effort to ensure greater accountability and the more uniform provision of services.

The next piece of legislation to be enacted, and the first following the shift to central governance and the establishment of the Lunatic Asylums Department, was the Lunatics Act of 1882. One hundred and forty four sections longer than the previous act, it increased the amount of regulation and provided greater detail and clarity on all aspects of lunacy provisions. Of most consequence were the changes made to the restraining of lunatics, in particular the allowing of evidence from friends and relatives in cases where the individual in question had not been found lunatic by inquisition. Additionally, the Act distinguished between dangerous, criminal, and lunatics charged with indictable offences, these respectively being lunatics likely to commit a criminal act, prisoners found to be insane, and individuals excused of offences on the grounds of insanity. The Act also removed the distinction between lunatics and lunatic patients and created an entirely new part solely devoted to the treatment of habitual drunkards as separate from lunatics. The reclassification of drunkards is interesting because although provision was made for their "treatment" in asylums, there is a clear acknowledgement that the excessive and habitual imbibing of liquor was not a form of insanity. The measures therefore appear more as a means of social control and also suggest that the primary function of asylums was the safe keeping and control of individuals deemed dangerous because of their faulty and unpredictable mental capacity.

The emphasis and tone of the earliest lunacy legislation made insanity an issue of law and order, and as such responsibility for its management fell under the purview of government. Lunatics were apprehended because of the threat which their disordered and unpredictable behaviour posed to public safety, and, prior to the construction of specialist treatment facilities, the detained were confined at government expense in gaols and prisons along with criminals and given little differentiation in treatment. Government responsibility for lunatics was, however, equally dictated by the absence of traditional support networks. 'In colonial societies', notes Waltraud Ernst, 'absence, rather than mere inadequacy of family and parochial networks, appears to have been, initially at least, a strong impetus for the emergence of institutional care'. Where relatives did exist, their ability to finance, or personally care for destitute, lunatic relatives was more often negated by their own impoverished economic position. Further, the absence of a wealthy philanthropic class meant that there was little alternative to state provision for the destitute. In order to ensure public safety and maintain the Queen's peace, government was forced to assume responsibility for the bulk, if not all, of the cost of confinement

and care. However, Ernst argues for a more intentional motivation than that of residualism (left over responsibility), instead suggesting that government involvement was driven by a policy of social control that was reflected in official preference for public (state run) asylums and in changes to lunacy legislation which extended the definition of lunacy to incorporate a broader range of abnormal individuals.

The first of these legislative changes came in 1911, when one year prior to the opening of Tokanui the Mental Defectives Act was passed. Influenced by the British Royal Commission on the care and control of the feeble-minded (1908) and growing public awareness and concern, from 1910 onwards, over subnormal individuals, the Act, and one of its subsequent amendments in 1928, was 'intended', Adrienne Hoult informs us, 'to improve the care, control and treatment provided in mental hospitals, but also to limit the spread of mental deficiency'. Most significantly, the Act replaced the 'lunatic' classification with that of mental defective which encompassed persons of unsound mind, the mentally infirm, idiots, imbeciles, the feeble-minded and epileptics. The greater attention given over to what would nowadays be called mental disability reflected a belief that such individuals were responsible for many of society's more insidious problems, including alcoholism, prostitution, poverty and crime. In addition to reclassifying insanity, the 1911 Act made two other significant changes. Firstly it officially removed the term 'lunatic' from legal nomenclature, and secondly it provided for voluntary admission. Both changes were aimed at reducing the stigma of insanity, the first by replacing negative terminology with less tarnished alternatives as a way of shedding any undesirable associations, and the second by removing the necessity of judicial committal, in theory leading to a reduction in the association between insanity and criminality and suggesting a greater likelihood of recovery as sufferers who were not detained against their will were more likely to cooperate with treatment.

Once viewed as a burden (1860s-1880s), by the 1890s the mentally deficient had come to be viewed as a menace – a perspective which would gain greater following from the turn of the century, and especially into the 1920s. Anxiety, fuelled by the then popular eugenics movements, a 1924 committee of enquiry into mental defectives and sexual offenders, and Inspector-General Grey's 1927 report into mental deficiency and its treatment (largely an echo of the 1924 committee's findings), culminated in the 1928 Amendment to the Mental Defectives Act. The Amendment established the short-lived eugenics board, intended to monitor the mental deficiency situation and the resources available for its management, but most significantly introduced a new class of mental defective. The 'social defective' was conceived as an individual suffering from mental deficiency that was associated with conduct of an anti-social nature, such that they required supervision for their own protection and that of the public at large. The broad definition was not without its opponents but was defended as being necessary to reach abnormal individuals who would otherwise fall outside the statutory classifications of the Act.

Tokanui in the Legal Landscape

On 24 June 1912, Tokanui Hospital was officially written up under section 44 of the Mental Defectives Act (1911) as a 'building provided for the reception of mentally defective persons'. A little under a month later, on 17 July, the new mental hospital commenced operation following the transfer from Porirua of its first four patients. While the latter of these dates is usually the starting point for histories of Tokanui, a more accurate representation of its narrative would, in fact, begin at least five years earlier; before a name and even an exact location for the new mental hospital were decided.

Reports in the *Appendix to the Journals of the House of Representatives (AJHR)* show that by 1907 the Inspector-general, Frank Hay, had been given permission to plan and construct a new institution. With the requisite authority secured, the next step was to select an appropriate site for the prospective facility, which according to the 1907 report needed to 'possess natural features contributing to future economy in management', 'be sufficiently large for a mental hospital made up of detached buildings', be 'capable of very considerable extension' including 'space apart for other institutions or "colonies"', and be 'situated where the best pressure on other institutions' could be relieved.

