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Changing Times, Changing Places

From Tokanui Hospital to Mental Health Services in the Waikato, 1910–2012

Edited by Catharine Coleborne and
the Waikato Mental Health History Group

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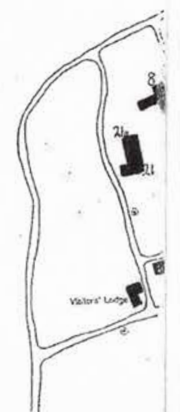

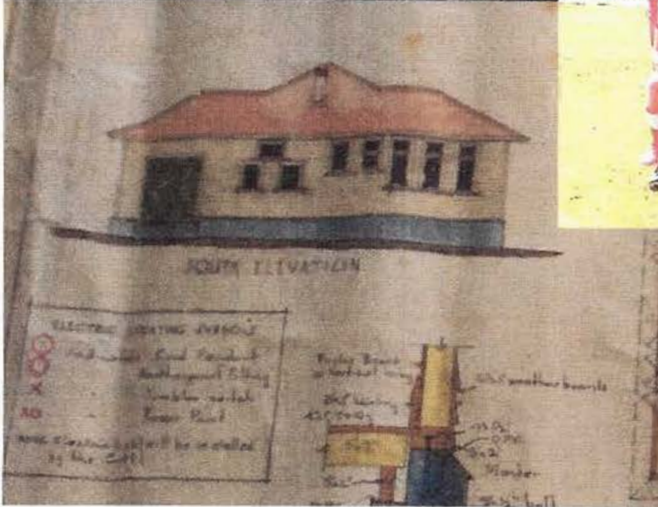

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Back cover photograph: Waikato Hospital Campus 2012, courtesy of Waikato District Health Board
Inside cover photographs courtesy of Waikato District Health Board, David Gemmell, Te Awamutu Museum, *Te Awamutu Courier*

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WAK0000200

CONTENTS

Foreword Janice Wilson v

Acknowledgments vii

List of Figures ix

Abbreviations xii

Editor biographies xiii

Author biographies xiv

Introduction Catharine Coleborne 1

Part One - Histories of place and people: mental health and policies, training and personnel 7

CHAPTER 1 ***Tokanui Te Whenua: A Tangata Whenua Perspective*** 9
Rovina Maniapoto-Anderson

CHAPTER 2 ***Mental Health and Legal Landscapes*** 13
Michelle Campion

CHAPTER 3 ***Mental Health at Tokanui in the Early Years*** 27
Michelle Campion, Catharine Coleborne and Kate Prebble

CHAPTER 4 ***Intellectual Disability: The Patient Population of Tokanui, 1912-1935*** 53
Adrienne Hoult

CHAPTER 5 ***Mental Health Nursing Education in the Waikato, 1912-2010*** 67
Kate Prebble

Part Two - Treatments, Patients, Care and Control: Institutions and Change 87

CHAPTER 6 ***Medical Care and Treatment*** 89
Eleni Nikolau

CHAPTER 7 ***Patient Journeys: Stories of Mental Health Care from Tokanui to Mental Health Services, 1930s to the 1980s*** 97
Catharine Coleborne

WAK0000200

CHAPTER 8 — ***Māori Mental Health*** — 111
Bob Elliott, Ron Baker, and Rovina Maniapoto-Anderson

CHAPTER 9 — ***Midland Regional Forensic Psychiatric Service, 1990-2010*** — 135
Suzette Poole in collaboration with a Service User, Ellie Wellington, Jeff Symonds and Rees Tapsell

Part Three - Memories, Stories and Communities: New Eras — 151

CHAPTER 10 — ***Reflections and Memories*** — 153
Various authors

CHAPTER 11 — ***'Snake pits' and the 'lock them away' concept: Tokanui and its Patients in the*** **Waikato Times** ***Press Articles of the 1970s*** — 197
Alexander Brown

CHAPTER 12 — ***Closing One Door and Opening Others*** — 209
John Graham, Ken Jamieson, Michelle Campion and Stephanie Lambert

CHAPTER 13 — ***Remembering Tokanui – collaborative approaches to history*** — 225
Stephanie Lambert

List of Sources — 237

Appendices — 249

Appendix 1: List of Buildings in Use at Tokanui Hospital — 251

Appendix 2: Staff at Tokanui Hospital and in Mental Health Services Over Time — 253

Appendix 3: Dr Henry Rongomau Bennett — 257

Index — 259

WAK0000200

FOREWORD

Janice Wilson

My first impressions of Tokanui Hospital were formed when once a month on a Sunday my father took my siblings and me out with one or two children who lived there. I was always left with a sense of abandonment and longing from the children, mixed with great warmth and caring from the staff, within the wonderful physical beauty of the grounds. This book, with its combination of factual history and people's stories, gives voice to these contradictory feelings. There is a blend of experiences and views that portray the commitment, energy, optimism, frustration and despair that characterises the last 100 years of the way we have cared for and treated people with mental illness and intellectual disability, or others who were considered misfits in society.

Although much is now known of the harm, mostly inadvertent, that results when vulnerable people are forced to live in an institutional way, psychiatric hospitals or mental asylums were conceived and built with noble and good intentions, as places to bring peace to the troubled and to provide a caring environment for treatments. Sadly these institutions, by the very nature of their administrative and geographical isolation, also supported strongly held societal views of shame and stigma associated with mental illness and intellectual disability. Throughout the history of all psychiatric hospitals over the past 100 years or more we see this dynamic and tension lived with every day by patients/residents and staff.

Nevertheless, people of great foresight and creativity searched for innovative and humane treatments, and advocated for increased understanding from communities and society. This book demonstrates that Tokanui Hospital had a tradition of such leadership and was at the cutting edge of reforming people's views. The development of Whai Ora, and the leadership given to Maori Mental Health, brought new ways of thinking and behaving towards Maori patients/residents/consumers, and also paved the way more widely in New Zealand for a more empowering and community driven approach to care and treatment. This strength has been carried forward into Waikato's mental health services today where the partnership with Maori is central. Also evident was Tokanui Hospital's leadership in training and development, particularly of nurses, and the strong support for a multidisciplinary approach to treatment.

The reflections in this book contain wisdom and insight. The integration of factual accounts with oral histories works well. We experience the wonderful sense of whanau and community that the hospital fostered, as well as the oft felt anguish, loneliness and fear of patients.

There is much that has challenged us over the years about the care and treatment of people with mental illness and the care of those with intellectual disability. There is much that continues to challenge. We can learn a great deal from reflecting on the last 100 years.

Janice Wilson was Director of Mental Health and Chief Advisor, Mental Health at the Ministry of Heath from 1993 to 2000. She was then appointed to Deputy Director General (DDG), Mental Health until 2007, and then until 2010 was DDG, Population Health which included mental health. Prior to joining the Ministry of Health, Janice was Acting Medical Superintendent of Porirua Hospital and then Manager of Mental Health Services at Wellington Area Health Board. A psychiatrist by background, she was also President of the Royal Australian and New Zealand College of Psychiatrists from 1997-1999. Today she is the Chief Executive of the newly formed Health Quality and Safety Commission. Janice lived in Hamilton with her family during the 1960s.

WAK0000200

ACKNOWLEDGMENTS

Catharine Coleborne, John Graham, Stephanie Lambert and Suzette Poole
The Waikato Mental Health History Group

Most books, but especially collective enterprises, incur a lengthy list of debts, and this book is no exception. The book has been a long and rewarding project with a solid group of people at its core, and was first suggested by Suzette Poole and John Graham. Together they built a terrific team of people committed to seeing the book published to mark the centenary of official mental health services in the Waikato region, beginning with the establishment of Tokanui Hospital. We call ourselves the 'Waikato Mental Health History Group' and have met regularly over a period of some years to drive this book, its authors, and a range of contributors, forward to completion. The team is thankful that Suzette and John showed ingenuity, found spaces, resources, and produced timelines to help us and support us along the way: their work has been vital to this book, and they have shown a very positive and strong commitment to the work of recognising the many dimensions of mental health, with expertise about people, events, places and many other aspects of the historical stories told here. We also acknowledge the earlier work towards this writing of Tokanui's history by Rodger McLaren, which has been a valuable source of information for us.

In another sense, this book also began life as an oral history project: a project jointly undertaken by Te Awamutu Museum, the then Department of History at the University of Waikato (now the History Programme), and with John Graham of Mental Health Services. Staff then employed at Te Awamutu Museum, including Toni Fortune and Shana Satanyand, were instrumental in realising the goal to create a body of oral history interviews for the museum. We thank the oral history participants and interviewees, and paid interviewers Jenny Robertson and Kate Hannah for their excellent and sensitive work during this project. The role of museum curator was later taken up by Stephanie Lambert who writes about this project and her experiences of it, including her work to curate and mount the museum exhibition focused on Tokanui's history, in this volume. Stephanie became a strong contributor to the team over time and helped with ideas, concepts, images, contacts, reading and reviewing chapters, and finally, captions for the many figures included here in this book. Stephanie provided also a warm spirit of enthusiasm to keep us on track, which was infectious!

Two summer studentships were held at the University of Waikato in the History Programme by Alexander Brown, a contributor to this volume, and Michael Healy. Together they built a fine collection of bibliographical materials and a small archive which has been used by the writing and research team. Michelle Campion began her commitment as a Research Assistant to this project and funded jointly by the funding sources mentioned later, but quickly showed herself to be a skilled and able contributor who was invited to produce whole chapters for the book. Michelle has been an amazing support to Catharine Coleborne in her research, writing, regular meetings, in her production of text boxes for chapters, her contribution to the Appendices, as well as her work in producing first a lengthy research bibliography for the team and later a List of Sources for the book. Thank you, sincerely, Michelle, from the team. Kate Prebble has also been a team member and is a contributor

WAK0000200

here, and features again for her support of the collective project along the way. Kate's discussions with Catharine have helped both of us forge ahead! Catharine would also like to thank her colleagues in the History Programme at the University of Waikato for thoughtful responses to this project and presentations about it over time.

Valuable and most welcome research funding was secured for this project at various junctures from the Mental Health Research Committee Waikato District Health Board (Waikato DHB), with initial thanks to Chris Harris and Professor Graham Mellsop, and subsequently to Jeff Bennett, Waikato District Health Board, Mental Health & Addictions Service Research Fund; the University of Waikato's Faculty of Arts and Social Sciences for Small Research Grant Funds, as well as central research funds during an internal secondment period, for Catharine Coleborne's research support; the Waikato Health Memorabilia Trust; and to Brian Thomas for his personal financial contribution to the project. We warmly thank all the financial contributors who have helped this book at all of its stages including proof reading, copy editing, layout and design, and printing and final production of hard copies. We also thank the Iwi Māori Council, Waikato District Health Board, for their consideration of the project at important times.

Kim Southey, during her time as Project Manager Māori Mental Health at the Waikato District Health Board, gave us significant guidance on the Māori mental health aspects of this book and the wider importance of including appropriate consultation with Māori. In particular we thank Bob Elliott for his generosity and creativity in sharing his views and knowledge about the culture and spirit of the Hospital. John Lomas came to us in the latter stages of the project and has worked to help produce clean and sharp chapters from the many different authors in this book. We thank him for his excellent work. Simon Dench has guided us through the process of production and printing and given us great advice about the book as an object; thank you Simon. Acknowledgements are also due to Judy Besley who provided family photographs and engaged with our project, as well as other contributors of images from several places and collections. We appreciate the assistance from the archivists and librarians at official archives and repositories and acknowledgments are also made in individual chapters. Thank you to Adrienne Hoult for allowing us to use part of her Masters thesis research conducted at the University of Waikato to inform our book; Adrienne's chapter is also included here as a contribution to the whole. Jacob Read also helped in the early stages of this project to help us create a chapter of personal recollections or reflections of Tokanui and mental health over time, and later this work was very ably taken up by others in the team: thank you. To all those people who provided memories, reflections and pieces of writing, thank you to all of you: we hope you enjoy the chapter. We are grateful too to Janice Wilson for agreeing to write the Foreword to this book.

Finally, we thank all our authors for their time, energy and careful engagement with this project, for without them this book would not exist. Commitment to a collectively authored book is a long and time-consuming process and we appreciate that you stayed with us until the end. We value your work. We have endeavoured to preserve individual authorial voices as far as possible, including retaining original author spellings of Maori words and the use of macrons. If readers find small inconsistencies in this book, they emerge from our sense of the author's own aims and styles used here.

We acknowledge and thank all our families and friends of the project group who have supported us over the years, the babies who have arrived, and to the dear ones who have departed during this time. And to all those people who lived, worked, suffered, recovered, or found respite at Tokanui, and still work with or are in contact with mental health services, this book is ultimately for you.

WAK0000200

LIST OF FIGURES

FIG 1.1: Aerial photo of Tokanui circa 1991 8
Photo Courtesy of Rovina Maniapoto-Anderson

FIG 3.2 Mr G Reynolds outside Mr W Melville's house on the corner of Mangapiko Street, Te Awamutu. 28
Photo Courtesy of Mr G Daysh, grandson of George Reynolds

FIG 3.1 Dorothy 'Dot' Whittle 28
Photo Courtesy of Judy Besley

FIG 3.3 Photo of wards F, G & H 37
Photo Courtesy of Waikato District Health Board

FIG 3.4 James Cran (right) and his friend Jack at Porirua Hospital in 1907. 47
Photo Courtesy of Judy Besley

FIG 4.1 Campus transport for people with Intellectual Disability 63
Photo Courtesy of Waikato District Health Board

FIG 5.1 Nurses outside the Nurses Home at the time of their 'Finals' (Senior Examination), 1939. 68
Photo Courtesy of Judy Besley

FIG 5.2 Robert Henry Gray, Head Attendant Tokanui Hospital early 1940s 70
Photo Courtesy of Jeanette Chynoweth, grand daughter

FIG 5.3 Sister Irene Netto was a tutor sister at Tokanui from 1959 to 1969. 72
Photo Courtesy of Waikato District Health Board.

FIG 5.4 Nurse looking towards D Ward 74
Photo Courtesy of Judy Besley

FIG 5.5 The old School of Nursing classroom 75
Photo Courtesy of Waikato District Health Board

FIG 5.6 The new Department of Nursing Education (D.O.N.E.) building constructed 1978 75
Photo Courtesy of Waikato District Health Board

FIG 5.7 The 16mm film projector played a significant role in New Zealand mental hospitals during the Twentieth Century. 76
Photo Courtesy of Waikato District Health Board.

FIG 5.8 Library in D.O.N.E/SSDU building 76
Photo Courtesy of Waikato District Health Board

FIG 5.9 Closer relationships developed between Wintec and the DHB during the 2000s. 80
Photo courtesy of Suzette Poole

FIG 8.1 Bob Elliott revisiting Tokanui in June 2006 112
Photo Courtesy of Stephanie Lambert

FIG 8.2 F Ward/Whai Ora circa 1989 113
Photo Courtesy of the Waikato District Health Board

FIG 8.3 K Ward/Whai Ora circa 1990 114
Photo Courtesy of the Waikato District Health Board

FIG 8.4 Whai Ora charge nurse Ron Baker 116
Waikato Times c.1988

FIG 8.5 Rovina Maniapoto-Anderson, Tokanui's Maori Health co-ordinator 116
Waikato Times c.1988

FIG 9.1 Midland Region serviced by the Regional Forensic Service 134
Map Courtesy of Half Court Press

FIG 9.2 Dr Niazi Kraya, Clinical Director, Forensic Psychiatry 137
Photo Courtesy of Waikato District Health Board

FIG 9.3 The Transcultural Psychiatry Conference organising committee 138
Photo and caption information: Health Waikato, 2 April 1998

FIG 9.4 Henry Bennett and Jeff Symonds 139
Waikato Times 1993

FIG 9.5 D Ward dormitory circa 1994 140
Photo Courtesy of Jeff Symonds

FIG 9.6 D Ward circa 1991 141
Photo Courtesy of Waikato District Health Board

FIG 9.7 Puawai logo launched in August 2010 146
Courtesy of Waikato District Health Board

FIG 9.8 and FIG 9.9 Kohatu (rocks) in Te Puna a Taane courtyard, August 2010 147
Photos Courtesy of Waikato District Health Board

FIG 10.1 Dr Henry Rongomau Bennett 152
Photo Courtesy of Bennett Family

FIG 10.2 John Howie senior, who was Head Attendant at Tokanui Hospital from 1927 to 1940 155
Photo Courtesy of Carole Seymour, daughter

FIG 10.3 Food distribution system until kitchen closed in the early 1990s 159
Photo Courtesy of Waikato District Health Board

FIG 10.4 St Barnabas Chapel, Tokanui Hospital, May 1964 163
Photo Courtesy of Waikato District Health Board

FIG 10.5 Charred relics salvaged after the fire, displayed as part of the Te Awamutu Museum exhibition, 2006 164
Photo Courtesy of the Te Awamutu Museum

FIG 10.6 The co-location of memorial stones from the Waikato Hospital Nurses' Chapel and Tokanui's St Barnabas chapel 165
Photo Courtesy of John Graham

FIG 10.7 Betty Paul and Joyce Dey (nee Rosser), circa 1949 167
Photo Courtesy of Joyce Rosser

FIG 10.8 Ann Donaldson and Vida Owens working in the sewing room, circa 1988/89 173
Photo Courtesy of Vida Owens

FIG 10.9 Doctors' residence 1964. Jill & Rachael Rolfe 175
Photo Courtesy of David Rolfe, son of Dr D Rolfe

FIG 10.10 Felicity & John Saxby circa 1992 188
Photo Courtesy of Halcyon and Blithe Saxby

FIG 12.2 Acknowledging the turning of the first sod of soil prior to construction on 7 March 1996 215
Courtesy of John Graham

FIG 12.3 Dr Henry Bennett in front of the centre under construction, 1997 215
Photo Courtesy of the Bennett family

FIG 12.1 Administration building circa 1990 215
Photo Courtesy of Waikato District Health Board

FIG 12.4 Staff reunion 'Halcyon Days and Tranquil Nights' over Labour weekend 2007 217
Courtesy of John Graham

FIG 12.5 The Henry Rongomau Bennett Centre in Hamilton, December 2003 218
Photo Courtesy of Waikato District Health Board

FIG 12.6 At official opening on 15 November 1997 (left to right) Hon Bill English (Minister of Health), Dr. Henry Rongomau Bennett, Tania Tapsell & Bishop Manu Bennett 219
Photo Courtesy of Waikato District Health Board

FIG 12.8 Ken Jamieson turns out the lights on 31 March 1998 220
Photo Courtesy of John Graham & Ken Jamieson

FIG 12.7 John Graham turns out the lights on 31 March 1998 220
Photo Courtesy of John Graham & Ken Jamieson

FIG 13.1 Cemetery plaque 1994 233
Photo Courtesy of Waikato District Health Board

FIG 13.2 Tony Moran pointing out a location on the Tokanui campus map at the Te Awamutu Museum exhibition, 2006 234
Photo Courtesy of Stephanie Lambert

WAK0000200

ABBREVIATIONS

MB: Bachelor of Medicine

ChB: Bachelor of Medicine, Bachelor of Surgery

Dip Psych: Diploma of Psychology

MANZCP: Member of the Australian and New Zealand College of Psychiatrists

LRCP: Diploma of Licentiate of the Royal College of Physicians

MD: Doctor of Medicine

CM: Master of Surgery

MRCS: Member of the Royal College of Surgeons of England

DPM: Diploma of Psychological Medicine

Edin: Edinburgh

Regd: Registered

Hosp: Hospital

C/N: Charge Nurse

NP: Nurse Practitioner

EDITOR BIOGRAPHIES: WAIKATO MENTAL HEALTH HISTORY GROUP

Dr **Catharine Coleborne** is Associate Professor in the History Programme at the University of Waikato, New Zealand. She is the author of two books, including *Madness in the Family* (Palgrave 2010) and the co-editor of four books, including *Exhibiting Madness* (Routledge 2011) and four Special Issues of refereed journals. Her research focuses on the social and cultural histories of illness and medicine, especially psychiatry, and histories of patients and families. From 2000, Cathy became involved in ongoing community-based research around mental health histories, also assisting with the oral history project (led by Te Awamutu Museum) and a local project around oral histories of intellectual disability experiences for the Spectrum Care Trust in Auckland. She is a Trustee of the Waikato Health Memorabilia Trust and wrote the short published history of the Waikato Medical Research Foundation (2000).

