Institutional responses to mental deficiency in New Zealand, 1911-1935: Tokanui Mental Hospital

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Abstract

This thesis considers the response of one New Zealand institution, Tokanui Mental Hospital, to legislation and policies for 'mental deficiency' introduced during the first half of the twentieth century. Institutional reactions to these policies have been under examined in New Zealand. While psychiatric or mentally ill patients have been the subject of a number of New Zealand histories of the asylum, 'mental defectives' have often been overlooked. Yet during the early-twentieth century, 'mental defectives' were thought to be a source of a number of social problems, and the New Zealand government considered a range of measures aimed at limiting the spread and effect of mental deficiency in society. Policies for 'mental deficiency' were influenced by contemporary anxieties about crime, sexuality and hereditarism. As a policy of segregation was formally prescribed, more 'mental defectives' were committed to mental hospitals and other institutions than ever before. An understanding of the responses to this perceived problem also provides an insight into wider social policies in New Zealand in the first half of the twentieth century. This thesis argues that gender was a significant factor in the decision to commit mental defectives to Tokanui. Subsequent categorisation and treatment within Tokanui was also affected by gender. Official reports inform us about the policies that were in place, and historical materials from Tokanui show how these worked in practice. Most of the archives of Tokanui Mental Hospital have been unexamined by historians before now, and close analysis of patient cases also reveals more about institutional practices. The connection between Tokanui and neighbouring Waikeria Prison is also explored, in the context of contemporary fears surrounding mental deficiency and crime.

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Introduction

'Mental deficiency', now known as intellectual disability, was not officially recognised as a condition separate from lunacy until the early-twentieth century. In New Zealand the *Mental Defectives Act* (1911) first acknowledged the number of categories, including 'idiot', 'imbecile' and 'feeble-minded', within the field of 'mental deficiency'. This legislation also sought to resolve the 'problem' of 'mental deficiency'. This thesis locates institutional responses to legislation and policy for 'mental deficiency' by examining one New Zealand mental hospital, Tokanui Mental Hospital, situated in the Waikato, in the early-twentieth century. An understanding of the responses to this perceived social problem also provides an insight into wider social policies in New Zealand in the first half of the twentieth century. The case study of Tokanui will consider how policies such as the *Mental Defectives Act* operated in practice.

This thesis argues that 'mentally defective' patients in mental hospitals during the early-twentieth century have been under examined in New Zealand histories of the asylum. Tokanui responded to the 'mental deficiency problem' by diagnosis and classification of 'mental defectives' in the hospital according to legal definitions, but also based on information provided by patients' families and their doctor's own expertise. These factors, as well as patient's actions and behaviour in the hospital, determined Tokanui's response to individual patients; that is, the type of work given to patients, whether they received parole, or eventually probation and discharge. Families were responsible for committal for most 'mental defectives', and for care and control if 'mental defectives' were discharged.

Gender was an important factor in the decision to commit a 'mental defective', and in their categorisation and experiences in Tokanui. Categorisation of 'mental defectives' was initiated by medical, educative and governmental authorities and reinforced the power these authorities and institutions had over individuals. In this thesis, gender and the construction of these 'medical'

categories are overarching themes. The thesis will also consider how gender and categorisation interacted with the following themes: policy and legislation; the care and management of 'mental defectives', particularly those at Tokanui; the role of families in institutionalisation; the social control of defectives, especially 'high grades'; and criminality.

The terms used in this thesis to describe intellectual disability, 'mental deficiency', 'defective', 'idiot', 'imbecile', 'feeble-minded', and 'social defective', are obsolete and have been rarely used in the last 30 to 40 years in New Zealand. The use of quotation marks around these terms in histories of mental deficiency is a common indicator of how highly constructed these categories were in the late-nineteenth and early-twentieth centuries.[1] This thesis argues that this was also the case for these categories in New Zealand.[2] Idiots and imbeciles were further categorised as 'low grade' mental defectives in Tokanui, while the feeble-minded and social defectives were 'high grade', or more intelligent defectives. These historically accurate terms will also be used throughout this thesis to describe the patients. The thesis is concerned to further explicate these categories where possible.

The thesis also situates New Zealand within an international framework. This Introduction explores the historiographical context for this study, first examining themes in the international setting, and then turning to New Zealand. A number of British and American histories from the late 1970s have examined institutions and policies for defectives in those countries.[3] Some 'idiots', the term

[1] Mark Jackson, *The borderland of imbecility* (Manchester: Manchester University Press, 2000), pp. 14-15.
[2] However, quotation marks will not be used throughout the thesis for typographical reasons.
[3] In Britain; Pamela Dale and Joseph Melling, eds, *Mental Illness and Learning Disability Since 1850: Finding a place for mental disorder in the United Kingdom* (London: Routledge, 2006); Jackson, 2000; Harvey G. Simmons, 'Explaining Social Policy: The English Mental Deficiency Act of 1913', *Journal of Social History*, 11, (1978), pp. 387-403; Mathew Thomson, *The Problem of Mental Deficiency: Eugenics, Democracy and Social Policy in Britain, c. 1870-1959* (Oxford: Oxford University Press, 1998); David Wright and Anne Digby, eds, *From Idiocy to Mental Deficiency: Historical perspectives on people with learning disabilities* (London: Routledge, 1996); David Wright, *Mental Disability in Victorian England: The Earlswood Asylum, 1847-1901,* (Oxford: Oxford University Press, 2001). In the United States James W. Trent, *Inventing the Feeble Mind: A History of Mental Retardation in the United States* (Berkley and Los Angeles: University of California Press, 1994); Steven Noll and James W. Trent, eds, *Mental Retardation in America: A Historical Reader* (New York: New York University Press, 2004).

most widely used to describe defectives during the nineteenth century, were institutionalised during this period. Mental defectives, in particular the feeble-minded, began to be problematised from the late-nineteenth century, by doctors, educators and governments in Western countries.