Having selected a site approximately 14 kilometres (9 miles) south-east of Te Awamutu at Te Mawhai,

Mental Hospitals Department

Formed in 1876 as part of the move to central government, the Mental Hospitals Department, formerly Lunatic Asylums, was responsible for the management of mental deficiency and its associated institutions. The idea of a national inspectorate had first been mooted in the early 1870s as a way to combat the inequitable provision of care by the various provinces without assuming full control and causing central – provincial disharmony. Although agreed to in principle, the financial disincentive of salary provision caused government to shy away from establishing the position. When eventually it was allowed for in 1874 expenditure estimates it had already become caught up in the grander political manoeuvring to abolish provincial government and was intended more as a contingency for the changes that occurred in 1876 than as an immediate allocation of funds.

Hierarchically organised, the department was, according to Brunton, 'a state bureaucracy in the classic sense of the term, with its own function, mandate and rules'. Most significantly, it had a 'virtual monopoly' on the provision of psychiatric services thus affording it considerable power and authority.² Amid high ministerial turnover, the department provided stability and continuity making it indispensable to the policy making process. Although the organisational structure developed over time, primarily to include greater numbers of clerical staff and additional subordinate deputy and assistant management roles, from inception to amalgamation the department was led by the Inspector-General. Brunton summarises the position as follows:

Between 1876 and 1947, the Department had seven leaders: F W A Skae (1876-81), 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 seven departmental heads held office for an average of 10.1 years. Each departmental head served at least two ministers, some as many as seven.³

The Inspectors-General were chosen for their medical and specialist psychiatric qualifications and because their training and experience provided a British reference point. Skae and Grabham were recruited from Britain, but thereafter appointments were made locally, largely because it was cheaper to do so. Politically neutral and anonymous, these career civil servants confidentially provided ministers with expert advice, briefing them on a near daily basis in order to avoid potential political embarrassment and criticism. In addition to providing vital information they also kept up a punishing schedule of hospital inspections, played a central role in policy decisions and were responsible for the overall administration of the hospitals and associated personnel. Although assisted in the latter of these tasks by clerical staff, prior to the 1920s this assistance was confined to a single individual. As late as 1945 Gray expressed a desire to divest himself of the minutiae of administrative responsibility in order to concentrate on planning and policy:⁴ On top of these tasks came the production of the annual departmental report which gave account of the past year's activities while casting an eye to the coming year's operations. The reports generally commenced their review with an account of the composition and distribution of the hospital network's patient population, before discussing, in turn, hospital weekly reports, accommodation, farming operations, financial results, staff, and ending with the various medical superintendents' reports and a statistical appendix. Although a legal requirement, the reports gave the department a certain degree of liberty to air concerns and make a case for improvements, as in the case of the perpetually over taxed accommodation system.

Although there was occasional cooperation between the Mental Hospitals Department and the Department of Health on matters of mutual concern, the departments remained separate entities for much of the first half of the twentieth century, the former surviving major restructuring of the health administration, 'perhaps', Brunton suggests, 'because mental hospitals were seen as having a specialized function'.⁵ However, the coincidental retirement of both Director-General Gray and Dr MH Watt, the Director-General of Health, in 1947 presented an opportunity for departmental amalgamation, a plan that was lent currency by the examples of two Australian states whose mental hospitals were administered as part of their health departments. Thus on 25 November 1947 the Mental Hospitals Department became the Mental Hygiene Division of the Department of Health with the role of the Director-General, then held by J Russell, being reduced in status to a departmental directorship. 'The amalgamation [overseen by the Public Service Commission] was not well handled, observes Brunton, 'and Russell resigned on principle in early 1950. He later described the amalgamation as a "colossal mess-up from an administrative point of view".⁶

Notes

¹ Brunton, 'A Choice of Difficulties', p. 146.

² Brunton, 'A Choice of Difficulties', p. 147.

⁵ Brunton, 'A Choice of Difficulties', p. 144.

³ Brunton, 'A Choice of Difficulties', p. 146.

⁴ Brunton, 'A Choice of Difficulties', p. 176.

⁶ Brunton, 'A Choice of Difficulties', p. 145.

the Mental Hospitals Department set about acquiring land, under the Public Works Act (1908), for the 'Use, Convenience, and Enjoyment of the Tokanui Mental hospital'.

Entries in the *New Zealand Gazette* for 1910 show that on 25 February the Government began this process, publishing a notice of intention to take land. It outlined exact details of the land intended for acquisition and informed that the plans would be deposited at the post office in Kihikihi where they could be viewed by interested parties and any 'well-grounded' objections expressed in writing to the Minister of Public Works within the following forty days.

Why State Institutional Care?