John Graham trained as a paramedic in the Rhodesian Army and has subsequently been in hospital management and administration in Zimbabwe and New Zealand. He has worked for the Waikato District Health Board in a variety of roles for the past twenty eight years: including as Manager of Te Kuiti Hospital, and Manager of Tokanui Hospital, along with other district responsibilities. John played a pivotal role in facilitating the closure of Tokanui and the opening of the Henry Rongomau Bennett Centre, and he has always had an historical bent, so for him, recording the history of mental health services in the Waikato has been very important.

Stephanie Lambert is a museum professional with particular interest in collaborative strategies of recording and telling histories. She was Senior Curator at Te Awamutu Museum from 2006 to 2011, and during that time worked with people from Tokanui Hospital, the military (particularly the Waikato Mounted Rifles), former postal and railway employees, tangata whenua, and the community at large, developing exhibitions and interpreting stories in a range of different media. She wrote a Master of Arts thesis titled 'Engaging practices: rethinking the use of narrative in exhibitions', and currently lives in Wellington where she is working towards a Post-graduate Diploma in Publishing.

Suzette Poole (Te Huia, Gisler) began her career at Tokanui Hospital in 1980 part-time as a psychiatric assistant in the psychopaedic wards. She registered as a psychiatric nurse in 1985 and most of her 30 years of practice has been in the Waikato area. She specialised in forensic mental health and worked for a brief period on site at Waikeria Prison. Suzette has been a clinical nurse educator and clinical nurse director for the mental health and addictions service, Waikato District Health Board. In 2007 Suzette left the area and took up a role in Wellington as the Nurse Advisor; Health for the Nursing Council. In 2011 she attained her current position as Clinical Lead, Te Pou o Te Whakaaro Nui (The national mental health workforce centre). Suzette is a Fellow of Te Ao Maramatanga, NZ College of Mental Health Nurses. Suzette has four children and their iwi is Ngati Maniapoto; hapu - Ngai Paretekawa and marae - Mangatoatoa, She has nine grandchildren and currently resides at Waikanae Beach with her partner Roger Moore, near Wellington. Suzette has a keen interest in mental health nursing history and is of the view that '*Understanding our past helps to inform our future*'.

WAK0000200

AUTHOR BIOGRAPHIES

Pepeha: Ko taku maunga he maunga tu, kare he maunga nekeneke. **Ronald Baker** is a Psychiatric Nurse who trained at Carrington Hospital, Auckland in 1979. Ron's twenty five year nursing career has been in Kaupapa Māori services and establishing new crown and iwi based kaupapa services. In the Waikato, Ron was a staff nurse and charge nurse at Whai Ora Cultural Unit at Tokanui Hospital. In Auckland, he was the manager at Te Whare Paea Māori Cultural Unit and involved in the development of Rapu Ora Māori mental health service at Kingseat Hospital, South Auckland, Tainui. On the East Coast, Ron helped develop iwi based Kaupapa Māori services in Mahia, and also worked with Ngāti Porou Hauora. In Northland he was the CEO of North Care Trust Mental Health Services, Whangarei. Ron is currently the Kaumatua for the Auckland/ Waitemata DHB Mental Health Services. He was granted a Winston Churchill Fellowship and an ANZAC fellowship to study Indigenous Health Services and Practices amongst the First Nation People in The USA and the central and southern Aboriginal People of Australia. Ron has provided cultural training to Crown Health Enterprises (CHEs) and Regional Health Authority (RHA) in Auckland and taught the Hauora Diploma for Te Whare Wānanga O Awanuiarangi. Ron is a Fellow of Te Ao Maramatanga, New Zealand College of Mental Health Nurses and in March 2012, was awarded the Whetu Kanapa medal in honour of his career long contributions, in the fields of Māori wellbeing and mental health nursing. Ron has three children and many mokopuna. He describes his career to date as simply *'service to our people'*.

Alexander Brown completed his Honours degree in History at the University of Waikato, taking social history of medicine and mental health as his research focus, working towards a dissertation focused on representations of mental health patients in the *Waikato Times* in the 1970s. This meant that Alex could utilise a specific body of printed materials and investigate the layers of ideas created about mental health across a decade. Alex also enjoys sports and is finishing his Masters thesis in History, looking at social histories of alcohol use and drunkenness in Hamilton, New Zealand.

Michelle Campion completed her Master of Arts in History at the University of Waikato in 2009. Her thesis, 'Narratives from the Mind's Eye: The Significance of Mental Health Pathography in New Zealand, 1980-2008', examines sufferers' personal accounts of their mental illness experiences and provides insights into the patient's perspective of mental health treatments. She currently works for the University of Waikato.

Robert Mingi Elliott (Bob) has tribal affiliations with Ngaati Maniapoto; Ngaati Hauraki & Ngaati Kahu-ngunu. His hapuu are Ngaati Paia; Ngaati Unu; Ngaati Ngutu; Ngaati Apakura & Ngaati Paretekawa. Bob registered as a Psychiatric Nurse in 1965 at Tokanui Hospital and gained a Registered Comprehensive Nurse qualification in 1980. During the span of his career, Bob has held many senior management positions including bicultural advisor to the Waikato Area Health Board. Bob has presented widely at national and international forums and was instrumental in the creation and development of Whai Ora at Tokanui Hospital and Hauora Waikato Maori Mental Health Service in Hamilton. In March 2012, Bob was awarded the Whetu Kanapa medal by Te Ao Maramatanga, New

WAK0000200

Zealand College of Mental Health Nurses in honour of his career long contributions, in the fields of Māori wellbeing and mental health nursing. *Whetū Kanapa are brilliant and gleaming stars, personifying Māreikura and Whatukura.* In 2006, Bob retired to track whaanau Waitangi land claims. He has seven children and eighteen grandchildren (with another arriving in Dec.) 'My experiences have been varied & wonderfully enhanced by the many people that I have met along the way. Life has been exceptionally generous'. Ngaa mihi tino aroha ki a koutou katoa. Noo reira, teena taatou katoa

Adrienne Hoult is a University of Waikato graduate in History. She completed her Bachelor of Arts (Hons) in 2004 and Master of Arts in History in 2007. Her chapter draws on her Masters thesis on the intellectually disabled patient population at Tokanui during its early years to 1935. Adrienne currently lives and works in Hamilton.

Ken Jamieson trained as a registered psychiatric nurse at Tokanui hospital and worked there for the majority of the time until its closure. He fulfilled a number of roles which included: Staff Nurse, Nursing Tutor, Nursing Supervisor, Assistant Principal Nurse and finally as Manager of the Intellectual Disability Services prior to its closure. Ken also qualified as a Registered General & Obstetric Nurse at Waikato Hospital. Currently Ken is a staff nurse/shift co-ordinator with the forensic services in the Henry Rongomau Bennett Centre.

Rovina Maniapoto-Anderson, Iwi – Ngāti-Maniapoto; Hapū – Ngāti-Paretekawa; Marae- Mangatoatoa – Tokanui Road, Te Awamutu. Rovina was born at the foothills of Kakepuku and Pirongia and attended primary and secondary school in Te Awamutu. She grew up with nine siblings who are now scattered world wide. At present, Rovina works for Open Wānanga as Cultural Ambassador, but is heavily involved with the Maniapoto Tribunal Claims as Translator and Quality Assurance. A sister to all the above, a mother to six, grand-mother to eighteen, and great-grandmother to six, Rovina's role now is to rewrite history from our perspective. Writing this chapter for our Tokanui Book has indeed been an honour. Kia Ora.

Dr **Eleni Nikolau** is a Consultation-Liaison Psychiatrist at the Waikato DHB who is a medical graduate of the Otago Medical School and practised in General Practice for a number of years before commencing her training in Psychiatry through the Upper Central North Island Training Programme. She is a Greek New Zealander who has an interest in both the history and transcultural aspects of psychiatry. Living and working in the Waikato for over 25 years exposed her to the still operational Tokanui Hospital and the impact of this Institution and subsequent closure on the staff, patients and wider community.

Kate Prebble, RN, PhD is a registered nurse and historian. She has had a lengthy career in mental health nursing in clinical, education and leadership positions. In 2007, she completed a PhD thesis at the University of Auckland titled 'Ordinary Men and Uncommon Women: A History of Psychiatric Nursing in New Zealand Public Mental Hospitals, 1939-1972'. Kate is currently employed as a senior lecturer in the School of Nursing, University of Auckland. She teaches mental health nursing at undergraduate and postgraduate levels and continues to pursue her research interests in the history of nursing and psychiatry, and in contemporary issues of mental health.

Jeff Symonds, RPN, NP started work at Tokanui Hospital in April 1979 as a student nurse, and became a staff nurse in 1981. A few years later he was appointed a Charge Nurse, initially in a psychopaedic ward (ward 16) then onto a group therapy unit Ward 21 (Kia Tukua Ki Te Arama) for a

WAK0000200

couple of years before helping start forensic inpatient services with Dr Niazi Kraya as the first Charge Nurse in Ward 2. Later, Jeff completed a Masters degree in Health Sciences at Auckland University, changed roles to work as Service Manager of the Regional Forensic Psychiatric Services for several years then switched again back to a clinical role and became a Nurse Practitioner (NP) in Adult Mental Health Services. Jeff is currently working as an NP in the Bay of Plenty predominantly in the Eastern Bay.

Ko Ngongotaha te maunga
Ko Kaituna te awa
Ko Te Arawa te waka me te iwi
Ko Ngati Whakaue te hapu
Ko Whakaue te marae

Ko **Rees Tohiteururangi Tapsell** taku ingoa

Dr Tapsell was born and bought up in Rotorua, New Zealand and hails from the Arawa tribe of that region. He attended the University of Otago where he graduated MB ChB in 1988. He spent several years working in family medicine and the field of alcohol and drug work and after a period of travelling, he began his postgraduate training in psychiatry, gaining his fellowship to the Australia and New Zealand College of Psychiatrists (RANZCP) in 1998. Dr Tapsell is currently the Executive Clinical Director of PUAWAI: The Midland Regional Forensic Psychiatry Service; a joint initiative between Health Waikato and Hauora Waikato and he is the Director of Clinical Services for the Mental Health and Addictions Services of the Waikato District Health Board. Dr Tapsell's particular professional and research interests are the epidemiology of mental disorders, Mental health service development, outcome measures in mental health, 'mentally abnormal' offenders and undergraduate and postgraduate education and training.

Mrs **Ellie Wellington** (RGON, RPN, P.Grad. Dip. Health Sciences) commenced employment at Waikato Hospital as a student nurse in 1965 and completed her general and obstetric training. In 1979 she commenced her bridging to psychiatric nursing and in 1981 Ellie began working in ward 29, an acute mental health unit based at Waikato Hospital. In 1990 she took up the first position in the new Midland Regional Forensic Psychiatric Service as a forensic nurse and shortly afterwards became the Team Leader for the service until she retired in 2001. Ellie did return in 2005 as a nurse consultant for the service for a short period.

WAK0000200

INTRODUCTION

Changing Times, Changing Places

Catharine Coleborne

> The hospital whanau now dissipated into the community and the Henry Rongomau Bennett Centre. The staunch and hard-working staff of the Psych and I.H. Divisions, the Main Office, the medics and the para-medics, the ancillary staff, the volunteers, the visitors, the bureaucrats, the students, the Official Visitor, the Press, the transients, the frightened and the bewildered, the manuwhiri and tangata-whenua, the young the old, the local farmers and wives, social sports teams from Porirua and Kingseat hospitals, touring drama, ballet and musical troupes – all have come through the main gate and have since passed on to Elsewhere.[1]

These are the words of Bob Elliott, a mental health nurse at Tokanui Hospital between 1965 and 1996. Writing fondly of Tokanui ten years after its closure, he described the trees, the wards, the swimming pool, and the 'once immaculate' vegetable gardens. Yet as his words also tell us, for Bob Elliott, and many others who lived, worked or who were hospitalised at Tokanui, the place was far more than the sum of its physical spaces. For many, it was home and whanau or family. For others, it was a sad place that took them away from home and family. This history of Tokanui Hospital and mental health services in the Waikato is a collection of the different stories of the many members of that community. We have chosen to tell these stories through the eyes of several writers, with some of them perhaps even competing perspectives, hoping to capture close to the full range of responses to and experiences of mental health in the Waikato over time. As Elliott reminds us above, Tokanui Hospital – for a time, the main focus of mental health services in the region – was itself plural and complex. One view of this story would not satisfy our different audiences. Through our collectively authored history, we also show, here, as Elliott again invokes, how the closure of Tokanui impacted upon its many residents and staff and the wider community around the hospital, and how the dispersal of mental health functions into the community has continued to evoke resounding memories of Tokanui.

This book is the result of a major research project over a long period of time to produce a written historical record of the Waikato Mental Health Services between 1910 and 2012, including Tokanui

WAK0000200

as a hospital, which provides a pictorial and narrative account of the environment, buildings, staff and patient activity, care and treatment, and the socio-political context of the time. Known as 'Garden City' for much of its life, the title 'From Garden City to Fountain City' was for some time the working title for this book, and is a phrase used by some of the authors here. We have tried to capture, too, the close relationships formed between the hospital at the local places and people in Te Awamutu and Kihikihi communities. It includes images and narrative accounts of the history of the Waikato Mental Health Services in the period, and expands upon information obtained about the building of the mental health institution, Tokanui Hospital, around 1910 through to the opening of the new Mental Health Unit, the Henry Rongomau Bennett Centre, in 1997. It also considers the wider context of mental health services beyond this date, and takes us, in some chapters, to the present.

Our approaches and methods

The authors of the various chapters in this book utilise a range of historical research methods, including archival and document research in appropriate libraries and repositories, the analysis of reports, publications, newspapers and official sources, including the collation of statistical information. Social history research is often based on a collection of unpublished and published materials that can shed light on the complex interactions of people in the past. Official sources, such as government documents or clinical medical notes, for example, are useful, but sometimes provide only the 'top down' view of the events of the past. Thus, other materials, such as personal writings and oral interviews, which can provide a broader perspective, are most valuable to the researcher. Therefore, importantly, the book also draws upon a set of oral histories collected as part of an oral history project about Tokanui conducted by Te Awamutu Museum between 2003 and 2005, as well as oral interviews and discussions conducted in an earlier phase of research. We have assembled a wide range of materials for some areas of the research, including photographic materials, in order to tell these stories. In our efforts to traverse the complex historical experiences of Tokanui and those interested in it, we also include a chapter which examines the media representations of mental health clients in the 1970s, and another which reflects on a museum exhibition.

This history of Tokanui and mental health services in the Waikato region is not a commissioned history that offers a chronological account of the institution, but rather, it offers up a series of histories that each present another window on the past. Many hospital or institutional histories in the field of medical history have been sole-authored works which sometimes include oral or reflective accounts, such as Wendy Hunter Williams' history of Porirua Hospital.[2] Warwick Brunton also produced a history of mental health services in the South Island, focusing on Seaview Hospital, Hokitika and West Coast mental health services between 1872 and 1997.[3] Although these books, and others, offer rich and detailed histories of their hospital sites, we faced quickly the enormous task of producing a history of an institutional site relatively close to the period of its closure. Recent history is often the most difficult to tell or capture in narrative. This problem, however, might also be a fine catalyst to include the sometimes raw and emotional responses of people still fairly close to the events and the place itself. Thus, most significantly, this book is a multi-authored volume. We believe it most accurately reflects the different viewpoints and values of the large community of psychiatric workers, patients and their families associated with Tokanui. We have continually ensured our sensitivity towards the issues surrounding psychiatric treatment and hospitalisation, as well to individuals being written about from all aspects of this community.