In Britain and New Zealand the introduction of compulsory universal education during this period has been identified as the beginning of the mental deficiency 'problem'.[4] Internationally, a range of solutions were considered as possible responses to the problem of mental deficiency. For example, in Britain, the United States, and New Zealand, strategies such as marriage regulation, birth control, sterilisation, as well as segregation, were all considered.[5]

By the early-twentieth century the feeble-minded were considered a menace, which coincided with the emergence of the 'science' of eugenics. Eugenics aimed to 'maintain or improve the genetic quality of the human species', by restricting the fertility of the 'unfit' with a variety of measures, of which segregation was most widely adopted.[6] Included in this group of the 'unfit' were the insane, alcoholics, criminals, prostitutes and the mentally defective. From about 1905 in Britain, the United States and other Western countries, eugenics movements found increased support, mainly from the middle-classes as the numbers of the 'unfit' appeared to swell.[7]

In New Zealand the eugenics movement centred on the Eugenics Education Society, established in Dunedin in 1907. Its members were mainly middle class, and academics, and doctors. Honorary Vice-Presidents of the Society included Prime Minister William Massey, Dr T.H.A. Valintine, Inspector-General of Hospitals and Chief Health Officer, and Dr Frank Hay, Inspector-General of the Mental Hospitals and Prisons Departments. Members of Parliament also served on the Society's council.[8] The Society sought politicians

[4] Thomson, p. 13; Stephen Robertson, '"Production not Reproduction": The Problem of Mental Defect in New Zealand, 1900-1930', BA (Hons) Essay, University of Otago, 1989, p. 10.
[5] David Barker, 'How to Curb the Fertility of the Unfit: the feeble-minded in Edwardian Britain', *Oxford Review of Education*, 9, 3, (1983), p. 197.
[6] P. J. Fleming, 'Eugenics in New Zealand, 1900-1940', MPhil thesis, Massey University, 1981, pp. 2-4.
[7] Barker, p. 197.
[8] Fleming, pp. 24-27.

to join in hopes of influencing 'worthwhile' legislation, such as the *Mental Defectives Act*.[9] By 1914, membership, and the influence of the Society were in decline due to limited financial and human resources. While the Society had disbanded, some support for eugenics in New Zealand continued through the 1920s until the 1930s when efforts to form a new eugenics organisation failed.[10] During the same period in Britain and the United States, eugenics movements also began to wane.

Segregation, or institutionalisation, became the preferred measure for the control of mental defectives in New Zealand as well as Britain and the United States. Sterilisation was seriously debated in Britain, but authorities thought such a drastic measure would never gain public support beyond the eugenics movement. In the United States, individual states were responsible for mental deficiency policy; institutions were common in individual states, some of which also introduced sterilisation. Historians have shown that between the years 1907 and 1960 over 60,000 intellectually disabled and mentally ill individuals were sterilised in the United States.[11] Chapter One will show that sterilisation was also debated in New Zealand.

As the apparent danger of mental deficiency increased, authorities realised there was no legal definition of the newly discovered categories of deficiency. New Zealand was among the first countries to legislate for mental deficiency. The results of the new legislation in different countries included enhanced classification systems and an increased number of potential defectives. Families had a significant role in the identification, certification and treatment of defectives.[12] The care and control of defectives had typically been the responsibility of families until the mid-nineteenth century, when the first institutions for mental defectives were established, and families were encouraged to place their defective family member into an institution, at least for the short

[9] Fleming, p. 32.
[10] For a more expansive discussion of eugenics in New Zealand see Fleming; and R.W. Metcalfe, 'The debate about eugenics: Eugenics and social legislation in New Zealand 1900-1930', MPhil thesis, Massey University, 2000.
[11] Philip R. Reilly, *The Surgical Solution: A History of Involuntary Sterilization in the United States* (Baltimore: The John Hopkins University Press, 1991), p. 2.
[12] Wright, 2001, p. 6; Thomson, pp. 258-267.

term. However, when mental deficiency was redefined as dangerous and hereditary, long term custodial care was advocated.[13] The provision of care, treatment and management of defectives increasingly came under the control of government departments and institutions during the early-twentieth century. The villa, or colony, system was developed in Britain and the United States from the 1890s. It was intended to provide better classification and treatment of all mental hospital patients. From the 1900s the villa system was introduced in New Zealand mental hospitals.[14]

Historians have argued gender was crucial in the categorisation of defectives, especially the feeble-minded. Delinquent or unruly males and promiscuous female defectives were targeted for segregation. While the regulation of the sexuality of mentally defective young women was a key reason for their committal, their continued segregation was dependent on other factors, such as poverty, moral worth, respectability, and employability.[15] The feeble-minded apparently lacked will-power, which 'precipitated feeble-minded men into lives of crime, [and] the same quality rendered feeble-minded women unstable, irresponsible and vulnerable to seduction'.[16] Contemporary scientific research contended that mental deficiency was hereditary and that feeble-minded women were responsible for passing on the condition as they lacked the sexual control of 'normal' women; which resulted in a large number of illegitimate and mentally deficient children. Within the wider context of contemporary ideas about the hereditary nature of mental deficiency, Australian historians have shown that the control of feeble-minded women and the classification practices of medical authorities were of concern in New South Wales in the early-twentieth century.[17]