Until the 1960s, the government's response to mental affliction was focused squarely on the lunatic asylum or mental hospital as it was later to become. Viewed, according to Brunton, as 'therapeutically indispensable',² the mental institution 'provided for complete and continuous supervision, facilitated treatment and allowed patients to be classified or separated into small groups'.³ Furthermore, institutional care was seen as being more efficient because 'it concentrated patients to make best use of specialised staff who were invariably in short supply'.⁴ An alternative system of boarding out failed to become established because of social aversion, a lack of financial support and an absence of the appropriate class with whom the mentally unsound could be boarded.⁵ Official preference for institutional care did not, however, extend to private (licensed) establishments, despite legal provision having been made for them in the 1868 Act. Although common overseas, licensed houses failed to gain currency in New Zealand and despite the significant attention given to them in the Act only one institution was ever licensed. Ashburn Hall, near Dunedin, opened in 1882, 14 years after the 1868 Act first authorised the development of private facilities. From 1895 onwards, in a move that followed English precedence, reflected a wariness for political scandal and a political preference for state provision of social services, and which paid heed to medical opinion that the civil liberties of committed patients were the responsibility of government, Inspector-General Duncan MacGregor opposed the licensing of more institutions.⁶ In so doing, he cemented the state's near monopoly on psychiatric services for well over half a century.

Notes

- ¹ In 1905 the title lunatic asylum was changed to mental hospital in an effort to reduce the stigma that attended association with such institutions, and also, Brunton notes, 'because it sounded "more scientific, euphonious, and less compromising", than "lunatic hospital" or other suggestions'. See Brunton, 'Out of the Shadows', p. 80.
- ² See Warwick Brunton, 'A Choice of Difficulties', p. 255.
- ³ Brunton, 'A Choice of Difficulties', pp. 225, 227.
- ⁴ Brunton, 'A Choice of Difficulties', p. 228.
- ⁵ See Brunton, 'A Choice of Difficulties', pp. 226-27.
- ⁶ See Brunton, 'A Choice of Difficulties', p. 231.

Roughly two months later, on 20 October there appeared a notice informing of land having been taken for Tokanui Mental Hospital.

This officially acquired all but two of the blocks from the original proposal. On 22 December a notice informing of the acquisition of the remaining two blocks, x and xi, from the original proposal appeared. A portion of the proposed estate, south of the Puniu River, was Māori land and objections to its acquisition were raised by the owners. The Department's Annual report for 1909 commented 'It was expected that by this time we should have been busy there with building operations, but to the taking of the Native portion of land objections have been lodged, and these have still to be heard before we can get to work'.

However by 1912 the Public Works Statement for 1912 reported that compensation had been paid for the native land taken at Tokanui.

In total the government acquired just under 5000 acres of land for the new mental asylum, two thirds more than would prove necessary given the resources available for its operation.

Construction, albeit initially of a temporary nature, followed the acquisition of land and by the end of 1912 the hospital had a recorded patient population of 64 males.

The care of these 64 patients, and others admitted for the greatest part of Tokanui's operation, were governed by the 1911 Mental Defectives Act. This legislation required Tokanui to have a Superintendent, a Medical Officer, and, as appropriate, one or more Assistant Medical Officers, the appointment of the latter being determined by workload. While the Superintendent did not have to be a medical practitioner, the other appointments, as was implicit in their titles, were required to be both medically qualified and registered in New Zealand. However, at Tokanui, and all subsequent institutions, the practice from the outset, as was allowed for in section 43 (3), was to combine the two roles into the single position of Medical Superintendent. The precedent of medical management had been set in 1876

with the appointment of FWA Skae, who was a qualified psychiatrist, to the position of Inspector-General and was extended over time to all hospital superintendence. Not only did the shift to medical management align with trends in Britain, it also reflected the increasing medicalisation of mental illness.

Similarly, the greater documentation and reporting required of institutions reflected the professional, clinical approach to which medical management subjected lunacy. Under sections 64 and 65 of the Mental Defectives Act Tokanui's Medical Superintendent was required to keep a Register of Admissions, a Register of Boarders, a Register of Discharges (including transfers), a Register of Absences on Leave (including returns from leave), a Register of Escapes (including returns from escape), a Register of Deaths, a Weekly Report Book, a Case-book, a Prescription-book, a Register of Restraint and Seclusion, and a Post-mortem Book. As was indicated by their titles, the various registers and books were a record of the hospital's main activities including admissions, treatment, discharges, escapes, and death, etcetera. For example, the admission register recorded basic information about the patients such as their name, age, sex, occupation, marital status, address, their form of mental disorder, duration of present attack, and whether they had had any previous attacks. As such, the registers were a largely statistical record of the patients admitted and discharged. The various medical books, in theory, provided more detailed information about the condition and treatment of patients at Tokanui. However, in practice, especially given that recovery was, above all else contingent on time, and hence the status of patients could remain static for long periods, they more often recorded the notable rather than the routine observations. In addition to keeping these records, Tokanui's Medical Superintendent was required, within twenty-four hours, to send notice to the Inspector-General of the admission of every patient, together with copies of the admission order and any supporting documentation, and a preliminary statement of the mental and bodily condition of the patient, to be followed within fourteen days by a further, more comprehensive statement as to the patient's situation.

Notices of discharge, transferral, absence on leave, cancellation of leave, return from leave, escape, return from escape and death were also required to be sent to the Inspector-General within twenty-four hours.