For some readers, parts of this book will seem 'academic'. The invited authors who have all participated in this project to produce a book were given a wide brief to write the piece they felt comfortable to write; some of these individuals invited co-authors and contributors, while others relied on more academic conventions for their chapters. Some of the chapters are the result of academic scholarship at university level and reflect the expectations of historical scholarship. Others, such as the personal reflective pieces in Chapter Ten, are individual recollections by those intimately associated with Tokanui and mental health care across the period. Where possible we have included the published and unpublished viewpoints of clients of mental health services, as I explain below. It was important

WAK0000200

to us to produce a history with reasonably detailed endnotes and references, so we also include here a select List of Sources for readers and future researchers.[4]

The academic context for this book

Histories of psychiatry have been part of a global trend in the social and cultural histories of medicine from the 1970s to the current moment. Historians interested in 'madness', 'insanity', institutions and medical professionals, and the institutional populations of the insane, have published their histories worldwide, often drawing upon the substantial archival productions of former institutions, sometimes dating back to the eighteenth century.[5] For former or current clients of the mental health system, such an academic pursuit might seem divorced from the 'reality' of mental illness for its sufferers. And yet these historians do have the political interests of psychiatric survivors in mind. Since the 1970s, a powerful anti-psychiatry movement to consider mental illness as one aspect of the nineteenth-century industrialising state's tendency towards the 'social control' of so-called 'difficult' individuals and social groups, has inspired much of this historical analysis.[6] Historians, then, have been concerned to find out if populations of those labelled 'mad' were sick, poor, transient, criminal, or a combination of these categories; in other words, how insanity and mental illness were understood or constructed at different historical moments began to drive social historical investigations of the medical field of psychiatry.[7] On the other side of the equation, some historians (and medical professionals with an interest in history) have also been interested in how medical professionals cared for people with mental illness, from psychiatrists, known as 'alienists', to mental health nurses. The caring professions and their histories too have benefited from these approaches to history.[8] Importantly, this volume should be seen and interpreted within a much larger international and national body of historical scholarly work about the histories of mental health. It now takes its place among the decades of research around these histories, and the people, which have shaped academic and popular thinking about mental illness and its treatments. Sometimes, this scholarship is overlooked in favour of popular understandings of the asylum as an unremittingly 'bad' institution. Research reveals much that could be understood as positive about psychiatric institutions of the past. We simply want readers to think about how Waikato's mental health history is part of a much larger international story.

People with mental illness

One aspect of this book that we feel strongly about is that it tells the stories of mental health from the perspectives of patients. The very word 'patient' is open to debate and discussion, a point articulated further in Chapter Seven. Instead of patient, we might say 'client', 'service user', 'survivor', 'sufferer', among other terms, but 'patient' also captures the dynamic we are evoking here in this book: a person who has become part of the medical model used to treat mental health clients over time, a sustained use of which is common in the historical literature. For example, Canadian historian of madness, Geoffrey Reaume, himself a former patient, or user of psychiatric services, writes sensitively about the histories of mental health patients.[9] In his book *Remembrance of Patients Past*, about Canadian mental health history, Reaume shows that the word 'patient' might be mobilised to re-examine medical notes from the patient's perspective, a project now undertaken by historians all over the world. By piecing together the inside worlds of institutionalised people, historians can convey something of the experiences not always written about from the patient's point of view, as Chapter Seven in this volume also suggests.[10]

We also understand that the term 'service user' is more appropriate when talking about the contemporary moment. While we did not commission an entire chapter from a current or former mental health services user, we have endeavoured to include oral and published accounts by former patients throughout the book, including one key section in Chapter Nine, focused on forensic psychiatry, contributed by one service user. Indeed, the many diverse stories of mental health patients at Tokanui across the twentieth century are represented through at least six separate chapters here. These chapters examine patient stories through oral and written accounts and clinical records, among other materials. We examine the first patients or inmates at Tokanui; intellectual disability to the 1930s,

WAK0000200

with a commentary on the period beyond this time; a psychiatrist's own perspective on changes in the treatment of mental illness over time through one clinical case; patients' journeys to and from Tokanui in the middle of the twentieth century, including their own reflections on mental breakdown and institutions; and representations of patients in the press of the 1970s; among other stories of mental illness.

The organisation of this book

We have organised this book using three parts, each of which coheres around a theme or collection of related aspects of the history of Tokanui and mental health. It begins with Part One: 'Histories of place and people: mental health and policies, training and personnel'. Here, in separate chapters, authors document and trace the early histories of Tokanui as a place of political, cultural and spiritual significance to Māori people; as an institution in a wider landscape of mental health in New Zealand, including its staff, and its legal and physical context; the education and training of nurses; and the intellectual disability population to 1935. Drawing on local, national and institutional histories, the chapters in this part feature the way that mental health was subject to legislative control, and how this had effects upon those committed for care and treatment. In Chapter One, Rovina Maniapoto Anderson shares with readers her whanau's close affiliation with and history of the land and its tangata whenua, most powerfully setting the scene for our stories, but also showing how history lives on in the hearts and minds of those who grew up near Tokanui. The European institutional models which came to dominate the spaces are examined by Michelle Campion in Chapter Two through the legal landscapes for mental health, with Campion showing how notions of mental health care and institutional treatment evolved and were part of a national system of healthcare. Campion again takes the lead in Chapter Three, with input from Catharine Coleborne and Kate Prebble, writing about the forms that early mental health took at Tokanui as an institution to the early 1930s. Campion takes us through a range of social histories of institutional life and work in a careful account of mental health in the period and people who shaped it. One of the most important aspects of Tokanui's history was the role played by intellectual disability in the formation of the spaces and ideas about institutional worlds. In Adrienne Hoult's Chapter Four, we find out more about intellectual disability (ID) in the formative years of Tokanui, with some final discussion of the role played by the ID sector in later years. Hoult also places her study in a much wider international perspective to show how ideas about intellectual disability were developing over time, and also in relation to notions of 'mental deficiency' and criminality, locating Tokanui firmly next to Waikeria Prison both spatially and in terms of their shared work. Finally in this part, Kate Prebble has produced a fine account of a long historical period of nursing training, showing how mental health nursing education was part of the story of mental health services.

Part Two, 'Treatments, Patients, Care and Control: Institutions and Change', reflects on treatment and institutional changes from the 1950s, the complex journeys made by patients who found themselves housed at Tokanui over the middle period of its operation, the role and importance of Māori mental health, and the relationship of forensic psychiatry to the wider functions of mental health in the region. In addition, Tokanui interacted with the prison system in New Zealand. These chapters draw upon archival research, biographies of staff, histories and first-hand accounts of clinical changes in psychiatry, drug therapies and practices. Eleni Nikolau's sensitive portrayal of a patient's clinical history allows her to reflect on changes in psychiatric practice over time in Chapter Six. Building on this story, but from the social perspectives of patients, Catharine Coleborne's Chapter Seven describes the 'journeys', both literal and figurative, taken by patients moving to and from Tokanui between the 1930s and the 1980s, using a selection of accounts, cases and interviews. Through a series of reflections and other sources, Chapter Eight discusses the impact of Whai Ora or Maori wellness in mental health, a Tokanui innovation of national and international significance. Finally, in this part, a collaborative chapter by Suzette Poole, Ellie Wellington, Rees Tapsell, Jeff Symonds and a Service User provides us with a critical view of regional forensic services for mental health in the late 1990s to the recent past.

WAK0000200

Part Three, 'Memories, Stories and Communities', reflects on Tokanui's history through the eyes of those who lived and worked on site in Chapter Ten, in a series of rich personal accounts of Tokanui, and also through the media's representations of mental health and patients in the twentieth century in Chapter Eleven by Alexander Brown. Chapter Twelve, written by those who were part of the closure of Tokanui, John Graham, Ken Jamieson, as well as Campion and Lambert, describes the story of the closure of Tokanui and the move to community-based care, also detailing the many community based agencies now devoted to caring for people with mental illness. The book concludes with a chapter from Lambert about 'Footprints on the Land', the exhibition of Tokanui's history held at Te Awamutu Museum in 2006. The many visitors to the exhibition also played a role in constructing aspects of its history for the curatorial team. Lambert, as a professional museum curator and knowledgeable historical researcher, has produced a fluent account of the way we might gain something by looking back at the way history is made, how it is shown and made visible, and the role of the museum exhibition in the forging of new memories.

Final thoughts

Like the museum exhibition, and the many rich recollections and memories shared in this book, we hope to reach, touch and educate many readers with our collective approach to these stories, which we feel no one individual author could tell effectively. Gaps, omissions and oversights remain our own, and more research can always be conducted and fresh accounts of historical change written. Yet we hope that when considered together, these separate chapters inspire some different ways of thinking about the pasts of Tokanui, mental health services and mental illness, and also create a new and vital sense of compassion for all of those engaged in the important work to make mental wellness a priority. No institution or system of care is perfect, but the many people who aim high will always help to make life better for those people and their families who are dealing with mental illness.

Notes

1. Bob Elliott, 'Tokanui Hospital Re-Visited', Te Ngira, *Hamilton Press*, 6 December 2006, p. 29.
2. Wendy Hunter Williams, *Out of Mind, Out of Sight: The Story of Porirua Hospital* (Porirua: Porirua Hospital, 1987).
3. WA Brunton, *Sitivation 125: A History of Seaview Hospital, Hokitika and West Coast mental health services, 1872-1997* (Hokitika, New Zealand: Seaview Hospital 125th Jubilee Committee, 1997).
4. In some examples of commissioned histories references are lacking which makes the task for future research more difficult. We have done our best to provide as much detail as possible, also including relevant appendices. An excellent example of academic historical research in this field in New Zealand is *'Unfortunate Folk': Essays on Mental Health Treatment, 1863-1992*, edited by Barbara Brookes and Jane Thomson (Dunedin: University of Otago Press, 2001).
5. Most studies situate histories firmly in the nineteenth century since institutional archival records are prevalent and plentiful in this period.
6. See for example Thomas Szasz, *The Myth of Mental Illness: Foundations of a Theory of Personal Conduct* (New York: Harper and Row, 1974); Michel Foucault, *Madness and Civilisation: A History of Insanity in the Age of Reason translated from the 1961 edition in French* (New York: Random House, 1965).
7. Andrew Scull, *Museums of Madness: The Social Organization of Insanity in Nineteenth Century England* (London and New York: Allen Lane and St. Martin's Press, 1979); Andrew Scull, *The Most Solitary of Afflictions: Madness and Society in Britain 1700-1900* (New Haven and London: Yale University Press, 1993). See also: *Mental Health and Canadian Society: Historical Perspectives*, edited by James E. Moran and David Wright (Montreal and Kingston: McGill-Queen's University Press, 2006); Pamela Michael, *Care and Treatment of the Mentally Ill in North Wales 1800 – 2000* (Cardiff: University of Wales Press, 2003); and *Asylum in the Community*, edited by Dylan Tomlinson and John Carrier (London and New York: Routledge, 1996).

WAK0000200

8 Kate Prebble, Lee-Ann Monk, *Attending Madness: At Work in the Australian Colonial Asylum* Clio Medica, Wellcome Series in the History of Medicine (London and Amsterdam: Rodopi, 2008).

9 Geoffrey Reaume, *Remembrance of Patients Past: Patient Life at the Toronto Hospital for the Insane, 1870-1940* (Oxford and Toronto: Oxford University Press Canada, 1997; University of Toronto Press, 2009).

10 Reaume, together with others, also founded the online archives of psychiatric survivors in Canada: see http://www.psychiatricsurvivorarchives.com/ (URL accessed 17 April 2012).

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Part One

Histories of place and people: mental health and policies, training and personnel

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FIG 1.1: Aerial photo of Tokanui circa 1991
Photo Courtesy of Rovina Maniapoto-Anderson

CHAPTER 1

Tokanui Te Whenua: A Tangata Whenua Perspective

Rovina Maniapoto-Anderson

Kakepuku-te-aro-aro o Kahukeke and her master Pirongia-te-aro-aro-o-Kahukeke, the two mountains created by Papa-tu-a-nuku, lie in the heart of the Waipa–Puniu Valley. Just to the south is the small hillock Te Kawa. Truly a picture that conjures the image that this was: the father mountain, Pirongia, the mother mountain, Kakepuku, and their wee sibling, Te Kawa. This then was the setting that eventually came to be the land of healing and protection for those whose minds were lost in the realm of wai-rangi and po-rangi. The contours of the land, its proximity to the Puniu River (te aukati line) proved most conducive to the environment that was needed to ensure a process of well health would begin. Geographically it was situated in the centre of the North Island and had close access to the main Trunk Line at Te Mawhai, to State Highway 3, and a mere 100 miles from Auckland city. The scene was set. Look carefully at the picture and you can see the beauty of the land that was chosen to be a haven for the mentally ill.

Te Timatanga – The Beginning

Let me return however to the days of yesteryear, long before Tainui Waka arrived on the shores of Kawhia Harbour. Once upon a time there lived on the banks of the Puniu River, where the present Mangatoatoa Marae (2) stands, a tribe of people known as Te Waiohua. Some say they came from the East Coast, some say they came from the Rotorua area. Archaeologists' findings indicate that they lived there prior to 1350. They were the indigenous people of this land. Many years later, when Rakataura,

WAK0000200

the tohunga of the Tainui waka came inland, his descendants eventually evicted these people from this area, and it is said that they migrated to Tamaki-Makau-rau (Auckland) and lived on the slopes of Maungakiekie (One Tree Hill). Genealogy tells us that some intermarried with descendants of Tainui Waka and their issue still live today, a proud race.

In researching the past history of this Tokanui area, I find that the name 'Tokanui' actually refers to the area known today as the Te Kawa Crossroads. This was where the seven foot giant Kiharoa lived. Stories tell us that at one stage Wahanui (the first) challenged Kiharoa to a battle but pointed out that due to the excessive difference in height, he should dig a hole, which would make both parties fight on equal height level. Kiharoa agreed and stepped into the hole. Wahanui immediately raced behind Kiharoa and before he could turn, Wahanui had decapitated Kiharoa, and the rest is history.

Let us now come forward and venture into the nineteenth century. The early 1800s for Māoridom, and in particular the sub-tribe of this area, Ngati-Paretekawa, was a time of turmoil and battle from all other tribes of the lower part of the North Island. The biggest battle in all of Māori history took place just north of Te Awamutu at a place called Mangeo on the banks of Lake Ngaroto. According to Pei Te Hurinui Jones, over 10,000 came to assist a Ngati-Toa-Rangatira Chief, Pikauterangi to annihilate Waikato and Maniapoto. By implementing the battle strategy 'Te Kawau Maro' the locals managed to defeat the enemy and many were drowned and killed at Ngaroto.

Immediately after this, our ancestor, Peehi Tukorehu, gathered a group of warriors and set out to avenge those who had come. This was known as Te Amio-Whenua – the encircling of the land. Much destruction took place during this period. By 1820, Te Rauparaha had left for Kapiti and shortly after, the missionaries arrived and our people adopted Christianity and learnt how to use the plough. They became prosperous and began transporting crops such as wheat, barley, maize, peaches and corn to Auckland via the small rivulets and the river Puniu and from there to the Waipa River which connected with the Waikato River at Ngaruawahia and from there to the Waikato Heads and then to Auckland. The Ngati-Apakura people who lived at Hairini — at Rangiaowhia — were industrious people, who were keen horticulturalists, and life flourished for them with the Catholic Religion on one side and the Methodist and Anglican Denominations on the other; their choice of religion remained wide open.

It was not long however, before circumstances changed and the first was the price of their goods came plummeting down, due to the buyers in Auckland. Secondly, the Edward Gibbon Wakefield Trust had begun to sell land to would-be settlers in England, but there was only one problem, the Maori people in Waikato refused to sell their land. In 1864, the Waikato Wars began, ending at Orakau on the 31 March to 3 April. The ultimate result was 180 killed and 1.2 million acres of land confiscated.

Waikato and Ngati-Paretekawa were evicted into Te Rohe Potae (later to be known as the King Country) and from Orakau to the tip of Pirongia and north to an area just south of Auckland, the Crown claimed this land as punishment for those Maori rebels who fought against the Crown. Ngati-Paretekawa were offered land space around (what became the) Tokanui Hospital area by their relatives, the Ngati-Te Kanawa, the descendants of Whati, brother of Paretekawa. In addition to a place to build their home, they were also given a place to bury their dead. This is the urupa that is situated at the top of the summit where the large water tanks are situated above the Hospital. This is known as Pukekawakawa. It is stated that there are over eighty of our Ngati-Paretekawa descendants buried here.

Later this area of one acre was set aside in the Maori Land Courts as an Urupa or cemetery. Access can only be gained to bury our dead if we first seek permission from the Ruakura Research Site Manager. We also note that the roadway to take our deceased for burial has also been changed making it very difficult to park all vehicles as this is on the edge of a steep slope. The land south of the Puniu bridge became known as Te Rohe Potae. In 1886 the Maori Land Court was initiated to hold Court sittings at Kihikihi, Otorohanga and Cambridge. The exercise was to encourage Maori to relate to the Court their Mana Whenua status indicating where they lived, how long they had lived there and from this, land areas were allocated to individuals in large land blocks. This was known as multiple ownership. Bear in mind that this only happened south of the Puniu River. Allocations (referred to as shares) were of course, made to our ancestors.