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[13] Trent, p. 29.
[14] Warwick Brunton, 'Out of the Shadows: Some Historical Underpinnings of Mental Health Policy', in *Past Judgement: Social Policy in New Zealand History*, edited by Bronwyn Dalley and Margaret Tennant (Dunedin: University of Otago Press, 2004), p. 83.
[15] Jan Walmsley, 'Women and the Mental Deficiency Act of 1913: citizenship, sexuality and regulation', *British Journal of Learning Disabilities*, 28, (2000), pp. 65-69.
[16] Jackson, 2000, p. 145.
[17] Rosemary Berreen, 'Illegitimacy and "Feeble-mindedness" in early twentieth century New South Wales', in *Forging Identities*, edited by Jane Long, Jan Gothard and Helen Brash (Nedlands: University of Western Australia Press, 1997), p. 205.

Delinquent or criminal young men were just as likely as defective women to be segregated. Some British mental deficiency campaigners thought there was a greater occurrence of feeble-mindedness among males; often identified by alcoholism or criminal tendencies.[18] British historian Mathew Thomson's analysis of evidence presented to the British Royal Commission on the Care and Control of the Feeble-minded (1908) suggests 'that recent historiography has gone too far in representing the problem of mental deficiency as an issue which was almost exclusively, one of controlling the reproduction of feeble-minded women'.[19] Thomson points out that Mary Dendy, a British mental deficiency campaigner, 'argued that there were three boys to every two girls, that boys were "quite as dangerous", [and] that mental defect was just as likely to be passed down the paternal line of the family'.[20] In Britain, prison wardens had responsibility for the classification, segregation, and surveillance of prisoners from the mid-nineteenth century.[21] Their observations were usually the basis for an examination of an alleged defective. Historian Janet Saunders suggests that the inability of the feeble-minded prisoner to conform to prison discipline was often 'sufficient to allow a certificate of insanity and transfer to an asylum'.[22] This seemed to be the case for some patients discussed in Chapter Four.

In New Zealand, prisoners were transferred to the control of the Mental Hospitals Department if they were found to be mental defectives. As in Britain, New Zealand prison wardens' observations and evidence were often the basis for these transfers. The introduction of the 'indeterminate sentence' in 1909 as part of reforms in the Prisons Department coincided with the changes in the Mental Hospitals system.[23] Indeterminate sentences were also used in Britain, the United

[18] Jackson, 2000, pp. 145-6.
[19] Thomson, p. 28.
[20] Thomson, p. 28.
[21] Stephen Watson, 'Malingerers, the "weakminded" criminal and the moral imbecile', in *Legal Medicine in History*, edited by Michael Clark and Catherine Crawford (Cambridge: Cambridge University Press, 1994), p. 223.
[22] Janet Saunders, 'Quarantining the weak-minded: psychiatric definitions of degeneracy in the late-Victorian asylum', in *The Anatomy of Madness, Vol. III*, edited by W.F. Bynum, Roy Porter and Michael Shepherd (London: Routledge, 1988), p. 279.
[23] John Pratt, *Punishment in a Perfect Society: The New Zealand Penal System, 1840-1939* (Wellington: Victoria University Press, 1992), p. 184.

States, and Australia.[24] The length of these sentences was determined by a prisoner's rehabilitation in prison and whether they were considered fit for release. The indeterminate sentence was recommended for prisoners that were mental or moral defectives, as well as juveniles.[25] The introduction indefinite segregation for defectives and some criminals was welcomed by legislators, medical and prison authorities, as an effective mode of control. The similarities between these methods also reinforced the connection between both groups. The links between mental deficiency and crime had been established in the early-nineteenth century in Britain, and strengthened as defectives were characterised as a menace. Between the 1880s and the introduction of the English *Mental Defectives Act* in 1913, debate over the mental defectives shifted focus from prisons and the habitually criminal imbecile to workhouses and 'transient weak-minded inmates, feeble-minded women in particular'.[26] The image of feeble-minded women moving in and out of workhouses and leaving illegitimate children behind was more compelling than one of 'depredatory male offenders, [and] habitual inmates of prisons'.[27]

Mental defectives and their supposed 'uncontrollable' sexuality were major concerns for authorities as well. These concerns were clear for female defectives, and in the case of some males, where homosexuality and cross-dressing appeared to be crucial reasons for committal. Certainly, Ruth Ford asserts that committal proceedings were instituted to regulate behaviour and control deviant bodies which threatened the dominant masculinist and heterosexual social order.[28] In some cases male and female mental defectives were transferred to Tokanui from other institutions because of their 'uncontrolled' sexuality.

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[24] Sean McConville, 'The Victorian Prison: England, 1865-1965', in *The Oxford History of the Prison*, edited by Norval Morris and David J. Rothman (Oxford: Oxford University Press, 1995), p. 158.
[25] Mark Finnane, *Punishment in Australian Society* (Melbourne: Oxford University Press, 1997), p. 77.
[26] Saunders, p. 289.
[27] Saunders, p. 289.
[28] Ruth Ford, 'Sexuality and "madness": regulating women's gender "deviance" through the asylum, the Orange Asylum in the 1930s', in *Madness in Australia*, edited by Catharine Coleborne and Dolly MacKinnon (St Lucia: University of Queensland Press, 2003), p. 115.