Under the 1911 legislation, all mentally defective persons admitted to Tokanui were received into the hospital under the authority of a reception order that was obtained on application in writing to a magistrate by a person over twenty one years of age. All such applications were required to contain a statement confirming that the subject of the application had been seen by the applicant not longer than three days prior to making the application, give an account of the grounds on which the applicant believed the individual in question to be mentally defective and outline the relationship between the applicant and mental defective stating either that they were the nearest relative or, if not, providing a reason for the application being made by them. All applications had to be presented to a magistrate within seven days and be accompanied by two medical certificates dated no more than three days prior. In addition to outlining the observed facts indicating mental defect, medical certificates were required to state any further evidence observed on other occasions, any evidence communicated by other individuals along with their name and address, the class of mental defect which the medical practitioner believed the subject to belong to, the supposed cause of the mental defect, whether the subject was considered suicidal or dangerous, any treatment administered for the mental condition, and a statement of bodily health with special reference to the presence or absence of communicable disease and any recent injury. As noted in the previous section, the 1911 Act extended the scope of mental deficiency replacing the broad, existing lunatic classification with six classes of mental defective; later the 1928 amendment would add a seventh social defective class. At Tokanui, as elsewhere, patients were thus classified either as being of unsound mind, mentally infirm, an idiot, imbecile, feeble-minded or as epileptic.

Accommodation pressures were the main reason for the transferral of patients between the network of public institutions, and excepting those sufferers detained for offences committed under Part IV of the 1911 Act, patients were transferred from Tokanui, mainly to other institutions, under order of the Inspector-General. This order was sufficient authority for the transfer of the patient from Tokanui and for their reception into the institution or house to which they were being transferred.

Each order was required to be complied with as soon as was practicably possible, providing that the patient was in a fit state to be removed, and a copy of all documentation relating to the patient, including a certificate stating mental and bodily condition immediately prior to transfer, plus any other material facts, were to accompany the patient. As well as authorising transferral, the Inspector-General

could permit any patient to be absent from Tokanui for a period of up to twelve months. Alternatively, Tokanui's Medical Superintendent could grant leave for a period not exceeding twenty-eight days. All leave could be extended by the Inspector-General for a period not exceeding twelve months and the patient could be discharged while on leave, provided a medical certificate confirming recovery was received by either the Inspector-General or Tokanui's Medical Superintendent. Individuals failing to return from leave were deemed to have been discharged as unrecovered and were liable to receive continued visitation from an Inspector or Official Visitor. At any time leave could be cancelled with written notification being sent to the individual with charge of the patient, and if the mental defective failed to return by the appointed time they were deemed to have escaped. Although Tokanui's isolated rural location made the prospect of successful escape less likely, escapes did occur from time to time. Under section 79 of the 1911 Act Tokanui's Medical Superintendent was required, within twenty-four hours, to record the escape of any patient in the Register of Escapes and send notice of the escape to the Inspector-General. Any patient or boarder that escaped from Tokanui could, within three months, be retaken by any person and returned to the hospital. If not retaken during the three month period the patient or boarder was deemed to have been discharged unrecovered.

The discharge of patients at Tokanui fell into one of three categories, either 'recovered', 'relieved' or 'not improved'. The decision to discharge was made by the medical Superintendent on the belief that the patient was fit to be released, and that their detainment was no longer necessary either for their own good or for public safety. Discharge usually followed a request for release by a relative or friend prepared to assume responsibility for the patient's ongoing care, and in all cases required suitable provisions to be made with regard to living arrangements. Hence, those individuals without the means to support themselves and without the support of family and friends, tended to become permanent residents of Tokanui in the absence of an alternative arrangement. In cases where opinion regarding the appropriateness of discharge was conflicting, the matter was referred to the Minister for consideration, resulting either in continued detainment, discharge, or further enquiry by a Magistrate. Failing transferral, discharge or escape, patients, either through illness or self-inflicted injury, died at Tokanui. The death of a patient required a death notice to be completed stating apparent cause of death, any pre-existing medical conditions, the patient's diagnosed illness, the names of all persons present at the time of death and whether there was occasion to hold an inquest. In addition to being sent to the Inspector-General, notice of death was also to be sent to the coroner and any named relatives or friends, or the person who last made payment on account of the patient or boarder.

Although it would be at least a decade before Tokanui admitted patients directly, the provision for voluntary admission, which appeared for the first time in the 1911 legislation, allowed sufferers to admit themselves to Tokanui, in theory avoiding the stigma attached to committal in a mental institution. Voluntary admission required the sufferer to sign a reception request which acknowledged an awareness that as a consequence of making the request they were liable to be detained in the institution for up to seven days after any request for release. Reception requests could be refused by Tokanui's Medical Superintendent on the grounds that, in their opinion, institutional care was inappropriate for the individual's affliction, or that the individual ought, more suitably, to be committed. As with patients admitted under reception orders, the Medical Superintendent was required within twenty-four hours to send to the Inspector General notice of admission, a copy of the signed reception request, a certificate setting forth their opinion of the case and a statement regarding the financial provisions for maintenance. All documentation was then placed before the Minister for Mental Hospitals, resulting in either an order for the individual to be discharged or consenting to their further detention. Voluntary Boarders were able to be discharged from Tokanui on orders from the Minister, the Inspector-General, or Tokanui's Medical Superintendent, either into the care of relatives and friends, or as a recovered patient. Alternatively, provided a Magistrate's reception order did not commit them, they were required to be discharged no later than seven days following their request for release. In his survey of Tokanui's population, KR Stallworthy noted that in 1929 only 9 per cent of total admissions were voluntary. Thirty years later voluntary admissions accounted for over half (59 per cent) of all admissions, leading Stallworthy to conclude that mental hospital care was 'clearly sought much more willingly than it used to be, probably much earlier, and often for disorders such as neurotic reactions for which previously care was only ever infrequently sought'.