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Twenty years later, in 1906 and 1907, the Crown decided that it wanted to build two institutions. One, a prison to cater for those who offended against the Law and two, for those who were mentally ill, bearing in mind this also included intellectually disabled and deformed, those elders suffering from senility, and of course the psychotically ill. Remember, they already 'owned' 1.2 million acres north of the Puniu River. However, for some unknown reason they chose to build these two institutions immediately south of the Puniu River. They took 10,000 acres under the Public Works Act: 5,000 acres for Tokanui Mental Hospital and 5,000 acres for Waikeria Prison (written as Reformatory). And that is how Tokanui Hospital happened to be built on its site. (The same applies to Waikeria.)

Ironically, my siblings and I were born and lived on Waikeria Rd. The past hospital administration records will show quite clearly how the hospital was built, the building of the bridge and later the construction of the roadway from the bridge to the Tokanui turn off. Our Hapu of Rewatu Pa (now known as Mangatoatoa Pa (2)) were given just over 60 acres to live on, including three acres as a cemetery. Our Te Haate whanau was given the area directly opposite the Hospital proper and this amounted to approximately 200 acres. No part of this area has been sold.

Interestingly enough the name of the larger block is Tokanui 1. Let me now refer to the Public Works Act. This Act states quite clearly 'that when the area of land taken is no longer required for its original purpose (for example, as a Mental Hospital – it was closed in 1996) it shall revert back to its original owners or their successors.' Try as we might at that time we were not even recognized nor listened to re our successor–ownership rights. I was a member of the Waikato Area Health Board at the time and I was conveniently shut out of all Corporate and Management discussions.

Unbeknown to us however, in 1975 the Crown decided to 'sub-let/change ownership' of all of the farm area to the Ruakura Research Station. My question is – where do we stand as the descendants of those original owners? This is the process that we are undergoing at the present time in taking our case of injustice to the Waitangi Tribunal.

The Puniu River flowed from the foothills of the Rangitoto Ranges and eventually flowed past Waikeria Prison, past our homestead at Waikeria Road and circumnavigated its way past the second Mangatoatoa Marae. In this, our growing-up years, we knew every inch of that river bank. We literally swam from daylight to dusk and caught eels for supper, fresh water koura and picked the water-cress for our evening meal. On Saturdays, we would help our mother take the washing down to the river and this would be our cleaning agent. This was our sustenance, this was our cleanser, this was our life line. As young children we heard our Dad talk about these very issues, but those were the days when Environment Waikato, Green Peace, and all these world saviours did not exist, and so his words fell on deaf ears or, more correctly, no ears, but he and his relatives would discuss this problem at length, if only, perhaps, for us to hear and eventually attempt to do something.

Then slowly, we saw it happen. The river began to change colour, ever so slightly, but change it did. The effluent from Waikeria Prison, the debris from the farmers sheds, the fertilizers from the paddocks, the waste material from Tokanui Hospital was being ejected and pushed into the Puniu River. By 1970 it was no longer safe to swim in the river.

Be that is it may. Nothing can take away the wairua and the aroha that practically all carers who worked at Tokanui over those 90 years experienced.

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CHAPTER 2

Mental Health and Legal Landscapes

Michelle Campion

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

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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.

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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

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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 principal, 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.
[3] Brunton, 'A Choice of Difficulties', p. 146.
[4] Brunton, 'A Choice of Difficulties', p. 176.
[5] Brunton, 'A Choice of Difficulties', p. 144.
[6] Brunton, 'A Choice of Difficulties', p. 145.

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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.

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.

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.

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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

WAK0000200

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'.

WAK0000200

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

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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

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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 colony[12], 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

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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 loosing 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.

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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.

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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, *AJH*R, 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 Mellsop, 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.

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CHAPTER 3

Mental Health at Tokanui in the Early Years

Michelle Campion, Catharine Coleborne, and Kate Prebble

> 1912. It wasn't like it is today. Large low villas, several two storey brick villas, large areas of lawns and gardens, but vast swamps and rushes. The first buildings were of corrugated iron and later still the long wooden buildings all connected and served by a long, long corridor. [1]

For Dot Whittle, reflecting back almost eighty years to the 1920s when she lived at Tokanui with her family, it is the hospital's physical imprint that is foremost in her memories. The daughter of James Cran, one of Tokanui's first two attendants, Dot's memories evoke an image of the estate that might euphemistically be termed 'pioneering'. Confronted by little more than swamp and scrub, the vast area of unbroken land acquired for Tokanui's construction must have presented a daunting sight to those latterly removed from the comparative civility of Porirua's well established grounds. The long wooden buildings which Dot draws attention to represented a significant departure from the large, austere, main building asylums that had characterised construction in the nineteenth century. Although other institutions experimented with smaller standalone additions, such as cottages, Tokanui was the first hospital to be built entirely to the villa design, and as such, its physically separate wards presented considerable opportunity for the classification and treatment of patients. Piecing together information contained in the remaining records, this chapter describes the formative years at Tokanui, during which not only a hospital, but also a community was established. The narrative which follows tells of buildings erected, land broken, cultivated and beautified, of hard physical labour and trying conditions. Above all, it is a narrative of the people who worked and lived, however fleetingly, at Tokanui and without whom the hospital would not have had a purpose. As the first new hospital to be built after provincial time, Tokanui, in many respects, led the way in developments made in the accommodation and treatment of the psychiatrically ill and those with intellectual disability.

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FIG 3.1 Dorothy 'Dot' Whittle

Photo Courtesy of Judy Besley

FIG 3.2 Mr G Reynolds outside Mr W Melville's house on the corner of Mangapiko Street, Te Awamutu with his team of horses and load of sand for Tokanui buildings. In the years 1910 – 1912 Mr George Reynolds with his team of horses carted the metal and timber and sand to Tokanui to build the Superintendent's house and the hospital. The first of the hospital buildings was finished and the patients moved to their new home in July 1912.

Photo Courtesy of Graeme Daysh, grandson of George Reynolds

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Space: A Mixed Blessing

According to the department's annual report for 1907, space was the primary consideration when selecting a location for its proposed new hospital. Not only did the site have to be 'sufficiently large for a mental hospital made up of detached buildings', and be 'capable of very considerable extension', it also required sufficient space, 'apart from [the] mental hospital ... for other institutions or "colonies" which may be placed hereafter under the control of this department'.[2] To this end, just under 5,000 acres of land was acquired at Te Mawhai, and although in 1926 this would be reduced to 1,200 acres[3], the sense of spaciousness which the estate engendered remained a feature of the hospital for the duration of its operation. In later years, when civilisation began to encroach and a greater connection was forged with the outside world, Tokanui's space would be remembered positively, by staff and patients alike, for the respite that it provided those who, as Lloyd Anderson put it, needed to 'get away from other people'.[4]

The viability of the hospital's villa design relied on ample space for the construction of physically separate wards, ideally spaced '30–50 yards apart'.[5] The space between the wards, which over time came to incorporate gardens, footpaths and streets, helped to create a feeling of community which officials were keen to foster. It was their belief that the sense of normality it would lend to the institution would aid patient recovery. To this end, each villa was envisaged as a separate house and, as with the community beyond Tokanui's boundaries, the inhabitants of each 'house' were required to venture forth into the 'streets' to work, eat, engage in recreational activities and visit the dentist. In this way, space helped to define both physical and social boundaries, reasserting a modicum of the normality that was lost in the artificial environment of the large, main building asylums.

The space required for Tokanui's development was most readily available in a rural location. In addition to being more easily obtained, and in larger quantities, than land within close proximity to an urban centre, Tokanui's rural situation made it more affordable and addressed concerns the government had regarding the conspicuousness of patients, public opposition to urban facilities, overcrowding and limited external space for work therapy, and recreation. Many of these concerns were the result of urban encroachment, where asylums, formerly on the outskirts of town and society, found themselves centrally located and the subject of a less than sympathetic public gaze as expansion eroded their isolation. The issue of encroachment arose most conspicuously in relation to Dunedin and Mount View asylums where special constraints necessitated the occupation of patients outside of asylum grounds, or kept the majority confined or restrained.[6] Disapproving of the 'extreme publicity'[7] which these institutions faced in their now central urban locations, Inspector-General Skae (1876-81) began favouring rural areas for the building of new asylums and, by the early 1880s, situating institutions in rural settings had become a distinct policy, which, Brunton notes, the *Evening Post* 'urged the government to adopt'.[8]

As a reflection of popular sentiment, newspapers expressed public opposition to the development of urban mental facilities, an opposition which was highly influential in the government's decision to shift focus to rural locations. Although positively projected as providing a calming and therapeutic environment away from the stresses of modern existence, removing patients from the prejudiced and fearful gaze of the public was equally a means, if not the primary motivation for some politicians, of mollifying public fears over potentially dangerous and certainly unpredictable lunatics. The isolation which a rural location afforded not only segregated but also confined as the greater visibility afforded by the surrounding landscape and the isolation from the wider community reduced the likelihood of patients successfully escaping. With few buildings to break the line of sight, the sense of space and isolation in those first few years at Tokanui must have been extreme and for patients transferred from existing institutions in major cities, the seclusion of Tokanui would only have been strengthened by the rural setting and low, flat character of the land.

The therapeutic effect of Tokanui's rustic landscape was enhanced by the creation of ornamental gardens. Towards the end of the 1920s Tokanui's medical superintendents began reporting various improvements to the hospital. In 1927 Dr MacPherson reported that extensive decorative work to the interior and exterior of the hospital had been carried out.[9] A year later, Dr Childs noted the greater

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freedom and improved outlook for patients following the removal of fences and elimination of shut-in airing-courts.[10] Then in 1929 he reported that '[t]he work of beautifying the grounds and the making of lawns had been proceeded with', remarking that, despite there being considerable work yet to be done, 'a distinct improvement has been noted'.[11] In 1932 Dr Prins reported the removal of more fences, the opening out of the front grounds, the sowing in grass of a new recreation ground and the draining of swamp land in front of the villas.[12] The following year he reported that the new sports ground had done much to improve the hospital's appearance, as had a number of ornamental trees and shrubs planted in the grounds and on the pathway to the Nurses' Home.[13] The planting of further trees and shrubs was reported in 1935, along with the completion of two new colfix tennis courts and, somewhat fittingly, after nearly a decade of improvements, a start was made once again on the repainting of the hospital.[14]

Although the planting of trees and shrubs was reported on several occasions, details of the exact planting scheme and types of plants used during those first few decades remain scarce. However, given a comparative description of Kingseat's gardens detailing the use of both native and introduced species, especially bright colourful flowers such as pansies, it seems reasonable to assume that Tokanui's planting scheme would have been similar.[15] A *New Zealand Nursing Journal* article, dated 1957, featuring a photograph of Tokanui with the admission block in the background and two men tending a flower garden in the foreground, provides further clues to the design of the grounds. The photograph shows a neatly trimmed hedge and a variety of well established trees and shrubs set among well kept lawns. Wendy Hunter Williams observes that:

> [b]eautiful gardens with trees and shrubs were seen as a very important part of the hospital, not only in providing healthy outdoor occupation for the patients but also in providing the pleasant surroundings which were on view to outsiders and therefore part of the hospital's public relations.[16]

Neat beautiful grounds, the result of staff and patient labour, brought an outward appearance of civility and normality to something perceived to be the direct opposite. In this way they helped to dispel public prejudice and dampen any outcry over asylum care.

Sir Frederic Truby King (1858-1938)

Although better known for his efforts to improve infant welfare as the medical founder of the Plunket Society, Sir Frederic Truby King made equally important contributions to asylum management and patient care, implementing changes that affected not only Seacliff but the wider asylum network. During his 31 years as medical superintendent of Seacliff (1889-1920), King worked to develop a "total environment" that he believed would be most suited to fostering recovery. Good nutrition, outdoor occupation, regular exercise, beautiful surrounds and staff discipline were the cornerstones of this environment. King believed that the well-being of the mind was contingent on the well-being of the body concluding that insanity was the result of ill health.[1] King overhauled patient's diets reducing the amount of meat served, allowing more oatmeal and more milk, and increasing the quantity and variety of vegetables on offer. By 1906 his wholesome diet had been adopted in all New Zealand asylums. Ideally patients would be involved in the production of their own nutrition, not simply because of the economic necessity but as their primary form of treatment. King rejected the use of drugs and psychotherapy instead favouring outdoor occupation because it had a calming effect and kept mind and body healthy. Idleness, he felt, was most aggravating to mental troubles. King also made changes to the surrounding landscape removing high fences, planting trees, flowers and shrubs, laying out extensive parks for the patients and generally opening out the grounds which helped to lessen the institutional impact and the feeling of imprisonment. 'Pleasant gardens' he believed 'would be an adjunct to recovery and help to stimulate a renewed interest in life, as would the work of creating them'.[2] Staff discipline also came under King's reforming gaze. In 1900 he produced a booklet outlining the rules and regulations which were to govern staff behaviour. Cleanliness of the wards and patients was the first priority and in carrying out their work staff were expected, Caldwell notes, to 'set a good example to patients [,] ... fulfil an "inspirational role" ...[and] bring about a "spirit of healthy comradeship and friendliness"'.[3] Violence towards patients was not tolerated and the use of restraint was to be kept to the lowest possible level.

Notes

1. Cheryl Caldwell, 'Truby King and Seacliff Asylum, 1889-1907, chapter in *"Unfortunate Folk": Essays on Mental Health Treatment, 1863-1992*, ed. by Barbara Brookes and Jane Thomson (Dunedin: University of Otago Press, 2001), p. 36.
2. Caldwell, p.42.
3. Caldwell, p. 44.

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The beautiful gardens, however, were not solely for the public's benefit. As well as providing therapy by way of occupation, Tokanui's trees, flowers and shrubs were therapeutic to patients in and of themselves. Cheryl Caldwell notes that in Frederic Truby King's opinion 'beautifying the grounds and the interior of the asylum buildings ... provide[d] "moral, and other elevating, refining and soothing influences"'.[17] Furthermore, James Beattie notes that 'in a society lacking effective medical intervention', as was especially the case with mental illness, environment was an integral player in the balance between sickness and health.[18] The plantings and other external works at Tokanui not only created attractive vistas that acted as a mental restorative, but turned a predominantly swampy, and by nineteenth century standards, unhealthy area into one that fostered health. Beattie notes that there was 'a firm belief in the therapeutics of landscape and trees, but also a belief that open-air exercise and work were morally and spiritually uplifting as well as physically healthy'.[19] The gardens fulfilled the additional function of reducing the institutional impact of the hospital, notes Brunton, by separating, both physically and visually, the ward blocks from each other.[20] This was important not just for the patients but for the staff as well, the majority of whom lived on site with the patients. The "Garden City", as it would be dubbed, has become a touchstone for memories that overwhelmingly evoke visions of healing spaciousness and tranquillity which eluded inner-city sufferers.

Space was also essential for Tokanui's economic viability. In the face of low government expenditure, the self-sufficiency of all mental hospitals was paramount. For Tokanui in its isolated location, where the cost to buy in supplies was considerable and getting them to the hospital challenging, the production on site of consumable goods was essential during the first few decades of operation. In particular obtaining fresh fruit was, it seems, an expensive exercise, with one source noting that in 1913 one dozen oranges cost one shilling and two dozen bananas one shilling, sixpence.[21] Throughout the first half of the twentieth century the cultivation of fruit, vegetables and other crops, as well as the rearing of livestock, both for meat and dairy, occupied the single biggest portion of land at Tokanui. It became the lifeblood of the institution, supplying not just physical sustenance but also therapeutic occupation.

The land at Tokanui was described in a 1919 article by estate manager, J Drysdale, as being comprised primarily of low hills, 'the greater proportion ploughable and suitable for cultivation', 'extensive' wide valleys and 'easily drained and decidedly fertile' swamps. [22] The natural vegetation was recorded as including 'bracken-fern, manuka, and tutu (taupaki), with a proportion of flax (phormium), toetoe, and koromiko', and the introduced shrubs as 'gorse and broom'.[23] The soil was described as being 'semi- volcanic' in nature, 'light and open', 'easily worked' and of 'medium fertility,... particularly responsive to the application of fertilizers'.[24] No wonder, then, that on several occasions official reports extolled the virtues of the estate and the wisdom of its acquisition,[25] especially 'in view of increasing numbers to provide for and the upward tendency in the price of meat, butter and other produce'.[26] However the sheer size of the estate seems to have been a mixed blessing. While on the one hand the copious amount of land helped to compensate for any deficiencies in

Camps

During the 1920s two semi-permanent, under-canvas work camps were established on remote parts of Tokanui's vast estate. Located at too great a distance to be worked from the central institution the camps, simply named No.1 and No.2, were respectively situated on Korokanui and Waikeria Roads. The twenty or so patients and handful of staff who took up residence at the camps were primarily employed in scrub-cutting, general land clearing and fencing. In 1921 a block-making shed was completed at No.1 Camp with the intention that it would supply the hospital with much needed building material. Work, however, was suspended the following year due to a shortage of cement.[2] At some point during the 1920s it appears that both camps were closed. However, on instruction from acting Inspector-General Sir F Truby King No.2 camp was reopened in 1924.[3] Although reports of its enterprise were highly favourable, the camp was "evacuated" in 1927 and as part of a total transfer of 3,500 acres, was handed over to the Prisons Department for use by the neighbouring Waikeria reformatory. Efforts were instead concentrated on No.1 camp which was reoccupied that same year.[4] Two years later in 1928 a new dormitory capable of housing 14 worker-patients and additional accommodation for staff were added and the existing dormitory transformed into a living room.[5] Operating for a further 20 years, No.1 camp was ultimately closed as a result of staff shortages in 1947, and in 1948 the land was transferred to the Lands and Survey Department before being used as farm settlements for ex-servicemen.