Social control theory became more dominant from the 1970s while older 'progressive' views of institutions as places of confinement, control and education were discarded in favour of a perspective where these institutions were seen as places to 'confine deviant and oppressed populations [which] was the result of prevailing cultural attitudes of aversions and fear'.[29] For social control theorists, the asylum was seen as a place of 'repression and incarceration' for the control of unfit or dangerous populations.[30] However, critics of social control have noted that it was 'not simply an imposition from the top down'.[31] By 'top down' critics meant legal and medical authorities. In asylum histories, the approach has been modified as the underlying issues such as the state, gender, race and class were addressed.[32] Such approaches have been questioned by historians such as David Wright, who have emphasised the importance of family agency in the diagnosis and committal of mental defectives.[33] Chapters Two, Three and Four of this thesis will argue that the desire for increased control of defectives was a key factor in their committal and that for female and child patients especially, families were instrumental in Tokanui's diagnosis and classification.

While there has been much emphasis on the intersection between gender and mental deficiency, class has not been explored to the same extent. Mark Jackson has been critical of historians' inattention to the role of class in the formation of Edwardian policies for mental defectives, and its interaction with gender. [34] He asserts that the segregation of the feeble-minded in colonies should be viewed as 'overtly political enterprises designed to subdue and control what were regarded as the sexual and criminal propensities of the working class'.[35] Jackson goes on to suggest that middle-class reformers in the early-twentieth

[29] Mary Ann Jimenez, 'Social Control', in *Encyclopedia of Social History*, edited by Peter Stearns (New York: Garland Publishing, 1994), p. 681.
[30] Constance M. McGovern, 'Asylums', in Stearns, p. 71.
[31] Jimenez, p. 683.
[32] McGovern, p. 71.
[33] Wright, 2001, p. 6.
[34] Jackson, '"A Menace to the Good of Society": Class, Fertility, and the Feeble-Minded in Edwardian England', in *Sex and Seclusion, Class and Custody: Perspectives on Gender and Class in the History of British and Irish Psychiatry*, edited by Jonathan Andrews and Anne Digby (Amsterdam & New York: Rodopi, 2004), p. 273.
[35] Jackson, 2000, p. 131.

century were driven by concerns about class relations, and that fears over the uncontrolled sexuality of feeble-minded women were 'framed primarily by a kaleidoscope of anxieties about the threat of contamination by the lower classes'.[36] Although class is a worthwhile category of analysis for histories of mental deficiency, as Jackson has argued, it is not explored in this thesis, due to the scarcity of information on class in the patient cases used here.

As Chapter One highlights, New Zealand largely followed trends in Britain, Europe and the United States in its responses to mental deficiency and its associated social problems during the early-twentieth century.[37] The *Mental Deficiency Act* (1911) re-classified idiocy, as mental deficiency was termed for much of the nineteenth century, shifting it from a form of lunacy to a separate condition altogether. Idiots were accepted into New Zealand asylums during this period, but no official recognition of idiocy's distinct nature was made in New Zealand or overseas until the early twentieth century.

Of critical relevance to this study, New Zealand histories of the asylum have only featured mental deficiency in the margins, with some brief references to idiot or imbecile patients. New Zealand mental hospitals such as the Seacliff, Porirua and Auckland Asylums have been the subject of a number of studies since the 1980s. Psychiatric practices and patients have been the focus of these histories, with particular focus on the role of gender in committal.[38] Mental health policy in New Zealand from 1840 until the mid-twentieth century has also been analysed by historians. It has been suggested that there were periods of 'quiet incremental change' and policy and building booms from 1871 to 1876, 1907 to

[36] Jackson, 2000, p. 147.
[37] New Zealand historians have argued this in recent years, for example, Warwick Brunton, '"A Choice of Difficulties": National Mental Health Policy in New Zealand, 1840-1947', PhD thesis, University of Otago, 2001; Metcalfe and Robertson, 1989.
[38] Barbara Brookes and Jane Thomson, eds, *'Unfortunate Folk': Essays on Mental Health Treatment, 1863-1992* (Dunedin: University of Otago Press, 2001); Wendy Hunter Williams, *Out of Sight, Out of Mind: The story of Porirua Hospital* (Porirua: Porirua Hospital, 1987); Barbara Brookes, 'Women and Madness: A Case Study of the Seacliff Asylum, 1890-1920', in *Women in History 2*, edited by Barbara Brookes, Charlotte MacDonald and Margaret Tennant (Wellington: Bridget Williams, 1992), pp. 129-148; Bronwyn Labrum, 'Looking beyond the Asylum: Gender and the Process of Committal in Auckland, 1870-1910', *New Zealand Journal of History*, 26, (1992) pp. 125-144.

1911 and 1925 to 1928.[39] There have been few New Zealand studies that have specifically examined mental deficiency during the twentieth century. However, Sandy Bardsley and Stephen Robertson's essays are two excellent examples.[40] Robertson considers what steps were taken by governments from 1900 to 1930 in New Zealand to 'solve' the mental deficiency 'problem'. Robertson describes this as a process of 'reconceptualisation, concern, investigation, debate, legislation and application'.[41] This comprehensive study uses a range of official sources, such as *Appendices to the Journals of the House of Representatives (AJHRs)* as well as evidence presented to the Committee of Inquiry into Mental Defectives and Sexual Offenders (1924). Although this thesis uses official sources as well, the analysis of Tokanui makes this research unique. Bardsley's essay focuses on a South Island educational institution, the Otekaieke Special School for Boys, from 1908 to 1950, and considers its place in the education system, its social function, and life within the school.