Individuals under the age of twenty-one were considered to be minors and their reception into Tokanui required an application to the Inspector-General from a parent or guardian. This application needed to be verified by a statutory declaration and accompanied by a certificate signed by two medical practitioners. Although, ideally, minors were to be accommodated separately from adult patients, accommodation constraints early thwarted such provision and it was not until the second half of the twentieth century, especially the 1970s that such separation became possible. Minors were discharged following an application in writing to the Inspector General from a parent or guardian, unless opposed within seven days on the grounds that further detention was desirable for their own good or in the interests of public safety. Similarly, on obtaining the age of twenty one, minors were required to be discharged unless, prior to the date, the Medical Superintendent challenged this on the same grounds as requested discharge. Alternatively, minors were able to be discharged if deemed by the Medical Superintendent to be 'fit' for the purpose.

A proportion of the mentally defective individuals admitted to Tokanui were detained because of criminal acts they had committed or because of those they were believed likely to commit. Under section 16 of the Mental Defectives Act, constables were able to detain, if necessary, and make an application to a Magistrate for a reception order relating to any person who they had reasonable cause to believe was mentally defective, neglected or cruelly treated by the individual responsible for their care, suicidal, dangerous, acted in a manner offensive to public decency, or who was not under proper oversight, care or control. Mentally defective individuals acquitted of offences on the grounds of insanity, or prisoners found to be insane following imprisonment, were required to be strictly confined until the Minister of Justice deemed them fit for discharge. However, if deemed to have recovered their sanity, they were able to be tried upon the original indictment or returned to prison to serve the remainder of their sentence. If acquitted because of insanity, criminal lunatics were able to be transferred to Tokanui, or any other institution, following an examination by a Magistrate on order of the Minister of Justice. This enquiry was to take account of the mental defectives state of mind and, if concluding that removal to an institution was desirable, to inform the Minister of Justice who was able to order this removal.

Inspectors, and/or Official Visitors, were appointed for each institution by the Inspector-General, in theory as independent watchdogs and critics. The 1911 Act required that Tokanui be visited at least once every three months by an Inspector or Official Visitor who could do so with previous warning on any day, at any hour (day or night), for any length of time, and had the authority to inspect every part of the hospital estate and every person therein detained. The Medical Superintendent was also required to lay before the Inspector or Official Visitor the registers and books kept under sections 64 and 65 of the 1911 Act in order that they be signed after the final entry, and all orders and documents relating to patients were required to be produced on request. In addition the Inspector or Official Visitor was required to record their visit in the Visitation Book together with any pertinent observations, a copy of which needed to be sent by the Medical Superintendent to the Inspector-General within forty-eight hours. Finally, the Inspectors and Official Visitors were required to report to the Inspector-General as required or directed.

Mental Health

Despite periodic surges of interest, usually driven by media revelations of shortcomings in the care received by sufferers, mental health has consistently occupied a lowly position in the schema of governmental responsibility. A complex, emotive subject, with a disenfranchised and undesirable clientele, mental health has never been a politically or socially popular topic. Eclipsed by expenditure on public works, defence, emergency services and education, spending on mental health care during the twentieth century never exceeded 10 per cent of the total allocated to health in general. Prior to the 1920s, government spent approximately twice as much on general hospitals as on their mental counterparts, and thereafter three times as much.² Indicative of an unwillingness to meddle, mental health legislation has been substantively reviewed only once a generation, while its policy history, according to Brunton, 'has consisted of booms interspersed with long intervals of quiet incremental change, indifference or even stagnation'.³

Notes

¹ Brunton, 'Out of the Shadows', p. 78.

² Brunton, 'A Choice of Difficulties', p. 152.

³ Brunton, 'Out of the Shadows', p. 75

Tokanui in the wider field of mental health in New Zealand

When it opened in 1912, Tokanui joined a network of seven existing mental hospitals that dated back to 1863 and which, by year's end, were responsible for the care and confinement of some 3,913 patients. Sunnyside (1863), Auckland (1867), Seaview (1872), Nelson (1876), Seacliff (1879), Ashburn Hall (1882) and Porirua (1887) were all built prior to the twentieth century, the majority, including three already closed by 1912, during the provincial period in response to large scale immigration. Five of the seven hospitals were situated in the South Island, leaving only Porirua and Auckland to service the north. The locations of the institutions reflect early patterns of land acquisition and settlement, the latter being considerably influenced by economic opportunities, most notably the discovery of gold in Otago and on the West Coast. In attracting large numbers of single males to a physically and mentally challenging existence, often on the promise of unrealised wealth, the gold rushes not only provided their respective provinces with the wealth to construct specialist lunatic facilities, but also contributed to the problem by conferring a number of stricken individuals to institutional care.

Many of the early provincial asylums were situated close to the towns they served and as these centres grew the asylums found themselves hemmed in by urban development and the subject of prejudiced and fearful public scrutiny. Issues of urban encroachment arose most conspicuously in relation to Dunedin and Mount View asylums where lack of space saw patients working outside of the asylum grounds and the absence of sufficient workable land led to them being confined and restrained. Disapproving of these practices and of the extreme publicity which the institutions faced in their now central urban locations, Inspector-General Skae began favouring rural areas for the development of new institutions.¹ By the early 1880s, situating institutions in rural settings had become a distinct policy which found favour with the *Evening Post*, presumably as an expression of wider public sentiment.² Aside from generating less public opposition, rural locations were secluded, reducing the likelihood of patient escape and allowing for a more complete confinement which provided patients with greater privacy and the department with greater confidentiality. Their rustic charms were considered therapeutically valuable, but, most importantly, rural locations provided much needed space for current and future accommodation needs and for agricultural activities which were not only essential to self-sufficiency but also to the therapeutic occupation of patients. Bottom line, rural land was cheaper, more readily available, and was able to be acquired in larger quantities than more urban land, which along with the advantages of its inherent isolation, made asylums situated in the countryside an attractive choice for department officials.