Notes

1 *AJHR*, 1922, H-7, p. 8.
2 *AJHR*, 1923, H-7, p. 8.
3 *AJHR*, 1925, H-7, p. 10.
4 *AJHR*, 1928, H-7, p. 6.
5 *AJHR*, 1929, H-7, p. 6

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fertility, on the other, as time passed, it became apparent that Tokanui simply lacked the resources to bring into cultivation and maintain the thousands of acres at its disposal. From 1917 onwards Tokanui's progress was limited by insufficient[27] and, in some cases, a lack of skilled labour.[28]

In 1925 Dr MacPherson reported that while all but 300 acres of the estate had been brought under cultivation (a significant milestone and one that had taken over a decade), a shortage of labour was hampering efforts to maintain the land and keeping down the new growth of scrub and fern was proving difficult, concluding that 'some parts of the property were in danger of reverting [back] to its original state'.[29] The following year he reported that 'the task of keeping down the growth of fern and noxious weeds' had reduced cultivation to bare necessity. [30] Even with the assistance of inmates from the neighbouring Waikeria Reformatory, an arrangement that hospital officials appear never to have been entirely comfortable with[31], the size of the property and the amount of work it required dwarfed the labour available to complete it. The alternative of external paid labour was understandably less appealing than the unpaid efforts of the male patients. While the department made no secret of the fact that patient labour was essential to keep running costs down and that the work patients engaged in helped to cover the cost of their treatment, or at least maintenance, ostensibly patients were not paid for their work because it *was* their treatment. In addition to providing occupation, the farm supplied a variety of fresh produce which, in the wake of Sir Frederic Truby King's initiatives, came to be viewed as an essential aspect of treatment. In assisting to grow their own food, patients not only occupied their mind but helped to feed, and hence heal it. The therapeutic value of the farm, including the orchards and kitchen gardens, was such that Inspector-General Hay, in his 1920 report, was moved to state that they were necessary 'even if we had to work them at a loss', and that their success had led to their primary objective – 'that of diffusing a sentiment of privacy and freedom while providing normal healthy occupation in the open air' – being overlooked.[32]

Things began to improve, however, following the transfer of the greater portion of the estate to Prisons Department for use by the Waikeria Reformatory in 1926. Dr Childs reported in 1929 that 'the work on the farm has proceeded steadily, and since a large part of the estate has been transferred to the Prison's department, a great improvement has been noted'.[33] The crops grown on the estate included red clover, turnips, swedes, marigolds, lucerne, wheat, oats, potatoes, vegetables and fruit, either for consumption by patients or by the livestock, which included pigs, Clydesdale horses, poultry and dairy cattle. Dot Whittle remembers that:

> The farm was one of the best with plenty of labour for the Byre (cowshed), standing where M.S.Q is now, down the hill to the stables and those lovely Clydesdale horses, wagons, drays and harness for everything .... In those early days and even up to after the second war, staff did the work, that went with a big independent hospital, which was a small town itself, having its own farm, cattle,

Water Shortages

Issues with the water supply began soon after operations at Tokanui commenced. Low water pressure prompted talk, in 1913, of a reservoir to be placed on a nearby hill, but it would be 1915 before one capable of storing 75,000 gallons was constructed.[2] Then in 1920 Dr Gribben, Tokanui's Medical Superintendent, began reporting serious water shortages.[3] Increased consumption and an inadequate pump were causing the well to run dry, forcing the hospital to ration water use with severe restrictions. Female patients were reduced to weekly baths while males were bathed in the Puniu River.[4] In particular, Gribben expressed his anxiety over the impossibility of maintaining an adequate reserve of water for fire fighting purposes.[5] Despite plans to dam two streams half a mile distant[6] and the installation of a new water pump, shortages continued into 1924.[7] By this time bathing had been entirely eliminated and the laundry closed; washing instead being sent to Auckland at the considerable expense of £40 per week.[8] In desperation Gribben appealed directly to the Inspector-General via telegram informing him that, despite all possible restrictions, the water supply was failing and describing the hospital's position as "grave".[9] Finally in 1925, four years after the idea was first broached, Tokanui was connected to the Te Awamutu water supply, effectively ending the shortages which had plagued the hospital for half a decade.

Notes

1. *AJHR*, 1913, H-7, p. 8.
2. *AJHR*, 1916, H-7, p. 4.
3. *AJHR*, 1921, H-7, p. 6.
4. A History of Te Awamutu Hospital, p. 5.
5. *AJHR*, 1921, H-7, p. 6.
6. *AJHR*, 1922, H-7, p. 8.
7. A History of Te Awamutu Hospital, p. 5.
8. A History of Te Awamutu Hospital, p. 5.
9. A History of Te Awamutu Hospital, p. 5.

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> milking cows, sheep, pigs, fowls and horses for doing the work. There was a farm manager, but he didn't wear a white collar, he always had his sleeves rolled up and with the help of male staff and patients they provided the food for Tokanui and other hospitals. Each section of the above had a manager. But in those days it was the Byres man, Gardener, Pigster, Teamster.[34]

In addition to emphasising the use of nursing staff and patient labour, Dot's memories draw attention to the fact that the majority of the produce grown on the estate was consumed there by staff and patients. Although the excess produce and livestock was sold to the wider public, the revenue it generated appears never to have exceeded the value of that consumed.[35] As well as selling surplus fruit, vegetables and other crops, the hospital sold excess stock. However, 'before any livestock could be sold to the public' notes Wendy Hunter Williams, 'the hospital had first to make enquiries as to whether any of the department's other hospitals required stock and an inter-departmental transfer could be arranged. The price was set by mutual agreement'.[36] A 'typical year', she explains, 'would be 1938 when 100 ewes and two Romney rams were sent to Tokanui which, in turn, supplied Porirua with twenty-five dairy heifers to replace old dairy cows'.[37] These exchanges, however, were not solely limited to livestock and 'could include anything from fence posts to sheep-dogs, from farm machinery to seedlings'.[38] Although receipts from the sale of produce and the savings made on the value of that consumed helped to defray the cost of expenses, until the 1930s the cost per patient of the farming operations at Tokanui remained the most expensive of the existing mental hospitals, at times by more than £10.[39] Unsurprisingly, the largest expense, not just at Tokanui, but generally across all the hospitals, was salaries and wages. Feed; stock; implements, harnesses and repairs; and seeds and manure rounded out the top five expenses. Ownership of sufficient land for cultivation removed the need to pay rent or rates, but the isolation which was the trade off made railage a necessary expense.

With the transfer of land, Tokanui reached a turning point. Its initial pioneering phase drew gradually to a close and the hospital settled into a steady routine as a largely custodial institution and a self-sufficient community. Although the farm remained an important aspect of the life of the hospital, it had become apparent that a proportion of the patients were not going to be able to contribute to outdoor work. Many were elderly, disabled, chronically mentally unwell or otherwise infirm. Rather than contributing as workers, these patients would need care and supervision from the nurses and attendants. In official reports, details of Tokanui's farming operations featured less, being replaced instead by accounts of the various recreational activities and amusements that were possible now that much of the basic infrastructure was in place. Despite only significant changes featuring in the superintendents' reports, such as the establishment of a new orchard and vegetable garden[40], or the installation of a new milking-machine and separator,[41] farming operations continued well into the 1950s. However, with the revolution in treatment brought about by new drug and shock therapies, the farms gradually became less important and in 1967 the Minister of Health, Mr McKay announced that farming activities at all mental hospitals would be discontinued in order that the institutions could concentrate on their primary function of treating patients.[42] On the 1st of July 1967 [t]he control and operation of the farm [at Tokanui] was ... handed over to the Department of Agriculture'.[43]

A Unique Community

Although the Inspector-General was responsible for the overall management of the Mental Hospitals Department and the institutions under its control, the day-to-day running of the hospitals was primarily the domain of the Medical Superintendent. As institutional head, medical superintendents, for much of the period covered by this chapter, ranked fourth in the departmental hierarchy, coming just below the Assistant Inspector who, in turn, was answerable to the Deputy and Inspector Generals. As the local controlling officer, medical superintendents were part of the bureaucratic process and after the first decade of the twentieth century an ever increasing amount of their time was taken up with administrative details. In control of a new and expanding mental hospital, Tokanui's medical superintendents were responsible not just for the care of the mentally deficient but, as the first institution to be developed entirely to the new villa design, also for the future direction of their treatment.

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Initially, those in charge of asylums tended to be medically unqualified lay keepers whose authority was derived from the extensive experience they gained while working as attendants. However, from the 1860s onwards this began to change as the curative role of the asylum was emphasised over their primarily custodial function. The drive to have medically qualified personnel in charge of asylums gained momentum with the shift to central administration in 1876. Under pressure from Inspector-General Skae, himself a psychologist, the preference became for qualified doctors to manage the institutions, starting with those responsible for more than 100 patients. Medically qualified superintendents were also appointed to all new mental hospitals built after the provincial era, the first of these being Tokanui.

Originally the role of medical superintendent was very hands-on, involving the direct oversight of all aspects (administrative, statutory and clinical) of institutional operation. While some functions of the role of Medical Superintendent would be set out in the 1940 yearbook, 'the absence of a clear-cut job description reflects', Brunton claims, 'the high discretion accorded professional staff', and explains the, sometimes overwhelming, extent of their job.[44] Medical superintendents lived on site, albeit removed from the wards in specially provided cottages, where their lives were easily subsumed by institutional routine. The lack of distinction between work and home life meant that personal wellbeing occupied a perilous position and was easily compromised. Included in the tasks undertaken by the Medical Superintendent in the early years of hospital management was a daily inspection round that toured the wards and estate facilities. Wendy Hunter Williams notes that 'Every single aspect of the entire estate was a matter of concern to Head Office and a significant part of the medical superintendent's daily tasks were those of the gentleman farmer; inspecting stock, scrutinising accounts and conferring with the farm manager'.[45] Additionally they were directly responsible for the treatment of patients and all correspondence with Head Office and patients' relatives. Late into the Nineteenth Century this correspondence, which dealt with all manner of issues, including concerns over infrastructure and the status of patients, continued not just to be signed, but personally written by the Medical Superintendents.

Gradually, however, administrative concerns overtook the clinical aspects of their role. Brunton notes that the '[h]ands-on management of [Sir Frederic Truby] King's generation was not easily sustained by succeeding generations of medical superintendents'.[46] With oversight of the estate's farming and construction operations absorbing an ever-increasing amount of time, delegation became a key aspect of the medical superintendent's managerial role. Senior and Assistant Medical Officers were given responsibility for the treatment of patients, and while the superintendent maintained a consultancy role he became increasingly reliant on daily reports and meetings with senior staff to keep abreast of significant events and cases. Retaining responsibility for correspondence, exercising disciplinary powers over staff and authorising various activities, the role of the Medical Superintendent became increasingly supervisory and less medically oriented.

Of particular importance, especially for the department Head Office, was the reporting function of the medical superintendents. Required to notify the Inspector-General of admissions, discharges, transfers, deaths and, in particular, escapes, as well as any other matters that might be politically damaging or cause public outcry, superintendents maintained a steady flow of correspondence with Head Office. Furthermore they produced an annual report for inclusion within the wider departmental review. The basic form of these reports followed a fairly consistent pattern, starting with an overview of the patients under care at the asylum, including a largely statistical account of how the population demographic had changed over the course of the year under review. This encompassed the number of patients (males and females) in residence at the start and end of the period, the number of admissions and whether they were first time or readmissions, the number of transfers, the number of voluntary boarders, the number discharged and their status (recovered, relieved, not improved), the number of deaths and their assigned causes, and a brief statement about the general health of the patients, including any significant ailments. For example, Dr Gribben's report on Tokanui for 1923 informed that 'The general health of the patients had been excellent throughout the year, especially so considering the advanced age of many of them. We had some fifty cases of influenza last November, all made a good recovery'.[47] Following this, the reports detailed any significant extra-curricular activities undertaken for

WAK0000200

patient stimulation, such as dances or visits to a local picture theatre, before giving updates on hospital accommodation and infrastructure. In theory the reports detailed important changes and events at the hospital, however in practice not all events, notably escapes, made an appearance in these publicly available documents. Information which might alarm the public or be politically damaging was dealt with in separate correspondence, leaving the reports to present a publicly acceptable version.

Between 1912 and 1935, Tokanui was overseen by five medical superintendents: Drs AH Crosby (1912-1919), LH Gribben (1919-1924), J MacPherson (1924-1926), TWJ Childs (1926-1928) and HM Prins (1928-1935). Information pertaining to these individuals – their career paths, personalities, training and qualifications, personal lives and, most importantly, their work at Tokanui – is scarce. Unlike departmental heads and ministers, the lives and work of all but a select few of the superintendents remain largely unrecorded. The little, chiefly professional, information that is known about these individuals is laid out in Appendix 2. Collectively viewed, it provides some insight into the position of medical superintendent and, more broadly, the psychiatric profession. The most obvious characteristic common to all was gender. All of Tokanui's first medical superintendents, and indeed all those who held the position for the duration of its operation, were male. Although from the late nineteenth century women were appointed as official visitors, medical superintendence was a male dominated profession. The hierarchical nature of the profession was reinforced by the medical tradition in which they were trained. All received their medical qualifications between 1883 and 1913 in the United Kingdom, the majority in Edinburgh. Long established, high-ranking, and steeped in tradition, Edinburgh's medical programme at that time proffered a scientific perspective on health and illness that was keenly focused on the body. As graduates of that somatic school of thought, Tokanui's future medical superintendents absorbed not just ideas of demonstration and systematic observation that characterised the scientific approach to treatment, but also the gendered social values that underlay their development.

By the time they were appointed medical superintendent, the majority, excepting MacPherson, were in their early forties, which given the nature of the profession and the time taken to become qualified, was roughly mid-way through their careers. Still comparatively young, and less likely to be plagued by the health problems of their more senior counterparts, their enthusiasm and energy would have been invaluable in Tokanui's challenging pioneering environment. All, except MacPherson, had also made psychiatry their chosen profession, progressing to superintendent following time spent as assistant medical officers. Furthermore, for over half, their appointment to medical superintendent at Tokanui was not the first time they had held the position. Crosby, Gribben and Prins had been medical superintendents at Mount View, Sunnyside and Auckland mental hospitals, respectively, where they gained valuable administrative experience, before being transferred to Tokanui. As the exception to the trend, MacPherson's additional twenty years and his lack of experience in the mental health field can be explained by the broader historical context. The Department's annual report for 1927 informs that MacPherson joined the department during World War One, a time when medical staff were in short supply.[48] Relieving a younger medical officer for service abroad, MacPherson worked first as assistant medical officer before being appointed medical superintendent on Gribben's transferral to Seacliff.

If medical superintendents were at the top of the institutional hierarchy, nurses and attendants occupied a considerably lower rank, especially in the early years when the position entailed little training. For the first three years of operation Tokanui's workforce was comprised solely of men. James Cran and Andrew Brown, the hospital's first attendants, arrived with four worker patients from Porirua Hospital in July 1912. Cran, an Englishman who had previously worked at Stirling Hospital for the Insane, had been employed as an attendant at Porirua in the previous five years.[49] Brown, a very experienced attendant, had worked in the Wellington area for many years. Both men were accompanied by their wives and families. As the hospital grew, attendants were recruited from other institutions and from the local area.

Attendants and Nurses worked at the coalface of patient care and were responsible for implementing the treatment regimes outlined by their medically qualified superiors. In her autobiography Janet Frame commented that 'the experts [medical professionals], who over the years as my "history" was

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accumulating, had not spoken to me at one time for longer than ten or fifteen minutes, and in total time over eight years for about eight minutes'.[50] It was the attendants, male and female, who worked alongside patients, cooking, cleaning, tending the gardens and stock and developing the grounds and in the earliest years they were almost entirely responsible for the domestic side of the hospital. In the absence of effective pharmaceutical treatment, their role was largely custodial in nature, with a focus on the bodily, not mental, health of patients. Ensuring that patients were fed, relatively clean, and kept from self harm were the priorities. The conditions under which staff operated were for the most part basic and physically challenging. 'Attendants' hours of work', observes Brunton, 'were also reminiscent of Victorian household servants'.[51] According to one source, working hours during the 1920s 'consisted of "short days" of 6.30am to 5.30pm and "long days" of 6.30am to 8pm. The roster was five days on and one day off'.[52]

Tokanui employed very small numbers of tradesmen and farm workers, because attendants were expected to be generalists. There was no strict boundary between 'attendance' and other occupations. A newspaper advertisement from 1921 calling for single attendants emphasises this: 'Wanted: Single attendant with farm experience for Mental Hospital, Kihikihi, Waikato'.[53] From time-to-time, men therefore chose to leave their roles as attendants for other positions in the institution, sometimes achieving a higher salary.[54] Hedley McKerrow, who was one of the first junior attendants at Tokanui, had an interesting career in this regard. He was appointed on 6 October 1913 and four years later was promoted to Deputy Charge Attendant'. In 1919, McKerrow exchanged his role of attendant for a position as engine driver and in 1924 he was appointed Assistant Farm Manager. A year later, he was promoted to Estate Manager and attained a salary that was second-only to the Head Attendant. Across the department non-treatment related staff accounted for about one fifth of all employment.[55] During the first two decades of operation the number of farming and building maintenance workers reached their peaks, accounting for nearly 5.5 per cent and 9.5 per cent of the labour force respectively.[56] Their roles gained greater currency as the number of worker patients dwindled and, consequently, a greater portion of attendants' working hours were taken up with the duty of care.