The introduction of special education in New Zealand during the early-twentieth century has also been evaluated by other historians.[42] The changes to special schools and classes and the methods of teaching are the focus of these studies. While these histories have not considered medical institutionalisation, the links between the Education and Mental Hospitals Departments during the first half of the twentieth century have been well documented.[43] Both Departments developed policies simultaneously, as a result of contemporary understandings of the abilities of different classes of defective. In New Zealand, mental testing, the major innovation for classification of mental deficiency, was developed mainly by educators.[44]

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[39] Brunton, 2004, pp. 75-90.
[40] Robertson, 1989; and Sandy Bardsley, 'The functions of an institution: the Otekaieke Special School for Boys, 1908-1950', BA (Hons) long essay, University of Otago, 1991.
[41] Robertson, 1989, p. 5.
[42] David Mitchell, 'Special Education in New Zealand: A History Perspective', in *Exceptional Children in New Zealand*, edited by David Mitchell and Nirbhay Singh (Palmerston North: The Dunmore Press, 1987), pp. 26-38.
[43] Bardsley, 1991, and Robertson, 1989.
[44] *New Zealand Official Yearbook (NZYOB)*, 1925, pp. 823-829 ; David McKenzie, 'Little and Lightly: The New Zealand Department of Education and mental testing 1920-1930', in *Mental Testing in New Zealand*, edited by Mark Olssen (Dunedin: University of Otago Press, 1988), pp. 76-89.

New Zealand histories of mental hospitals for the intellectually disabled have tended to focus on the major events that affected the running of the institution rather than providing an analysis of the hospital's operation and responses to legislation and policy. In the last twenty years, histories of Kingseat, Templeton Farm Colony, later renamed the Kimberley Centre, and Lake Alice have been published.[45] Usually these histories were brief and nostalgic, written to mark an anniversary, or jubilee celebrations, and have been based largely on the memories of staff rather than patients. The Tokanui publications, *Tokanui 50th Jubilee, 1912-1962* and *A History of Tokanui Hospital, 1912-1997*, also marked significant points in the hospital's history and give detailed, descriptive accounts of the major events in the history of the institution.[46] For the period 1912 to 1935 these histories focus on the developments of the hospital, problems with water supply, building of new villas and some social events for the patients. Patients are mentioned only briefly, for example, a description of the annual patients' picnic.[47]

However, two recent articles have considered different approaches for histories of Tokanui, suggesting possibilities for writing about Tokanui from the 1950s to its closure in 1998; and using the recent Tokanui oral history project as a way of understanding the different meanings given to the hospital by interviewees.[48] Although discussed briefly, intellectually disabled patients are not the focus of these articles. Rather, they suggest alternative ways for writing about

[45] *Kingseat Hospital, 50 years, 1932-1982* (Papakura: Kingseat Jubilee Editorial Committee, 1981); Brian Shephard, ed, *Fifty Years of Templeton Hospital and Training School, 1929-1979* (Christchurch: Templeton Hospital, 1979); Anne Hunt, *The Lost Years: From Levin Mental Deficiency Colony to Kimberley Centre* (Christchurch: Anne Hunt, 2003); Bob Baird, ed, *Lake Alice 40 years* (Wanganui: Community Health Services, Manawatu-Wanganui Area Health Board, 1990).

[46] *Tokanui 50th Jubilee, 1912-1962* (Tokanui: 1962); Roger McLaren, ed, *A History of Tokanui Hospital Te Awamutu*, 1912-1997 (Te Awamutu: Tokanui Hospital, 1997).

[47] McLaren, p. 5.

[48] Catharine Coleborne, 'Preserving the Institutional Past and Histories of Psychiatry: Writing about Tokanui Hospital, New Zealand, 1950s - 1990s', *Health and History*, 5, 2, (2003), pp. 104-122; Coleborne, '"Like a family where you fight and you roar": Inside the "personal and social" worlds of Tokanui Mental Hospital, New Zealand through an oral history project', *Oral History in New Zealand*, 16, (2004), pp.17-27. The oral history project between Te Awamutu Museum and the University of Waikato, begun in 2004, culminated with a museum exhibition, Footprints on the Land, in late 2006. Most interviews were with former staff members who were employed at Tokanui from the 1950s until its closure in 1998.

Tokanui. However, this thesis uses a more conventional patient focussed approach.

The 'invisibility' of disability history in New Zealand has been recently observed.[49] However, the number of histories of disability has increased since the 1990s.[50] It has been argued that New Zealand historians should 'follow the lead of disabled people who make a distinction between impairment (what people have) and disability (society's reaction to impairment)'.[51] This thesis contributes to these histories by discussing a previously unexamined group, patients with intellectual disabilities at Tokanui during the early-twentieth century. The experiences of these patients were shaped by their families, as well as authorities' fears over gender and sexuality, doctors' developing knowledge of mental deficiency.

In order to explore the themes identified earlier, this thesis has used official sources such as the *AJHRs, New Zealand Parliamentary Debates (NZPD)* and *Statutes of New Zealand (Statutes),* some contemporary publications on mental deficiency, and archival material from Tokanui. Official sources are analysed in more detail in Chapter One, and patient case information gathered from Tokanui is the focus for the other three chapters.

Gaining access to the restricted files held for Tokanui Hospital at National Archives required the approval of the Mental Health and Addictions Service at the Waikato District Health Board (WDHB). Respect for patients' privacy was a condition of access. Thus, patients in this thesis are only identified by their first name and initial letter of their last name, William C., for example. Patient files were the main source of information as well as the Case Book, Registers of Admissions and the Registers of Discharges and Transfers. This thesis is the first history of Tokanui to use these patient records.