Greater space also afforded officials the opportunity to adopt new asylum designs, however, it was not until the development of Tokanui that officials fully departed from older asylum models. Despite the experiments at, and additions to existing hospitals, utilising smaller scale cottage, pavilion and villa style designs, all of the asylums predating Tokanui were initially constructed along traditional English Victorian lines. Primarily large, single edifices, these asylums were inefficient, unsanitary, and according to Duncan MacGregor, 'gloomy and depressing'.³ Furthermore they were costly and time consuming to build, extend and alter. From start to completion, the original design for the Whau in Auckland took 14 years to construct, while the main building at Sunnyside was developed in four stages over a period of 19 years.⁴ From 1876 onwards, Skae and his successors began favouring the smaller cottage, pavilion and villa designs being trialled overseas. However, despite this preference, Seacliff (opened in 1879) and Porirua (opened in 1887) remained architecturally wedded to older designs. Brunton believes the continued construction of such edifices was largely the result of opinions held by the Colonial Secretary, Colonel GS Whitmore (1877-9), 'that buildings should be permanent in character'.⁵

The largest and most iconic of the asylums built prior to the twentieth century was Seacliff, located 20 miles north of Dunedin. Its daunting gothic façade, strongly reminiscent of old English workhouses and prisons, featured turrets on corbels, a gabled roofline and a large central tower, all of which popularly evoked ideas of imprisonment and misfortune. An infamous fire in 1942 which destroyed ward 5 (also known as the Simla building) killing all but two of the female patients, who were unable to escape from their locked and barred rooms, reinforced these impressions. Seacliff became emblematic of lunacy and the system responsible for its treatment in New Zealand, a system which was viewed with

fear and aversion. Inefficient and imposing, these structures came to epitomise all that was negative and punitive about institutional care, and as therapeutic despair set in they increasingly became sites of confinement for incurable sufferers and the socially aberrant.

In contrast, Tokanui, as the first asylum to be built entirely to the villa design, was comprised of smaller separate ward blocks. Conceived of as individual “houses”, they were intended to be ‘more natural and homely’ than vast asylums, and to engender a greater sense of community.⁶ Believed to provide an environment more conducive to recovery, villas allowed for greater and more effective classification and treatment, and had the additional advantages of being cheaper and quicker to build and easier to extend; these latter points being most advantageous given chronic accommodation shortages which had, by the early 1900s, reached crisis point. An increase in the number of admissions, especially those of an incurable nature for whom the institution would become ‘a long, even life-long, refuge’ created greater demand and forced the government to provide more accommodation to address the seemingly perpetual problem of overcrowding which was hampering basic standards of care, not to speak of effective treatment.⁷

When it opened in 1912, Tokanui became not only the first mental hospital sited in the central North Island, but the first new institution to be built in New Zealand in over 20 years. By this time overcrowding and insufficient accommodation were already established burdens of the system, inherited from the provincial era of management which lacked sufficient resources to provide adequately for demand. ‘Failure to implement a long-term building plan’, Brunton observes, ‘put more or less unrelenting pressure on the available accommodation’.⁸ Hospital superintendents were forced to make use of any available space for bedding, including corridors, day rooms, attics, lavatories, table tops and even underneath the tables themselves.⁹ The increase in chronic patients was also a symptom of the ‘therapeutic despair’ that characterised the period beginning with the shift to central administration in 1976. Waltraud Ernst specifies that ‘in the Wellington area, for example, they increased from 73 per cent of the total in 1875 to 93 per cent in 1902’.¹⁰ The overwhelmingly pessimistic outlook remained until the 1940s and 50s when, as Campion notes, the ‘therapeutic and pharmaceutical revolutions rekindled optimism with the promise of widespread cure’.¹¹

Although Tokanui was conceived by Frank Hay to be a central repository for chronic and incurable patients, the *Parliamentary Debates* indicate that there was some initial confusion over just how dominant the institution would be. Perhaps influenced by earlier proposals of a central lunatic asylum intended to serve the whole colony¹², Mr Herries, the MP for Tauranga, ‘understood the idea was that all the other hospitals would be closed and that there should be one large mental institution at Tokanui’.¹³ While Hay’s vision of a “garden city” where each ward block was linked by a light rail system failed to come to fruition, his grand plans for Tokanui were never intended to supplant the existing institutions.¹⁴ Rather it was anticipated that the transferral of the most challenging, long-term and chronic cases to Tokanui would free up the other mental hospitals to treat the more hopeful cases of persons of unsound mind. In line with this intention, Tokanui received only transfers for the first decade of operation, helping to alleviate the overcrowding at Porirua and Auckland in order that they could continue to admit new cases. However, Tokanui’s villa design attests to the fact that its development was about more than the basic provision of accommodation; it was also an experiment in improved asylum design and treatment, with the lessons learnt at Tokanui being applied at all of the subsequent hospitals. Following the construction of admission wards in the first half of the 1920s, Tokanui began receiving admissions directly, a change which enabled it to function less as a repository for the incurable and more as a general mental hospital treating a greater array of mental complaints, including acute illnesses such as neuroses. By the late 1950s, the overwhelming majority of sufferers were discharged within the year, the average stay being 8–10 weeks.¹⁵ From humble beginnings, Tokanui would grow to be one of New Zealand’s foremost psychiatric institutions, reaching a peak population of over 1,100 patients in the mid 1950s.¹⁶