Just two years after Tokanui opened, New Zealand entered World War One. Not only did the war delay progress of the building programme for all mental hospitals, it also had a huge impact on staffing. By 1915, 11.7 per cent of the Department of Mental Hospital's male staff was at the front or in military training. Over the next three years, a large number of experienced doctors and attendants went away to war. The Department did what it could to manage the situation: men were employed on a temporary basis to fill the gaps and the hospitals relaxed the rule that they must remain single for the first two years of employment.[57] As the experience level of the workforce plummeted, vacancies 'had to be filled with what offered' and hospitals relied heavily on their senior staff to provide some stability.[58]

1918 Influenza Pandemic

As World War One drew to a close a new threat, more deadly than war, cast its shadow across the globe. The Spanish Flu, so named because of the popular belief that the disease had originated in Spain, proved a particularly virulent strain of Influenza, claiming an estimated 50 – 100 million people worldwide. It was notable not only for its high mortality rate, but because its victims were atypically young, healthy adults , more than half between 20 and 40 years of age. Also known as the black flu because of the colour its victims turned, the majority of deaths were the result of a secondary bacterial pneumonia infection which cause massive haemorrhaging and oedema in the lungs. On 6 November 1918, the 'Spanish Flu' was introduced to Tokanui staff and patients. The epidemic, which was causing havoc throughout the world, had reached New Zealand in October that year. Over the next few months, it killed over 8600 New Zealanders and brought the country to a standstill. At Tokanui, the infection was thought to have been brought by the mail messenger who had visited a picture-show in Te Awamutu. Over a period of five weeks, 41 male patients out of a total of 114 contracted the illness and four died, resulting in a death rate of 9.75 per cent - the highest of all the hospitals. Significantly, none of the 43 female patients succumbed to the illness. However, nine of the 11 nurses, and nearly all of the attendants (22 of the 28) contracted influenza. Although only one attendant died, this still equated to a death rate of 3.45 per cent, surpassed only by Hokitika.[2]

Notes

1. 'The 1918 flu pandemic', URL: http://www.nzhistory.net.nz/culture/influenza-pandemic-1918 (Ministry for Culture and Heritage), updated 23 July 2009.
2. Twenty-two of the 28 attendants and seven of the 11 nurses contracted influenza: AJHR, 1919, H-7, pp.3-4.

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Initially, only one Tokanui man volunteered. David Onion, a junior attendant, enlisted in the first few months of war. Unfortunately, Onion was reported missing, believed dead, in 1916.[59] By March 1917, the situation at Tokanui had changed dramatically. Nine men, five of whom were senior attendants, had left to serve their country. This was almost one-third of the attendant workforce. A year later, three very experienced men, George Fowlie, Robert Gray and Gilbert Unwin also went to the front, their absence leaving a substantial gap in the upper levels of the attendant hierarchy.[60] Tokanui managed the shortages by employing more probationers, many of whom were married. This caused problems because of the lack of 'married accommodation' in the district. The hospital was forced to build another four cottages on the estate and to adapt the original, temporary kitchen and staff rooms to create 'married quarters'.[61]

In the year following the commencement of World War One, charge nurse E Lindsey and three junior nurses, one of whom (IEA Campbell) was soon promoted to deputy charge nurse, were transferred from Porirua Hospital to Tokanui, along with fifty women patients. Their occupation of the first female villa in 1915, heralded the beginning of the female side of the hospital, which, as at other institutions, existed for the most part separately from the male side. Indeed, when the completion of F, G and H wards in 1930 resulted in three male wards being situated between six female wards, a reorganisation followed to ensure that the male and female wards were kept separate. To that end, the patients from A, C, and H and 1, 2 and 7 changed around'.[62] Not only were males and females kept physically separate, they were also occupied separately according to their gender. Whereas male patients

FIG 3.3 Photo of wards F, G & H

Photo Courtesy of Waikato District Health Board

and staff worked outdoors assisting with the hospital's development, females spent much of their time indoors or in airing courts and were engaged in pursuits such as cleaning, laundry or sewing; tasks that were traditionally thought suitable for women. During this period male attendants solely staffed male wards. However, in 1937 it was noted that female nurses were working in both male and female wards until 1939 when severe female staff shortages, the result of the outbreak of World War Two, caused the practice to cease. The gendered environment which governed practices at all mental hospitals, not just at Tokanui, reflected wider social values about the appropriate conduct and occupation of each of the sexes. For staff and patients alike, their experiences differed considerably depending on their sex.

Although male attendants were initially numerically dominant, after 1925 this reversed with the percentage of female nurses peaking, in 1935, at just over seven per cent greater than males. This changing dynamic reflected Inspector-General MacGregor's preference for nurses and his low opinion of male attendants. Female nurses were more attractive for fiscal and disciplinary reasons. 'Ordinary female attendants', Brunton notes, 'were paid about two-thirds as much as their male counter-parts, so more could be employed'.[63] In 1915 a male probationary attendant at Tokanui earned £115 per annum, as opposed to a probationer nurse who earned £85 per annum.[64] Figures for 1918 reflect a similar disparity with males earning £7 10s per month and a nurses earning £4 11s 8d comparatively. Disturbed by what he perceived to be the poor calibre of attendants, MacGregor worked, from the late nineteenth century onwards, to improve their quality, focusing in particular on staff discipline. Staff rulebooks were produced initially as local editions until 1901, at which point a national code was adopted.[65] According to Brunton these rulebooks were 'studded throughout with the standards

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expected of attendants, usually expressed as prohibitions'.[66] For example, the 1910 edition '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'.[67] From a disciplinary position, female nurses were favoured because of their perceived tractability. Not only were they more likely to comply with the outlined rules, they were, according to Brunton, more 'likely to follow the instructions of male doctors, prefer collegiality, be generally unambitious, and submit to bureaucratic control'.[68]

Tokanui, like other mental hospitals, had considerable difficulties in recruiting and retaining nurses. None of the first intake of junior nurses remained more than two years - three transferred to Christchurch in the first 12 months and the others resigned. The senior nurses, Lindsay and Campbell, also resigned within the first two years. Their departure left a gap that proved difficult to fill - the female ward did not have a charge nurse until after World War One. To the Department's surprise, nursing numbers fell more steeply than those of attendants during the war. Young women were exposed to novel opportunities to engage in work that was more lucrative and attractive than the relatively unpopular option of mental hospital nursing.[69] At times, Tokanui had trouble filling vacancies even amongst the probationers. The retention of female staff was also hindered by the fact that a choice had to be made between career or marriage. Whereas '[m]ale attendants could expect to work in the service until retirement at age 65, with the prospect of superannuation', notes Brunton '[f]emale Public Servants had to resign if they married'.[70] The marriage barrier meant that the majority of female staff were young, their turnover high and consequently their prospect of promotion was greater. In comparison, male attendants waited much longer for promotion. Brunton specifies that in 1907, 'the average length of service of head attendants was 15.5 years; matrons 8.25 years; 9.75 years for male charge attendants; and six for charge nurses'.[71]

Like all bureaucratically governed institutions, Tokanui operated under a hierarchical system in which power, concentrated at the top with the Medical Superintendent, was dispersed in ever diminishing amounts down the pyramid of medical officers, head and assistant attendants and nurses, charge staff and probationers to the committed patients who languished at the very bottom, totally disempowered. Of the staff, Cheryl Caldwell notes that 'there were two distinct groups – the medical professionals and the general nursing staff'; the former's qualifications and level of training entitling them to a higher status.[72] Brunton notes that 'the place of doctors and medical superintendents at the head of an institution was firmly secured by practices such as saluting, inspection parades of attendants by their head, or the matron's preliminary inspection in advance of the daily ward round'.[73] 'Doctors dined separately from nurses, clerical staff dined on their own and nurses dined according to rank'.[74] Furthermore, uniforms and other objects, such as keys, not only helped to distinguish staff from patients but also the various ranks among staff.[75]

Both male attendants and female nurses at Tokanui wore a prescribed uniform which visibly distinguished them from the patients and, along with other items such as service keys, were a potent symbol of their authority. Most importantly, uniforms brought a sense of professionalism to the role, and in turn the asylum, which complemented wider efforts to place mental hospitals on an equal footing with general hospitals. In particular, the near mirroring of general nurses' uniforms attests to the strength of official desires to foster greater credibility and respect in the field. For males, the standard uniform consisted of a blue serge jacket and trousers and a peaked cap, brass buttons and gold braid.[76] Although the brass buttons, braid and cap were dispensed with in the early 1930s, the appearance, demeanour and bearing of male attendants was custodial in nature and, according to Brunton, 'epitomised MacGregor's view that attendants were warders'.[77] The uniforms of female nurses underwent more considerable changes from their first introduction as they were swayed by the dictates of fashion. Although starched cuffs and collars and some form of veil remained part of the uniform until at least the 1930s, when, according to Brunton, 'they were discontinued as a depression economy,' the austerity of a full length Victorian dress gave way first to lighter colour variations (used to distinguish and reinforce hierarchy) and less rigid styles, and then to the partialities of a rising hem.[78] In the history of Tokanui Hospital , it is reported that in the 1930s the women's uniform consisted

of pink tunics with starched white cuffs, a veil which tied at the back of the neck to form "butterfly wings", plus black stockings and shoes in winter, and white in summer'.[79] The 50th Jubilee booklet goes on to note that, '[s]hortly after[,] the black shoes and stockings were abandoned altogether [and in] ... 1950 the Department of Health decided to provide footwear for the nurses'.[80]

In the absence of formal quarters during the initial years of Tokanui's operation, staff were forced to travel to work on horseback from the surrounding district. Although a policy on staff accommodation dated back to the provision of cottages for married male attendants in the 1870s,[81] providing adequate accommodation for staff was a problem at many of the public mental hospitals.[82] 'A policy on staff accommodation', Brunton observes, 'was motivated as much by the need for 24-hour cover and emergency back up'.[83] In remote rural locations, the provision of staff accommodation for retention purposes was seen as more important than for city asylums. In the 1940s, according to Brunton, Tokanui's medical superintendent reported that 'attendants wanted staff residences as an incentive to work at Tokanui'.[84] Prior to the twentieth century unmarried staff were accommodated in single rooms adjacent to the wards and, when possible, cottages were provided for married men. Officials were aware of the less than ideal nature of this arrangement, in particular the absence of notable differentiation between work and off-duty hours, and from the turn of the century began to provide nurses homes.[85] 'Male staff quarters', Brunton notes, 'were developed more slowly and most live-in attendants continued to do so in single rooms adjacent to wards'.[86] At Tokanui, as numbers of female nurses increased, the hospital first provided a sitting-room for them, and in 1926, converted an old storeroom into a dining room (mess room) for the women.[87] In 1931, the first purpose-built Nurses Home was opened. This freed up the old nurses quarters for the attendants and in turn, gave room to expand the male patients' accommodation.[88]

1930s Economic Depression

The 1930s economic depression proved to be a boon for Tokanui. For the first time, the hospital was fully staffed on both the male and female sides. This released pressure on the wards and had a positive effect on nurse training, see Chapter Five. Better staffing raised the expectations of the workers. As the economic depression lifted, mental hospital attendants and nurses demanded improved conditions. In 1936, in response to industrial pressure, a new roster was introduced for mental hospital attendants and nurses. The roster, based on a 42 hour week, consisted of three-day rotations in which the staff worked one long day of 13 hours, one short day of ten and a quarter hours, then one day off. Night shifts started at 7.45pm and finished at 7am. The Department also introduced one month's leave after every five months.[2] To facilitate the changes, an extra 270 new nursing positions were created across the Department.

Notes

1. Pressure for change came in response to the Government's granting of a 40 hour week to state employees in 1935.
2. Kate Prebble, 'Ordinary Men and Uncommon Women: A History of Psychiatric Nursing in New Zealand Public Mental Hospitals, 1939-1972' (PhD thesis, University of Auckland, 2007), p.42.

One repercussion of the roster changes that occurred as a result of the 1930s depression was that staff accommodation became very tight. At Tokanui, the new junior nurses had to sleep in rooms attached to the wards until there was space available in the Nurses Home. When Laura Condon started as a junior, she slept in a room at the top of the villas and was on-call at night for emergencies. She and the other young nurses were locked in at night but some found ways around the restrictions. As Condon recalled, 'We could not get out unless you were a bit slim and could crawl though a small bit of space – might have been twelve inches I suppose. Sometimes you could watch the head nurse going back (after checks) and that was the time to escape and you would escape and you would get back in again when you had had your bit of fun'.[89] Once they moved into the Nurses Home, the rules were more tightly enforced. The front doors were locked at 11pm and nurses were expected to be back by then.

In addition to the unsanctioned extra-curricular activities some junior staff engaged in after dark, staff partook, as part of their duty of care, in the recreational activities on offer to patients. As medical superintendent of Seacliff, Sir Frederic Truby King expected staff, Cheryl Caldwell notes, 'to join in with the patients in work and recreation in such a way as to bring about a "spirit of hearty comradeship and friendliness"'.[90] Annual picnics, balls, walking parties, weekly film screenings, various sports and external visits were all engaged in, in a primarily supervisory role. The 50th Jubilee booklet noted that 'staff had their own social club and during the winter held monthly dances'.[91] For one staff dance in the 1920s, one bottle of brandy and five of sherry were purchased at a cost of two pounds, seven shillings

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and six pence'. The further cost of eight-shillings was incurred when a sugar bowl was broken during the dance.[92] As well as the dances, a popular annual ball was held. According to the Jubilee booklet '[t] ickets for these balls were 2/6 [two shillings and sixpence] for a double ticket and the holders of one of these tickets could invite another couple to join them. Thus for 2/6 the two couples were given a sit-down supper, danced to a four piece band, and all attending thoroughly enjoyed themselves'.[93] Although such efforts were designed to provide staff with interests outside of work, the isolation of Tokanui's situation made retention, especially of the younger staff, difficult. Hay, Brunton notes, was well aware of this issue and commented that 'staff who worked in remote asylums needed compensation for the loss of the "temptations of living in the heart of a town"'.[94]

A narrative of Tokanui in the early years would, of course, not be complete without an account of those individuals for whom the hospital was built. While the journeys of individual patients will be explored at greater length in Chapter Seven, there is scope within this narrative of the first twenty-three years to provide a brief overview of the patient population. As Chapter One noted, the records indicate that Tokanui's first four patients arrived in mid-July 1912.[95] Accompanied by James Cran and Andrew Brown (Tokanui's first attendants), their arrival set a precedent that would last until 1915 when the transferral of 50 female patients brought to an end the brief period of male exclusivity. The numerical dominance of male patients, although most marked in the first 10 years, continued throughout the first decades. One explanation for this imbalance is that the work required to develop the estate was of a physically demanding nature. Often conducted outdoors, it typically belonged to a masculine sphere of work. The viability of all other institutions at this time, but especially Tokanui as it built accommodation and brought land into cultivation, relied on the labour of patients to be self-sustaining. In the pioneering environment of those early years at Tokanui, the practicalities of institutional life were most suited to accommodating male patients, and it was their labour that was most valuable.

In keeping with its intended purpose as a site for the reception of the yearly increment of sufferers, those first four men, and all patients made resident until 1919, would be transferred to Tokanui from existing institutions.[96] Even once patients began to be received directly, transfers remained the bulk of new and existing patients. As such, the information pertaining to them in the statistical appendixes of the Departmental reports is limited, having been originally collected on first admission at a previous hospital. Falling under the category of transfers or readmissions, it is often not until discharge or death that information, beyond the basics of age and gender, is recorded for a patient. One interesting exception is the data collected on native countries. Figures indicate that at the beginning of the period, patients at Tokanui were most likely to have been born in New Zealand, followed by England and Wales, and Ireland. Just over a third of all transfers had their native country listed as New Zealand.[97] By 1934 this had nearly doubled, and although England and Wales, and Ireland, remained the next closest categories, their numbers were significantly less than they had been in 1912.[98] The fact that the New Zealand born sufferers were predominant, not just at Tokanui but across the institutional network, illustrates that by the twentieth century, insanity had well and truly become a New Zealand problem, not just a burden transferred from 'home'.

In terms of age, the first patients, and the majority of the residents for the first 10 years, were aged between 20 and 40 years. No patients exceeded 80 years, and there were no children or young adults under the age of 20. In the decade that followed, this gradually changed as the existing population aged and Tokanui moved out of its initial construction phase to become an established institution. By 1930 over half the patients accommodated at Tokanui were aged between 40 and 60 years of age, and the range of ages had considerably broadened to encompass sufferers as young as five and as old as 90.[99] The listed causes of illness would also alter over the first 23 years with some categories 'officially' disappearing altogether. Although data pertaining to Tokanui's residents in those early years of transfers is absent, a broader institutional perspective offers some insight. In 1912, when causes of mental defect included religious excitement, masturbation, sexual excess, constipation and lead poisoning, the most common cause of insanity for males was alcohol, followed by senility and heredity. Comparably for females, heredity, previous attacks, and senility were the top three reasons given for suffering. Although senility remained within the top three listed causes of mental abnormality, by 1934, mental stress and

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Death at Tokanui

In October 1913, a male, aged somewhere between 20 and 30 years, had the dubious honour of becoming the first patient to die at Tokanui. Like many of the patients who died during the first decades of operation, little else is known about him, other than that he had been a resident in the system for 5-7 years and that his death was the result of septicaemia.[2] With recovery, for the most part, contingent on time and good fortune, death was the inevitable outcome for many patients at Tokanui. Warwick Brunton notes, more generally, that 'deaths accounted for 44 per cent of all deregistrations among committed patients; slightly more than the proportion discharged'.[3] Between 1912 and 1935, 282 patients, 162 of them male and 120 female, died at Tokanui.[4] The majority were over 50 years of age and if they had not died within the first three months of arrival were most likely to have been resident for more than 10 years.[5] Although certain 'Diseases of the Nervous System', including general paralysis of the insane, and exhaustion from confusional insanity, mania and melancholia, became more common from the late 1920s, the majority of deaths which occurred during this period were attributed to physical causes that had no direct relation to the sufferer's mental illness. Senile decay, heart disease and various respiratory illness, including pneumonia, tuberculosis and bronchitis, were the most frequently attributed causes of death. After 1928, all bodies would have been moved to the hospital mortuary for examination. Records indicate that not one, but two mortuaries were constructed on site, one in 1928[6] and another some 10 years later, presumably as a replacement for the first.[7] Post mortems were conducted on site until 1971, when the last was conducted by local GP and police pathologist, Dr Laurie Neil.[8] According to the department's 1914 annual report, a coroner's inquest was 'held into every case of death in an institution, irrespective of the cause'.[9]

Many of the patients who died at Tokanui during this time were transferred from outside the local area, and as a result were buried in the hospital cemetery, located behind the farm wool shed. However, in addition to accommodating those patients for whom relatives or guardians could not be contacted, or whose burial there was requested by relatives, the cemetery also functioned for a time as the pauper burial ground for the Waipa district, and thus some of the individuals buried there have no medical association with the hospital. Patients were buried in unmarked graves in one of three sections according to their religion; section A for Anglicans, B for Non-conformists and C for Catholics.[10] The graves, it is somewhat macabrely reported, were originally dug by patients themselves or by staff.[11] In total, approximately 500 individuals were interred in Tokanui's cemetery between 1912 and 1964 when in September, following a request by the Medical Superintendent to the Director of Mental Health, the cemetery was closed due to 'poor access for relatives and low usage'.[12] A year later the Health Department proposed the erection of a plaque engraved with the names of the deceased, however, this was turned down by the Medical Superintendent as 'being potentially distressing to the patients' relatives'.[13] Then 'in the early 1990s Waipa Community & Training Centre Manager Ken Jamieson undertook a project to have the site surveyed and formally identified'.[14] As a result the 'boundaries of the cemetery are now defined by four marker posts and a plaque identifying its history'.[15]

Notes

1. *AJHR*, 1914, H-7, pp. 14, 16.
2. *AJHR*, 1914, H-7, pp. 19-2
3. Brunton, 'A Choice of Difficulties', p. 246
4. Calculated from *AJHR*'s, H-7, 1913-1936.
5. See *AJHR*'s, H-7, 1913-1936.
6. *AJHR*, 1928, H-7, p. 3.
7. *AJHR*, 1938, H-7, p. 2.
8. John Graham, 'Tokanui Hospital Photo Show', created 18 December 2008, held by John Graham, Slide 51
9. *AJHR*, 1914, H-7, p. 4.
10. 'A History of Tokanui Hospital', p. 14.
11. 'A History of Tokanui Hospital', p. 14.
12. 'A History of Tokanui Hospital', p. 13.
13. 'A History of Tokanui Hospital', p. 14.
14. 'A History of Tokanui Hospital', p. 14.
15. 'A History of Tokanui Hospital', p. 14.