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[49] Hilary Stace, 'The invisibility of disability history in New Zealand', *Phanzine,* 12, 1, (April 2006), p. 4.

[50] Ken Catran and Penny Hansen, *Pioneering a vision: a history of the Royal New Zealand Foundation for the Blind, 1890-1990* (Auckland: RNZFB, 1992); Pat Dugdale, *Talking hands, listening eyes: the history of the Deaf Association of New Zealand* (Auckland: Deaf Association of New Zealand, 2001) and Greg Newbold, *Quest for equity: a history of blindness advocacy in New Zealand* (Palmerston North: Dunmore Press, 1995), Julia Millen, *Breaking Barriers: IHC's first 50 years* (Wellington: IHC New Zealand Inc., 1999).

[51] Stace, p. 4.

The number of patients sampled is 111: 69 males and 42 females. This number was the total number of mental defectives admitted to Tokanui between 1911 and 1935, based on the category given to patients in patient files, and the hospital Registers.[52] The patient files provided categories through medical certificates and doctor's notes. Some patients were only recorded cursorily by the authorities; the only information that was available was name, gender, admission dates, previous and subsequent hospitals and their classification. These cases have been included to provide a more complete picture of the number of patients admitted to Tokanui between the years 1912 to 1935 as mental defectives. These Registers listed the category of patients upon their admission only; this was sometimes found to be incorrect upon viewing the patient's file, and these were excluded from the sample. However, more emphasis is placed on a discussion of cases where information was abundant.

The case materials used most in this thesis belong to 51 patients, 30 males and 21 females, categorised as idiot, imbecile, feeble-minded, social defective and 'other'.[53] These patient cases were chosen for closer analysis because of the contents of their files. Typically these files contained doctor's notes, certification documents, admission examinations and letters, which provided a picture of a patient's life before committal, the reason for their admission, and their experiences in Tokanui. As Tokanui's staff had control over the information included in the files, the patient's perspective on, or feelings towards, institutionalisation are hard to gauge, especially for idiots and imbeciles. These case materials are the basis for Chapters Two, Three and Four.

Chapter One of the thesis will examine the legislation and policy that shaped institutional responses to mental deficiency, and in particular Tokanui's response to these. Four key documents inform the chapter: the *Mental Defectives*

[52] The number of psychiatric patients at Tokanui was higher throughout the period. Figures from the Mental Hospitals Annual Reports in the *AJHRs*, show that in 1912 Tokanui had just 50 patients, by 1920 it had 200 patients, and in 1935, the hospital had 612 patients. Psychiatric patients made up approximately two-thirds of all Tokanui's patients during this period. However, this thesis will not discuss these patients.

[53] 'Other' is used only in this thesis to describe patients with overlapping classifications, that is, those who have not had a single category clearly assigned to them either on admission, upon diagnosis in Tokanui Hospital or both.

Act (1911); the Report of the Committee of Inquiry into Mental Defectives and Sexual Offenders (1924); Dr Theodore Gray's report, Mental Deficiency and its Treatment (1927) and the *Mental Defectives Amendment Act* (1928). *Statutes* and *NZPDs*, as well as the annual reports of the Mental Hospitals Department in the *AJHRs*, are used in this chapter.

Chapter Two examines the case material gathered from Tokanui. Statistical data gathered from patient cases is analysed to create a picture of the mental defectives at Tokanui during its early years of operation. Factors such as age, gender, patients' classifications, the role of the family in a patient's committal and treatment, the year of admission, and length of stay, will be assessed. The language contained in the patient's files is also analysed, to understand medical knowledge of mental deficiency in New Zealand institutions during the early-twentieth century.

Chapter Three considers the concepts of 'care' and 'control', and how these were applied to female defectives in particular at Tokanui. Although female patients in New Zealand asylums have been the subject of a number of histories, there have been few that have focussed solely on mentally defective women. International historians have argued that there was a paradox and interaction between notions of 'care' and 'control'. That is, a tension between providing care for these individuals, and at the same time maintaining some control over their health, reproduction, education and employment. The chapter will argue that 'control' was maintained over all female defectives at Tokanui, but 'care' was only extended to low grade defectives that also had a physical disability.

Chapter Four explores of the connections between mental deficiency and criminality in the 'institutional landscape' created by Tokanui and neighbouring Waikeria Prison. The chapter focuses on 'criminal' male defectives specifically and the different categories that Tokanui assigned to these men. Age, the type of offence that had been committed, the likelihood of re-offending or rehabilitation, as well as their mental capabilities, were all factors in this informal classification. The chapter seeks to extend the care and control concept, and considers how it was applied to this group of men and also explores the concept of criminality.

In order to understand Tokanui's provisions for these mentally defective patients some analysis of legislation is first required. New Zealand was among the first countries in the world to introduce legislation that recognised mental deficiency. Chapter One examines New Zealand’s legislation and policies for mental defectives created between 1911 and 1928.

Chapter One

Legislation and policy for mental defectives in New Zealand, 1911-1928

Legislation that specifically recognised the category of mental defective, and the classifications within this, was not introduced to New Zealand until 1911. The *Mental Defectives Act* (1911) was the result of a growing awareness of 'subnormal' individuals in society, and pressure from medical and educational authorities as well as the public, to pass legislation to bring these individuals under control. It was influenced by the British Royal Commission on the Care and Control of the Feeble-minded (1908). Several historians in New Zealand and overseas have identified a number of common factors in the emergence of the mental deficiency 'problem'.[1] Among these were the introduction of compulsory education, industrialisation, immigration, urbanisation and the new scientific ideas that began to appear around the late nineteenth century: eugenics, hereditarism and mental testing. This chapter explores the social, medical and political context for this thesis. It focuses briefly on nineteenth-century legislation for lunatics; the *Mental Defectives Act* (1911); the Report of the Committee of Inquiry into Mental Defectives and Sexual Offenders (1924); Mental Deficiency and its Treatment (1927), two key documents that shaped the *Mental Defectives Amendment Act* (1928); and the establishment of Tokanui Mental Hospital. This chapter argues that legislation introduced in New Zealand between 1911 and 1928 was intended to improve the care, control and treatment provided in mental hospitals, but also to limit the spread of mental deficiency. These policies were implemented at Tokanui, although aspects were adapted to its own institutional practices.