From 1925 onwards ‘Tokanui’s practices became’, according to Adrienne Hoult, ‘refined and distinctive’ and its interpretation of some aspects of legislation, particularly classificatory criteria, was unique from other mental hospitals’.¹⁷ As the first new institution to be built following the introduction

of the Mental Defectives Act, Tokanui became a key site of policy implementation, diagnosing and classifying patients according to the legal definitions outlined in the Act while tailoring treatments to suit the varying needs which the differing classifications prescribed. In particular, Tokanui's villa design facilitated the classification of patients according to the new definitions outlined in the Act by affording the means to separate psychiatric patients from those deemed mentally deficient. Although the majority of Tokanui's admissions were individuals classified as neurotic and schizophrenic, there was also an initially small, but not inconsequential, number of intellectually 'subnormal' idiots, imbeciles and feeble minded, who along with those suffering from melancholia, schizophrenia and senile state, accounted for the majority of the hospital's accommodation needs.¹⁸

Between 1912 and 1935, Tokanui housed 111 patients classed as 'mentally subnormal' who represented approximately a third of the total population. A portion of these patients were classified as criminally deficient and were committed because of unlawful acts they had perpetrated or because of the potential it was believed they possessed for carrying out such acts. By the time Tokanui opened, there was widespread anxiety over mental defectives because of the perceived association they had with criminal and moral deviance. Not only were the mentally deficient believed to have a genetic predisposition towards degeneracy, which was conceived as the root cause of crime, prostitution, alcoholism and poverty, they were also seen to be the product of these. While the link between mental deficiency and criminality was, Hoult informs, 'established internationally about forty years before Tokanui and Waikeria were built in the Waikato', the close proximity and concurrent construction of Waikeria, which was also opened in 1912, 'strengthened the correlation between crime and deficiency made by authorities during the early twentieth century'.¹⁹ Joint work schemes and the transfer of 4000 acres of land from Tokanui to Waikeria cemented the associations between the two institutions and their socially 'othered' inhabitants.

Although comprising only 'a small proportion of the admissions to Tokanui', the intellectually deficient, in the absence of curative treatment, were more likely to become long-term residents, and by 1959 were second only in number to schizophrenia sufferers for requiring long-term care, accounting for 'about one-fifth of the total resident' population.²⁰ Indeed, the numbers of mentally defective patients admitted to Tokanui increased from the mid-twentieth century until the closure in 1998, by which time they made up the majority of Tokanui's residents.²¹ In Chapter Four Adrienne Hoult discusses these patients in greater detail, looking at their committal, classification and subsequent life within Tokanui, as well as how their gender influenced their experience.

Another trend which became apparent mid-way through the twentieth century was the growing number of Māori patients being admitted, and re-admitted, to psychiatric hospitals. 'Whereas prior to 1970 Māori admission rates were lower than non-Māori, by 1976', Mason Durie informs us, 'Māori rates had exceeded those of non-Māori'.²² Concern over the disproportionately high rates led, in the 1980s, to the establishment of dedicated kaupapa Māori programmes. The first of these, a Māori cultural treatment unit named Whai Ora, opened at Tokanui Hospital in November 1984. The result of six years planning by Te Roopu Awhina ō Tokanui (a group of Māori health professionals at Tokanui), supported by Dr Henry Bennett, Whai Ora was a twenty bed unit, separate from the existing 'mainstream' services, which Durie says 'incorporated Māori values, beliefs, and management styles into the treatment environment ... without losing sight of modern treatment methods or professional standards'.²³ Central to the treatment philosophies was the premise that many young Māori suffered from social, rather than formal, psychiatric problems which stemmed, in part, from a cultural disconnect. According to Dr John Saxby, Whai Ora was established 'in order to provide a therapeutic community which would assist (young) Maori people who had become alienated from their cultural roots ... to re-establish their affiliation to their family, their tribe and their culture'.²⁴ Despite many challenges, not least the deaths, within five months, of seven people connected with the unit, Whai Ora proved a success, avoiding the negative publicity and administrative politics which plagued its contemporary, Whare Paia, Carrington Hospital's Māori unit.²⁵ Chapter Eight discusses Maori Mental health at Tokanui in greater detail, and in particular looks at the development and success of Whai Ora, which was arguably New Zealand's first and most successful bicultural hospital unit.

Tokanui's construction would be followed by that of a further six hospitals before a decision was made in 1973 to stop building further institutional accommodation. Opened in 1929, seventeen years after Tokanui, Kingseat was the first of three additional mental hospitals to be established in the North Island. Situated south of Auckland at Papakura it became the Department's showpiece treatment facility and, like Tokanui, employed a self-contained villa design for its wards. Both Tokanui and Kingseat were influenced by the latter's namesake – Scotland's first villa style mental hospital – but their connections were not confined to similarities of building design. Tokanui played a foundational role in the development of Kingseat, supplying the necessary resources to establish the hospital's farm and initial infrastructure. Aside from food and utensils, Tokanui provided skilled labour in the form of its farm manager Al Rodgers, its ploughman T Brown, and its carpenter Riordon, the latter being sent to Kingseat to erect temporary sheds.²⁶ Nor would this be the last time Tokanui and Kingseat shared staff. According to the 50th Jubilee history, 'in 1959 one psychologist was shared by Tokanui and Kingseat Hospitals. The psychologist used Tokanui as a base and spent two months at each hospital in turn'.²⁷ Built, as was Tokanui, to supply more accommodation for an overtaxed system, Kingseat received the majority of the overflow from Auckland, as well as patients from the surrounding South Auckland area. Its advent meant that Tokanui was left to concentrate on patients from the Waikato and the more southern North Island regions.