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congenital predisposition had become numerically dominant, illustrating the traumatic impact of World War One and changes in psychiatric understandings of mental illness.

However, at Tokanui, the principal causes of illness for the first patients are likely to have been different, reflecting a younger and more capable class of defective. The departmental report for 1909 stipulated that the patients transferred to Tokanui would be of a less demanding class, comprised 'for the most part [of] patients who keep very fairly well under skilled supervision, but are quite unable to adjust themselves to the larger environment of the world outside the institution'.[100] Selected based on their ability to work, the transfers were intended 'to assist in developing the new estate' and were therefore less disabled mentally than some of their counterparts in other institutions.[101] In 1912 all 64 of Tokanui's patients were listed as being employed, which included such tasks as land clearing and scrub cutting, working on the farm and assisting with the construction of further accommodation.[102]

As worker patients, the classification of Tokanui's sufferers was most likely to be within the curable realms of the mentally unsound, as opposed to that of the incurable imbeciles and feeble minded. In 1920 the overwhelming majority of those classified were listed as being of 'unsound mind' with the next largest group, comprised of eight imbeciles, being only a fraction of the 182 mentally unsound sufferers.[103] Although their ability to work reflected a certain level of functioning capability, the former occupations of patients indicate that the majority of sufferers in public institutions were of a labouring class, either listed as such, or as unemployed. These statistics make it apparent that insanity, at least publicly, was an illness of the lower classes, not of the upper, professional echelons of society.

Accordingly, a typical patient throughout the first twenty-three years of Tokanui's operation was most likely to be a working class male, between the ages of 30 and 50, who had been transferred to the institution as a working patient to assist with the estate's development. Listed as being of unsound mind, the cause of their illness was most likely to be congenital or alcohol related, or to be the result of mental stress. In the first decade of operation, that patient was unlikely to have left Tokanui, instead becoming a long term resident of the institution. For the few that were discharged, all as 'not recovered', their prospects were not favourable. As the population aged, things began to change, especially from the mid 1920s onwards. Even though admissions still easily outstripped discharges, exits from the hospital increased. Sadly, deaths were responsible for a considerable portion of the numerical reduction, roughly equal with those who were discharged. However, for those who were discharged, it was most likely to be as 'recovered'. Of the quantifiable factors affecting patients' institutional experiences discussed above, the most significant was sex. Males and females lived and worked in largely separate spheres. Their conformity to idealised gender roles influenced their prospects of recovery and release, as well as the tasks they were expected to perform and the treatment they received.

Accommodating Insanity

Prior to the pharmaceutical, psychosurgical and shock therapy revolutions of the late 1930s and 1940s, the treatment of the mentally afflicted was dominated by ideals of moral management and non-restraint. The moral element was supplied by staff, whose example, in addition to the quiet routines and order of the hospital, 'was intended to permeate to the patients' real selves and restore their mental order'.[104] Essentially a holistic approach which sought to influence the mind's recuperation by addressing the physical, spiritual, and social dimensions of the individual's being through diet and an 'activation programme' consisting of regular exercise and recreation, religious observance and occupation, moral management did little to address the underlying causes of mental distress, and treatment was primarily a matter of supervision and containment. Underlying this approach was an understanding that recovery was contingent on time, and for many patients this meant long, even life-long stays in mental institutions.

Occupation and exercise in the form of work was the main therapy available for patients until well into the mid-twentieth century. In the early years of construction, this work was not only held to be best treatment but was essential for the hospital's operation and growth. Work took the form of domestic chores including sewing, cooking, and cleaning for females and outdoor work on the farm

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and in the gardens for the men. Those patients confined to the wards also assisted with the domestic tasks and males did the heavy work in the kitchens and laundries, helped out at the bakery, store and butchery and transported supplies around the wards. Although males worked indoors, outdoor work was exclusively a male domain. The lack of outdoor employment for females made them, in the opinion of Inspector-General Hay, more dangerous than males who were pacified by the nature of their work.[105] Suggestions, initially by MacGregor, and later by CA Corban (assistant medical officer at Tokanui in 1932), that female patients be employed on the farm where physically possible, did not eventuate, despite finding Inspector-General Gray's favour. Several months later, Brunton notes, Gray sternly rebuked Tokanui's medical superintendent for 'the lack of effort to afford "a rational outlet for the energies of the female patients"'.[106]

Aside from the therapeutic benefit, patients were believed to derive from work, their occupation with everyday tasks had, it appears, a calming, even tranquilising effect, making them more manageable and reducing the need for restraint. Given the department's ideology of non-restraint, and the measures, including restraint registers, put in place to monitor and regulate its use, the pacifying effect of work, as well as the fact that unpaid patient labour was essential for keeping running costs down, ensured that it was the primary treatment used. Although non-restraint was strived for, the use of restraining devices was never able to be completely dispensed with. Insufficient staff, overcrowding and limited medical solutions, meant that restraint and seclusion remained in use throughout the first half of the twentieth century. Pharmaceutical alternatives prior to the 1940s were limited and officially discouraged. 'Potassium bromide, chloral hydrate and paraldehyde', Brunton informs, 'were to be found on dispensary shelves, along with an array of tinctures', as well as opiates, which 'were used in the nineteenth century until their addictive properties became known'.[107] Unlike in later decades, these anticonvulsant, hypnotic and sedative medications were not a main aspect of the treatment regime. The introduction of drug registers, intended to record and control the use of sedatives, reflected administrative concerns over the use of powerful drugs as chemical restraints and '[s]uch attitudes', Brunton notes, 'largely limited pharmaceutical treatment to house medicines, stimulants and a few sedatives'.[108] The registers for Tokanui no doubt confirm the use of both chemical and physical restraint during the first two decades of operation, although possibly not as frequently as other institutions given the type of patient originally selected for transferral. Largely spared the problems of overcrowding which plagued other mental hospitals, Tokanui was, however, still a victim of limited funds, staff and cures, all issues which necessitated the use of restraint.

Mental stimulation also included recreational activities, which were an important aspect of the activation programme and integral to fostering a sense of community. For the first eight years of Tokanui's operation, the provision of recreational activities and other amusements took a back seat to the development of basic infrastructure, then were frustrated by the fiscal constraints and staff shortages brought about by World War One. However, by the 1920s the hospital had become more settled and the medical superintendents began to report the various activities that were on offer to alleviate 'the monotony' of institutional life.[109] Initially, this consisted of fortnightly dances during the winter months and concerts put on by the musical people of the district, both of which were to continue throughout the 1920s and into the 1930s.[110] Visits to the picture theatre in Te Awamutu were also conducted on a fortnightly basis throughout the first half of the 1920s, however by 1924, following connection to the hydro-electric system, Dr Gribben called for the hospital to be provided with a cinematograph that all patients could enjoy.[111] In 1927 this was finally installed and patients were weekly shown a silent film courtesy of Australian Films Ltd., who provided the pictures free of charge.[112] However the silent films were to prove relatively short-lived. Just four years later, Dr Prins reported that screenings had ceased because of a lack of availability, and although it was noted that a further supply had been secured[113], a year later in 1932 the pictures had again ceased.[114] Fortunately, in the following year, the old cinema machine was converted to a "talkie" allowing weekly screenings to resume.[115]

A radio set, donated by the Sunshine League and installed in B ward in 1927 with loud-speaker connections made to F1 and FH wards, provided additional amusement,[116] as did the annual picnic and fancy-dress ball,[117] and visits to the Te Awamutu races and agricultural show.[118] Throughout the

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1920s and 1930s the generosity and kindness of the Official Visitors in bringing magazines, sweets and other gifts to the patients was noted.[119] Sports were also engaged in and by 1933 included tennis, bowls, croquet, swimming, cricket and ping-pong.[120] Religious services were held either twice or thrice monthly by Anglican, Presbyterian and Methodist clergymen. The mental stimulation provided by all these activities was in fact part of the hospital's therapy. In a similar way to work, these activities helped to calm patients and address the social and spiritual aspects of their recovery which the moral management approach was concerned with.

From the nineteenth century onwards, the classification of patients according to the nature and status of their affliction became central to treatment ideologies. Patients were classified either as recoverable or as chronic; the former being comprised primarily of persons of unsound mind, including individuals suffering from depressive disorders, various neuroses, acute reactions to stress, certain affective psychoses, alcohol dependence and puerperal conditions'. [121] Brunton notes that 'some of these patients could be treated and stabilized in a relatively short time ... on average about two-thirds of committed patients who were discharged as recovered had spent less than one year in a mental hospital'.[122] However, the majority of committed patients, including those suffering from senility or other dementias, from schizophrenic psychoses, personality disorders, paranoid states, and mental retardation, were classified as chronic and generally faced long, even life long, stays in a mental hospital.[123] Brunton observes that 'someone who had not been discharged after six months was a "lifer"'.[124] However, the reality of insufficient accommodation leading to overcrowding, which characterized asylum operation during the late nineteenth and early twentieth century, limited the classification of patients to two separate groups – those who were reasonably quiet and moderately tidy and those who, in being noisy, destructive and dirty were the extreme opposite. Although accommodated separately, the treatment of each group remained the same, and in this respect was effective only in shielding the less deranged from the horrors of the utterly depraved. Brunton notes that '[k]eeping recoverable and sensitive patients apart from chronic patients was the bottom line of patient classification.'[125]

Around the time Tokanui opened, two events brought the practice of classification into sharper focus. The first was the passing of the Mental Defectives Act in 1911 (see Chapter Two) which replaced the single lunatic classification with six classes of mental defective in an attempt to better identify and detain subnormal individuals who were held responsible for society's more insidious problems. The second event was World War One. Soldiers returning home with 'shellshock' challenged the public's perception of mental illness and it was thought inappropriate that these brave men should be treated the same as the insane. In classifying patients, medical staff took into account a range of contributing factors including, according to Brunton, 'the date of admission, the duration of the malady, and the existence and nature of any bodily disease'.[126] Furthermore,'[a] tendency to suicide or violence was important, [as was] [f]eebleness or vigour, noisiness, offensiveness of habits and sexual tendency.... "Industry or the reverse, and occupation" were other factors, as was the amount of liberty that could be safely allowed'.[127]

Tokanui's villa design allowed for more sensitive and specialised classification, and made separation easier and more complete. Not only were the separate blocks cheaper, quicker and easier to build and extend, better ventilated and more sanitary, their real advantage in terms of treatment was that the principles of classification could be incorporated into the planning and design of the hospital. Furthermore, although the ideal of complete non-restraint was unrealistic, separate blocks allowed more readily for a system of graduated restraint where the level of confinement patients experienced could be determined to a greater extent by their individual behaviour thus reducing the 'pressure and friction among the inmates', notes Brunton.[128] Those who exhibited less violent and unpredictable tendencies were rewarded with greater freedom.

At Tokanui, the main division amongst patients, after the arrival of female patients in 1915, was that of sex. Separate accommodation for males and females underpinned all other classificatory divisions. Intended as a central repository for chronic and incurable cases, the majority of patients, until 1919 when Tokanui began to receive admissions directly, were long–term chronic residents of the system with unenviable prospects for recovery. Initially chosen for their ability to assist with developmental works, these patients needed less management and were collectively housed, regardless of their

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individual ailments, as accommodation allowed. However, in later years, as the hospital grew and the population aged, further divisions for the infirm, criminally minded, epileptics and those of unsound mind were made possible, although as Brunton points out, practicalities often meant juggling shared accommodation, with only the most difficult, dangerous and depraved being assured of complete segregation. [129]

The information pertaining to the construction of wards at Tokanui is, at times, conflicting, making it difficult to pinpoint exact dates for their completion. However, it appears that during the first few decades of operation around half of the wards were erected. By all accounts, the first permanent ward to be constructed was Ward 1 in approximately 1912. It was closely followed by Wards A, 2, and C, in 1915, 1916 and 1917 respectively. All were typical examples of the villa style – being single storied wood buildings with high pitched roofs. Wards 1 and A, respectively, were male and female admission wards until the construction of Wards 3 and B, thereafter becoming refractory (not responding to treatment) and long-stay rehabilitation units. Similarly Wards 2 and C were used for male and female refractory and long-term rehabilitation accommodation. The flow-on effect of wartime shortages meant that the next ward, D Ward, was not completed until 1919 when it became another female refractory ward. Also constructed of wood, it was described in the 1919 Public Works Statement as being comprised of:

Alpha-Numeric Divisions

The villas at Tokanui were divided by designation into two groups. They were either numbered or lettered and until mid-century this was used to distinguish between gender – letters for the male wards and numbers for the female wards. In approximately 1967 this order was reversed for a mixture of safety and logistical reasons. The end result was that the female wards, formerly 1,3,4,5,6,7,8 and 9, became, A, B, H, F, G, C, K and E respectively and the male wards, formerly A, B, C, E, H, M, R, S, and T became 1, 6, 2, 4, 3, 5, 7, 9, and 8.

> two large dormitories and one small one, also [including a] large day-room with double fireplace in the centre. Adjacent to the day room on the eastern side are twelve single rooms for patients; on the western side are the nurses' quarters, consisting of six single-bed rooms, also storeroom, scullery, and all kitchen conveniences. Leading off the day-room, patients are provided with extensive lavatory and bathroom accommodation.[130]

In October of the same year, work commenced on the foundations of the male and female admission wards, but it would be 1921 before Ward 3, for males, and 1925 before Ward B, for females, were completed. Both buildings were two-storied brick constructions, the male admission block being Tokanui's first multi-storied building. Out of necessity the bricks for Ward 3's construction were fabricated on site at the No. 1 Camp block-making shed. However, a shortage of raw materials hindered fabrication causing building delays for B Ward and eventually necessitating a contract for its construction to be let. Unlike Wards 1 and 2, and A and C which were designed to accommodate between 40 and 50 patients, the admission wards were considerably smaller, housing just 20 patients each. In the first decade of the twentieth century, admission wards, or reception houses as they were also known, found favour with officials. An extension of efforts to protect sensitive, recoverable patients from the main wards, they were run on the general hospital model of individualised specialist treatment. Their function, based on the principle of early intervention, was to assess, treat and hopefully cure and discharge the sufferer without the need for committal.

The next stage in Tokanui's development was the construction of additional female accommodation. However, before work could begin on the new units, a suitable site needed to be identified for their foundations. The 50th Jubilee Booklet makes clear the problem and its solution:

> All the flat land had been built on and the rest of the land was either hills or swamp. After many discussion and changes of plans it was decided to "kill two birds with one stone"; all available patients were equipped with spades and wheelbarrows and proceeded to take off the top of the hill to the Northwest of C Ward, and at the same time fill up the swamp at the front of the hospital which formed the foundation for the present sports field.[131]

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Thus, in 1928 a contract was let for the construction of three female villas[132] and in 1930 these were completed, providing accommodation for 150 patients.[133] Wards F, G and H were virtually identical two-storied brick buildings used for refractory and long-term stay accommodation.

The final ward to be constructed in the first couple of decades of operation was Ward 7. A return to the single storied wooden villa, it was completed in 1934 and was used for male farm-worker patients of a chronic, long-stay nature. All of the wards went on to have multiple and varied lives accommodating what would become known as the intellectually disabled, forensic patients, Māori mental health, adolescent and geriatric sufferers (See Appendix 2). Of the two-storied buildings, only B Ward remains standing. Wards 3, F, G and H were demolished in the early 1990s because it was believed that, having been built prior to changes in the building code following the 1931 Hawke's Bay earthquake, they posed a significant safety risk in the event of another such disaster.