[1] The creation of the 'problem' of mental deficiency, and its supposed causes, is discussed by Bardsley, 1991, Jackson, 2000, Robertson, 1989, Thomson and Trent.

New Zealand legislation included idiot within the legal classification of lunatic as early as the *Lunatics Act* (1846), but without any clarification of the definition of the term. Included alongside idiot were the terms, 'any insane person … lunatic or person of unsound mind … incapable of managing himself or his affairs'.[2] The *Imbecile Passengers Act* (1873) stated that if a Superintendent of any province certified a passenger as 'being either lunatic idiotic deaf dumb blind or infirm, and likely in his opinion to become a charge upon the public or upon any public or charitable institution, the Superintendent shall require [from] the owner charterer or master of such ship, … a bond to Her Majesty in the sum of one hundred pounds for every such passenger'.[3] If such a passenger was then admitted to a public or charitable institution within five years, this bond would be taken as payment for their maintenance.[4] Throughout the nineteenth century, idiots were included in all successive amended *Lunatic Acts*. But this legislation did not refer to mental defectives in any meaningful way. The use of the common term idiot, alongside lunatic, and 'persons of unsound mind', provided little explanation as to who exactly could be called an idiot. The *Lunatics Act* (1868) used the single category 'lunatic' to apply to 'any person idiot lunatic or unsound mind and incapable of managing himself or his affairs and whether found lunatic by inquisition or not'.[5] The *Lunatics Act* (1882) retained this interpretation of 'lunatic'.[6] During the nineteenth century there was little official or legislative recognition that the group of people identified within the term idiot, was not homogenous.

In the nineteenth century in Britain and the United States opinions of mental deficiency changed dramatically. Voluntary idiot asylums had been established in Britain in the 1840s, with the specific mission of treating so-called 'educable' idiots, which reflected of early notions of mental deficiency.[7] For

[2] *Statutes of New Zealand (Statutes),* 1882, No. 34, Lunatics Act, section 2.
[3] *Statutes,* 1873, No. 70, Imbecile Passengers Act, sec. 3.
[4] *Statutes*, 1873, No. 70, sec. 4.
[5] *Statutes,* 1868, No. 16, Lunatics Act, sec. 3.
[6] *Statutes,* 1882, No. 34, Lunatics Act, sec. 2.
[7] David Gladstone, 'The Changing Dynamic of Institutional Care: The Western Counties Idiot Asylum, 1864-1914', in *From Idiocy to Mental Deficiency,* edited by David Wright and Anne Digby (London: Routledge, 1996), p. 134.

example, the Earlswood Asylum for Idiots opened in Britain in 1847.[8] The United States also established educational institutions for defectives, the first school for the feeble-minded opened in Massachusetts in 1848, and others followed as its successes were demonstrated.[9] But by the 1890s institution superintendents in both countries started to claim that education was unsuitable for some defectives, and began to recommend custodial care in some cases, particularly for low grade defectives, considered hopeless cases, while the feeble-minded who could benefit most from training, were difficult to identify within the general population.[10] In both countries the mentally deficient, especially the feeble-minded, were becoming a concern, and were blamed for a number of society's problems.

Poverty, crime, alcoholism, prostitution were all attributed to so-called 'degenerate' and feeble-minded elements. With economic, social and political changes in the United States and other Western countries, an increased number of people were classified as feeble-minded and institutionalised, as this 'economic and social stress allowed for new parameters and definitions of feeblemindedness'.[11] The feeble-minded were perceived differently by authorities and the public; from a 'burden' in the period from the late 1860s to 1880s, to a 'menace' from the 1890s to the 1920s.[12] Scientific advances during this period also seemed to prove to medical authorities, social workers, and social reformers, that the feeble-minded had a biological predisposition to degeneracy. Interpreting this in the last decade, historians have shown that feeble-mindedness was a highly constructed category in both Britain and the United States.[13] Understanding how mental deficiency was re-conceptualised in these countries during the late-nineteenth and early-twentieth centuries helps to explain the social context for New Zealand's legislation.

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[8] Wright, 2001.
[9] Reilly, p. 12.
[10] Trent, p. 82.
[11] Trent, p. 79.
[12] Trent, p. 141.
[13] Jackson, 2000, Thomson, Trent, and Wright and Digby, have each argued that this construction coincided with the characterisation of the feeble-minded as a menace. Indeed, historians have used the terms, 'construction', 'fabrication', and 'manufacture', to describe this process.

By the 1910s mental deficiency had become a significant source of anxiety for New Zealand authorities. The Mental Hospitals, Education and Prisons Departments were all concerned with the effects defectives had on society and the increasing number of social problems, which they attributed to mental defectives. The mental deficiency 'problem' in New Zealand was 'developed and refined as a result of the increased employment of classification by the Government Departments concerned with the issue'.[14] Adult defectives in particular, who were potential criminals, sexual offenders, and parents of illegitimate defectives, all needed to be separated from society in a mental hospital, where they would be cared and protected for, and more importantly, where society could be protected from them. However, nineteenth-century legislation had a limited effect. In the twentieth century, new legislation was created to deal with these concerns.