Conclusion

Many of the legal foundations under which Tokanui operated were in place more than forty years prior to the commencement of construction, with lunacy legislation dating back to the first decade of official European settlement. This early legislation was primarily concerned with the maintenance of law and order, and enabled officials to confine potentially dangerous lunatics in order to preserve public safety and prevent the perpetration of crimes. Because lunacy was framed as an issue for law enforcement, it was an accepted and expected government responsibility and when gaols and prisons proved less than ideal for confining the mentally afflicted, it was a natural progression and a continuation of that responsibility for officials to provide alternative institutional accommodation. Given a settler population with a preponderance of single males, the absence of traditional familial support networks, and a lack of other charitable support, government was forced to assume financial as well as physical responsibility for the care of lunatics. However, later legislation appears to support an alternative argument that the state monopoly on the provision of psychiatric services was the deliberate result of a policy of social control. The 1911 Mental Defectives Act and its 1928 amendment, which cast a broader net over abnormality, redefined lunacy, drawing distinction between the mentally subnormal and mentally unsound individuals in order to ensure that even the mildly divergent would be appropriately detained and treated. Enacted one year prior to the opening of Tokanui, the Mental Defectives Act governed all aspects of Tokanui's early operation, from admission to the administering of medication, documentation of treatment, notification of escapes and death, and the discharge of patients as either recovered, improved or not recovered. When it was completed in 1912, Tokanui became the eleventh mental hospital constructed in the dominion, the third to be situated in the North Island, and brought the number of institutions then currently in operation to eight. Architecturally divergent from the older main building asylums, Tokanui was the first hospital to be entirely constructed to the villa design and, although from its initial conception Tokanui's primary purpose was to provide additional accommodation that would ease the chronic overcrowding which plagued the hospital system, its smaller, separate ward blocks reflected changes in official ideology regarding how the mentally deficient should be housed and treated and became the blueprint for all subsequent institutions, most especially Kingseat with which Tokanui had many connections. In the chapter which follows, the early years of Tokanui's operation, from the development of its grounds and buildings to the plight of patients and staff, are explored in greater detail with the intention of elucidating what it was like to work, live and suffer at Tokanui during the pioneering years.

Notes

- 1 Report on Mental Hospitals of the Dominion for 1877, *AJHR*, 1878, H-10, p. 3.
- 2 Brunton, 'A Choice of Difficulties', p. 240.
- 3 Inspector-General's Report, Auckland, 8 April 1886, *AJHR*, 1887, H-9, p. 11.
- 4 See Brunton, 'A Choice of Difficulties', p. 249.
- 5 Brunton, 'A Choice of Difficulties', p. 248.
- 6 Brunton, 'A Choice of Difficulties', p. 248.
- 7 Brunton, 'A Choice of Difficulties', p. 228.
- 8 Brunton, 'A Choice of Difficulties', p. 237.
- 9 Report on Mental Hospitals of the Dominion for 1878, *AJHR*, 1879, H-4, pp. 3, 7
- 10 Ernst, p. 72.
- 11 Michelle Campion, 'Narratives from the Minds Eye: The Significance of Mental Health Pathography in New Zealand, 1980-2008' (Unpublished Masters Thesis, University of Waikato, 2007), p. 11.
- 12 See Brunton, 'A Choice of Difficulties', pp. 91-91.
- 13 *New Zealand Parliamentary Debates (NZPD)*, vol. 165, 3 October 1911, p. 310 (Mr Herries)
- 14 See Brunton, 'A Choice of Difficulties', p. 256.
- 15 Stallworthy, p. 387.
- 16 Report of the Director, Division of Mental Hygiene, Report of the Director-General of Health, Department of Health for the year 1955-56, *AJHR*, 1956, H-31, p. 35.
- 17 Hoult, p. 36.
- 18 Stallworthy, p. 386-87.
- 19 Hoult, p. 95.
- 20 Stallworthy, p. 388.
- 21 Midland Health, *From Institution to Independence: The Movement of People with an Intellectual Disability from Tokanui Hospital into the Community* (Hamilton, N.Z.: Midland health, 1996), p. 2.
- 22 Mason Durie, *Mauri Ora: The Dynamics of Māori Health* (Auckland, N.Z.: Oxford University Press, 2001), p. 225.
- 23 Durie, *Mauri Ora*, p. 226.
- 24 J. R. B. Saxby, 'Whai Ora: An "Introduction for Pakehas"', letter to Professor Graham Mellsoy, Department of Clinical Psychology, Wellington Clinical School, Wellington Hospital (14 March 1988), p. 2.
- 25 According to Mason Durie, 'Te Whare Paia failed to produce the same positive results [as Whaiora] and was not able to integrate treatment protocols with cultural inputs; instead it became a somewhat isolated unit lacking a Māori perspective, unable to achieve any significant health gains, and preoccupied with political point scoring rather than patient welfare'. See Durie, *Mauri Ora*, p. 226.
- 26 *Kingseat Hospital, 50 years, 1932-1982* (Papakura, N.Z.: Kingseat Jubilee Editorial Committee, 1981), p. 6.
- 27 *Kingseat Hospital, 50 years*, p. 14.