Conclusion

The first two decades of Tokanui's operation were largely consumed with the development of land and basic infrastructure. During this building-up phase, the bulk of the wards were constructed, all to a villa design, ushering in a new era of patient care and classification that was intended to more effectively

A Family Tradition of Psychiatric Nursing

It was not uncommon for a career in psychiatric nursing to run in families. For Judy Besley, who grew up in the Tokanui community and nursed patients in the hospital until it closed in 1998, there were three generations of role models to follow.

In the early 1900s her grandfather, James Cran, trained as a psychiatric attendant at Paisley Asylum in Stirling, Scotland. In 1907 he immigrated to New Zealand and worked at Porirua Mental Hospital alongside many others who had made the seven week voyage to the colony. In 1911 he contracted typhoid fever, but was fortunate to survive, and also to marry Adeline MacArthur, a general nurse in the public hospital where he was treated. On his return to duty, they were offered a transfer to Tokanui and subsequently travelled north by train, accompanying the hospital's first four patients, tasked with building an institution and setting up a farm to support it.

James and Adeline started a family, and their second child – Dot – was Judy's mother. In the family story Dot later recorded, she described growing up at Tokanui, living in the 'new settlement up by the reservoir' until 1922. 'The staff houses were built around the edge of a big paddock where the staff horses grazed. All heads of department had a horse'. When she left school she also took up nursing at Tokanui. In order to qualify, there were two exams to be passed – 'the junior exam, which you had to get within six months or leave, and the finals at the end of three years. So you can see, everyone working there was either trained or training, and you knew and respected your seniors'. Dot married Charlie Whittle, who became Head Gardener, responsible for providing vegetables for the kitchen, as well as landscaping the grounds.

In 1967, Judy began her nursing training, entering a world where her mother was still a well-known entity. She recalls:

> My mother made Tokanui her life. She was a very respected, proud, straight lady (tough). She was much loved and respected by the patients and for years I was often afforded the goodwill and mana that was hers, from patients who asked "how's Sister Whittle?"
>
> My mother was often called from all over the hospital to bath Alice in D Ward – a patient who barricaded herself in her room ... until "Whittle" had been ordered by matron to attend her. I was later thankful when Alice accepted me as my mother's daughter and allowed me the privilege of opening the bathroom door for her.
>
> My mother then became a Sister-in-Charge of the Nurses' Home for many years, until my sister tried her luck at nursing. Because trainee nurses had to live in, Mum transferred back to ward work at that point to avoid any conflict of interest. When she eventually retired, I don't think she ever recovered from missing the work and society of Tokanui.

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FIG 3.4 James Cran (right) and his friend Jack at Porirua Hospital in 1907. In 1911 both men contracted typhoid fever which left Jack dead and James with a weak heart.
Photo Courtesy of Judy Besley

treat sufferers in a less institutional setting. At a time of therapeutic despair, when increasingly patients were presenting as chronic cases and treatment was still very much based on nineteenth-century moral therapy, the construction of villas represented a significant step forward in care, providing a more favourable outlook for patients. The villas allowed patients to be separated and grouped based on their affliction and recovery prospects. However, in the early years, when the majority of worker patients transferred to Tokanui were classified as mentally unsound, the main divisions which the villas enabled were those of gender and prognosis. For the medical superintendents and staff at Tokanui, the pioneering environment presented many challenges and, for the patients, their prospects of recovery and release were not great. Many would spend a number of years at Tokanui, and some would never leave, ultimately being buried in the hospital cemetery. The vast space originally acquired for Tokanui's construction proved excessive, even for a villa hospital with accompanying farm and gardens, and was ultimately reduced to 1500 acres. The estate and, in particular, the sense of spaciousness which it engendered, has become a touchstone for memories of Tokanui. From unbroken land to functioning hospital, the first decades of Tokanui's existence laid the foundations of what would become one of the foremost mental hospitals in the country.

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Notes

1 'A family story by Dot Whittle née Cran', Reproduced by John Graham, July 2001, held in John Graham Archival Collection, p. 2.

2 Report on Mental Hospitals of the Dominion for 1907, *Appendix to the Journals of the House of Representatives (AJHR),* 1908, H-7, p. 5.

3 Report on Mental Hospitals of the Dominion for 1926, *AJHR,* 1927, H-7, p. 7.

4 Transcript of interview with Lloyd Anderson, [n.d], Interviewer's name not given. Held Te Awamutu Museum, Side A, p. 6

5 Warwick Brunton, '"A Choice of Difficulties": National Mental Health Policy in New Zealand, 1840-1947' (unpublished doctoral thesis, University of Otago, 2001), p. 256.

6 Report on Mental Hospitals of the Dominion for 1877, *AJHR,* 1878, H-10, p. 3; Report on Mental Hospitals of the Dominion for 1876, *AJHR* 1977, H-8, p. 13 and Report on Mental Hospitals of the Dominion for 1880, *AJHR* 1881, H-13, p. 9.

7 *AJHR,* 1878, H-10, p. 3.

8 Brunton, 'A Choice of Difficulties', p. 240.

9 *AJHR,* 1927, H-7, p. 10.

10 Report on Mental Hospitals of the Dominion for 1927, *AJHR,* 1928, H-7, p. 6.

11 Report on Mental Hospitals of the Dominion for 1928, *AJHR,* 1929, H-7, p. 6.

12 Report on Mental Hospitals of the Dominion for 1931, *AJHR,* 1932, H-7, p. 5.

13 Report on Mental Hospitals of the Dominion for 1932, *AJHR,* 1933, H-7, p. 7.

14 Report on Mental Hospitals of the Dominion for 1934, *AJHR,* 1935, H-7, p. 6.

15 Supporting this assumption is a description of Kingseat's gardens. At Kingseat it was reported that staff returning from days off or holidays contributed to the beautification of the hospital by bringing with them "boots full" of native trees, shrubs and plants that they had acquired for planting. Kingseat also benefited from the gift of surplus plants from the Ellerslie Racecourse including 'hundreds of boxes of pansy plants grown from imported French seeds. Built after Tokanui, also to a villa design, both hospitals would have been governed by the same policies, and while there is no record of staff or other facilities gifting plants, the use of natives and bright, colourful flowers such as pansies seems certain. See *Kingseat Hospital, 50 Years 1932 – 1982* (Papakura, N.Z.: Kingseat Jubilee Editorial Committee, 1981), pp. 7-8.

16 Wendy Hunter Williams, *Out of Mind, Out of Sight: The Story of Porirua Hospital* (Porirua, N.Z.: Porirua Hospital, 1987), p. 115.

17 Cheryl Caldwell, 'Truby King and Seacliff Asylum, 1889-1907, chapter in *"Unfortunate Folk": Essays on Mental Health Treatment, 1863-1992,* ed. by Barbara Brookes and Jane Thomson (Dunedin, N.Z.: University of Otago Press, 2001), pp. 40-41.

18 James Beattie, 'Colonial Geographies of Settlement: Vegetation, Towns, Disease and Well-Being in Aotearoa/New Zealand, 1830's-1930's', *Environment and History,* 14 (2008), p. 584.

19 Beattie, p. 593.

20 Warwick Brunton, 'Colonies for the Mind: The Historical Context of Services for Forensic Psychiatry in New Zealand' in, *Psychiatry and the Law: Clinical and Legal Issues,* edited by Warren Brookbanks (Wellington, N.Z.: Brookers, 1996), p. 30.

21 'A History of Tokanui Hospital: Te Awamutu, 1912-1997', ed. by Roger McLaren ([n.p.]: [n.pub.], 1997). Located as photocopy at the National Archives Auckland Branch, YCBG., p. 3.

22 J. Drysdale, 'The Tokanui Mental Hospital Estate: King-Country Development', *New Zealand Journal of Agriculture* (January 20, 1919), p. 34.

23 Drysdale, p. 34.

24 Drysdale, pp. 34; 36.

25 Report on Mental Hospitals of the Dominion for 1911, *AJHR,* 1912, H-7, p. 8; Report on Mental Hospitals of the Dominion for 1912, *AJHR,* 1913, H-7, p. 10.

26 *AJHR,* 1913, H-7, p. 10.

27 Report on Mental Hospitals of the Dominion for 1916, *AJHR,* 1917, H-7, p. 6.

28 Report on Mental Hospitals of the Dominion for 1917, *AJHR,* 1918, H-7, p. 6.

WAK0000200

29 Report on Mental Hospitals of the Dominion for 1924, *AJHR*, 1925, H-7, p. 10.

30 Report on Mental Hospitals of the Dominion for 1925, *AJHR*, 1926, H-7, p. 9

31 In the 1925 department report it was hopefully commented that accommodation in the vicinity of No.1 camp would enable the whole property to be worked to advantage allowing labour from the Waikeria Borstal Institution to be dispensed with entirely. See *AJHR*, 1925, H-7, p. 9

32 Report on Mental Hospitals of the Dominion for 1919, *AJHR*, 1920, H-7, p. 4.

33 *AJHR*, 1929, H-7, p. 6

34 Dot Whittle, p. 2.

35 In 1913 the value of produce consumed versus that sold for cash was £408 8s 9d compared with £66 18s 5d. By 1920 the respective figures were £2,577 15s 7d versus £1,811 12s 3d. See Report on Mental Hospitals of the Dominion for 1913, *AJHR*, 1914, H-7, p. 8;*AJHR*, 1920, H-7, p. 4.

36 Hunter Williams, p. 132.

37 Hunter Williams, p. 132.

38 Hunter Williams, p. 132.

39 *AJHR*, 1920, H-7, p. 22.

40 *AJHR*, 1932, H-7, p. 2.

41 *AJHR*, 1935, H-7, p. 6.

42 Hunter Williams, p. 137.

43 Letter to Mr. Chapman from A.D. Croasdale, Medical Superintendent, regarding the provision of services to assist the Agriculture Department with running of the farm, p. 1 of Tokanui File: Land, Building & Accommodation; Land: General, Grazing, File No.8/9, p. 1.

44 Brunton, 'A Choice of Difficulties', p. 451.

45 Hunter Williams, p. 125.

46 Brunton, 'A Choice of Difficulties', p. 452.

47 *AJHR*, 1912, H-7, p. 7.

48 *AJHR*, 1928, H-7, p. 3.

49 Prior to transferring from Porirua, James Cran had just recovered from typhoid which he contracted during an epidemic at the hospital. While recovering at Wellington Public Hospital, Cran met his wife, Adeline Agnes McArthur who he married before they transferred to Tokanui.

50 Janet Frame, *An Autobiography* (Auckland, N.Z.: Century Hutchinson, 1989), p. 221.

51 Brunton, 'A Choice of Difficulties', p. 325.

52 'A History of Tokanui Hospital', p. 6.

53 Newspaper advertisement, 7 October 1921, Archives New Zealand (ANZ), Wellington, H-MHD, 1, 8/116/0.

54 'Notice of Appointments, promotions and transfers', Supplement to the *New Zealand Gazette* (*NZG*), 1914, vol. 2, p. 4202.

55 Brunton 'A Choice of Difficulties', p. 305.

56 Brunton 'A Choice of Difficulties', table 13 p. 307.

57 Report on Mental Hospitals of the Dominion for 1914, *AJHR*, 1915, H-7, p. 6.

58 Report on Mental Hospitals of the Dominion for 1915, *AJHR*, 1916, H-7, p. 4

59 'List of Persons Employed in the Public Service on the 31st Day of March', Supplement to the *New Zealand Gazette* (*NZG*), 1915, vol. 1, p. 1582 & 'Notice of Retirement', Supplement to the *New Zealand Gazette* (*NZG*), 1916, vol. 1, p. 872.

60 'List of Persons Employed in the Public Service on the 31st Day of March', Supplement to the *New Zealand Gazette* (*NZG*), 1918, vol. 1, pp. 1578-9.

61 *AJHR*, 1917, H-7, p. 6.

62 'Tokanui 50th Jubilee', [No Further Publishing Details Available]. Located as photocopy at the National Archives Auckland Branch, 5931/1a, p. 6.

63 Brunton 'A Choice of Difficulties', p. 333.

64 'A History of Tokanui Hospital', p. 3.

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65 Brunton 'A Choice of Difficulties', p. 327.

66 Brunton 'A Choice of Difficulties', p. 327.

67 Brunton 'A Choice of Difficulties', p. 327.

68 Brunton 'A Choice of Difficulties', p. 333.

69 Report on Mental Hospitals of the Dominion for 1918, *AJHR*, 1919, H-7, p. 10.

70 Brunton 'A Choice of Difficulties', p. 340.

71 Brunton 'A Choice of Difficulties', p. 340.

72 Caldwell, p. 43.

73 Brunton 'A Choice of Difficulties', p. 304 -05.

74 Brunton 'A Choice of Difficulties', p. 304.

75 Brunton notes, regarding keys, that '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'. See Brunton 'A Choice of Difficulties', Footnote no. 5, p. 304. Regarding uniforms, Brunton notes that in 1885, Gribben, then superintendent of Hokitika, 'wanted attendants to wear striped trousers and caps with a distinguishing badge of rank: an oak leaf band for attendants, and silver lace band and crown for the Head Attendant'. See Brunton 'A Choice of Difficulties', Footnote no. 178, p. 336. By 1934 Brunton notes that 'probationers wore pink and white striped frocks, and nurses a blue uniform. Charge nurses wore cream but later white uniforms'. Brunton 'A Choice of Difficulties', Footnote no. 201, p. 340.

76 See Brunton 'A Choice of Difficulties', p. 337.

77 Brunton 'A Choice of Difficulties', caption for image which appears after p. 328.

78 Brunton 'A Choice of Difficulties', Footnote no. 201, p. 337.

79 'A History of Tokanui Hospital', p. 7.

80 'Tokanui 50th Jubilee', p. 8.

81 Brunton 'A Choice of Difficulties', p. 338.

82 *AJHR,* 1926, H-7, p. 6.

83 Brunton 'A Choice of Difficulties', p. 338.

84 Brunton 'A Choice of Difficulties', p. 346.

85 Brunton notes that '[t]he proximity of staff rooms to the wards meant that "one does not get the freshest, and therefore the best, work from officials who have had had little leisure, and who cannot in their hours of rest be disassociated from their office"'. See Brunton 'A Choice of Difficulties', p. 338 – 39.

86 Brunton 'A Choice of Difficulties', p. 339.

87 *AJHR,* 1927, H-7, p. 10.

88 *AJHR,* 1932, H-7, p. 5.

89 Transcript of Joint Interview with Laurie (Monty) Mills and Laura Condon, 13 June 1996, Interviewed by John Graham and Bub Lubline, John Graham Archival Collection, p. 1.

90 Caldwell, p. 44.

91 'Tokanui 50th Jubilee', p. 8.

92 'A History of Tokanui Hospital', p. 5.

93 'Tokanui 50th Jubilee', p. 8.

94 Brunton 'A Choice of Difficulties', p. 338.

95 'A History of Tokanui Hospital', p. 3; 'Tokanui 50th Jubilee', p. 1; *AJHR,* 1913, H-7, p. 17 – See note at bottom of page pertaining to average number of patients resident during the year for Tokanui.

96 Report on Mental Hospitals of the Dominion for 1909, *AJHR*, 1910, H-7, p. 7.

97 *AJHR,* 1913, H-7, p. 21.

98 *AJHR,* 1935, H-7, p. 13.

99 Report on Mental Hospitals of the Dominion for 1929, *AJHR*, 1930, H-7, p. 16.

100 *AJHR,* 1910, H-7, p. 7.

101 *AJHR,* 1910, H-7, p. 7.

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102 *AJHR,* 1913, H-7, p. 7.

103 *AJHR,* 1920, H-7, p. 2.

104 J. Conolly, 'The Treatment of the Insane without Mechanical Restraints', London, 1856, Cited in Hunter Williams, p. 5.

105 Hunter Williams, p. 66.

106 Brunton, 'A Choice of Difficulties', Footnote 88, p. 373.

107 Brunton, 'A choice of Difficulties', p. 381.

108 Brunton, 'A Choice of Difficulties', p. 382.

109 Report on Mental Hospitals of the Dominion for 1923, *AJHR,* 1924, H-7, p. 7.

110 *AJHR,* 1924, H-7, p. 7.

111 *AJHR,* 1925, H-7, p. 10.

112 *AJHR,* 1928, H-7, p. 6.

113 *AJHR,* 1932, H-7, p. 5.

114 *AJHR,* 1933, H-7, p. 7.

115 Report on Mental Hospitals of the Dominion for 1933, *AJHR,* 1934, H-7, p. 4.

116 *AJHR,* 1928, H-7, p. 6.

117 Mention is first made of the annual picnic in the 1928 report, however the way it is written makes it appear that it was already an established event. See *AJHR,* 1928, H-7, p. 6. The fancy dress ball is first mentioned a year later in the 1929 report. See *AJHR,* 1929, H-7, p. 6.

118 'Tokanui 50th Jubilee', p. 7.

119 *AJHR,* 1924, H-7, p. 7.

120 *AJHR,* 1934, H-7, p. 4.

121 Brunton, 'A Choice of Difficulties', p. 259.

122 Brunton, 'A Choice of Difficulties', p. 259.

123 Brunton, 'A Choice of Difficulties', p. 259.

124 Brunton, 'A Choice of Difficulties', p. 259 - 60.

125 Brunton, 'A Choice of Difficulties', p. 265.

126 Brunton, 'A Choice of Difficulties', p. 264.

127 Brunton, 'A Choice of Difficulties', p. 264.

128 Brunton, 'A Choice of Difficulties', p. 255.

129 Brunton notes that although Mercier believed that recent cases, new admissions and epileptics should be accommodated in separate wards, he '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.' See Brunton 'A Choice of Difficulties', p. 264.

130 *AJHR,* 1919, D-1, pp. 40-41.

131 'Tokanui 50th Jubilee', p. 6.

132 *AJHR,* 1928, D-1, p. xxiv.

133 *AJHR,* 1930, D-1, p. xxvi.

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