Mental Defectives Act (1911)

The most important feature of the *Mental Defectives Act* (1911) was the official introduction of new classifications, thus recognising that mental deficiency could not simply be covered by the term idiot. However, the *Education Amendment Act* (1907), responsible for the introduction of special schools and classes in New Zealand, was the first legislation to expand its definition of idiot.[15] This Act defined defective children in terms of ability and showed authorities were aware of classifications beyond idiot. The *Lunatics Act* (1908) was the last piece of mental health legislation before the 1911 Act, to include idiot within the single category of lunatic.[16]

The *Mental Defectives Act* was influenced by the contemporary British legislation and the British Royal Commission (1908), a possible reason why the broader classifications for mental deficiency were not implemented in the 1908 Act. The Royal Commission was established to find the best way to provide, care,

[14] Robertson, 1989, p. 39.
[15] *Statutes,* 1907, No. 47, Education Amendment Act, sec. 15.
[16] *Statutes,* 1908, No. 108, Lunatic Act, sec. 2.

and/or control, for those not being certified under the Lunacy Acts. This Commission was faced with 'creating a more rational and efficient system for those mental defectives currently under care and those for whom no care was available'.[17] The eugenic influence on the Mental Defectives Bill has been noted elsewhere, and was to be expected given the increased popularity of eugenics in New Zealand from about 1905 onward.[18]

During the second reading of the Bill in 1911, this Commission was referred to by Minister of Justice, John Findlay, who stated, 'we here in the present legislation are following, first, largely in the footsteps of the English legislation, and secondly, a little further in the footsteps of the recommendations of the Commission itself'.[19] For example, part three of the Act, which dealt with children and young adults, as Findlay asserted, 'is really drawn along the lines of the English Idiocy Act, which was passed a few years ago, and is recognised as up-to-date and effective legislation'.[20]

Much of the debate over the Mental Defectives Bill was focused on the most effective ways to control mental defectives.[21] Questions of gender and class were central to this debate as women and the working class were considered the source of mental deficiency. Most of the evidence put forward during debate on the Bill was concerned with the reproduction of the 'unfit' or degenerates, a major point of discussion for legislators. This is understandable given the contemporary idea of degeneracy as the root of mental defectiveness, and that poverty was the cause of degeneracy. Proponent of the Bill, MP J.T. Paul, argued, 'unless you get right down to grapple with the problem of poverty, of which the slum is outward and visible evidence, this is all a waste of time. … poverty, right down at the bottom of things, is the cause of most of the degeneracy'.[22]

Segregation of defectives was debated as a method of control for both children and adult defectives. Findlay stated, 'there is full call for some legislation

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[17] Thomson, p. 25.
[18] Metcalfe, p. 62.
[19] *New Zealand Parliamentary Debates (NZPD),* Vol. 155, 6 September 1911, p. 299 (J. G. Findlay).
[20] *NZPD,* Vol. 155, 6 September 1911, p. 303 (J.G. Findlay).
[21] Metcalfe, pp. 62-84.
[22] *NZPD,* Vol. 156, 21 September 1911, p. 2 (J.T. Paul).

which will prevent imbecile women particularly from throwing upon this country the burden of maintaining children – illegitimate, for the most part – that are imbecile'.[23] However, such children would need to be under control of the State; defective parents would be under control in an institution and their defective children would require care in an institution. As Findlay asserted:

> I apprehend that people might say that parents should not be allowed to place their children in the institution at all, but be compelled to look after them themselves. Now, I think that is short sighted. There are many cases where the parents have neither the time nor the facilities to do what is needful for defective children; there are other cases in which it is not only the right thing for the child, but eminently fair to the parents, that the State should provide some means under which the child should be properly and scientifically treated.[24]

However, State institutions for defective children and young adults were unable to cope with the numbers of admissions. For example, Templeton Hospital Farm near Christchurch opened in 1929 and was soon full.[25] Parents seeking to place their child in specialist care had no other option than to commit their child into a mental hospital where 'proper' and 'scientific' treatment for children was unavailable. Indeed, there were children admitted to Tokanui by their parents for various reasons. This group of patients will be discussed further in Chapter Two.

The *Mental Defectives Act* (1911) was the first legislation to classify mental defectives beyond one category, and indicates the seriousness with which the mental deficiency 'problem' was viewed by medical and educational authorities and in turn, legislators. These authorities considered that appropriate legislation to manage mental defectives would make it easier to provide care, control and supervision.

The categories 'idiot', 'imbecile' and the 'feeble-minded' were now officially recognised. An idiot was 'unable to guard themselves against common physical dangers and therefore [would] require the oversight, care and control

[23] *NZPD,* Vol. 156, 6 September 1911, p. 300 (J. G. Findlay).
[24] *NZPD,* Vol. 155, 6 September 1911, p. 303 (J. G. Findlay).
[25] *Appendices to the Journals of the House of Representatives (AJHR),* 1931, H-7, p. 3.

required to be exercised in the case of young children'.[26] The higher grade imbecile could guard against physical dangers, but was incapable of 'earning their own living by reason of mental deficiency existing from birth or from an early age'.[27] The feeble-minded could be 'capable of earning a living under favourable circumstances' but, due to their deficiency they were incapable of 'competing on equal terms with their normal fellows, or of managing themselves and their affairs with ordinary prudence'.[28] The classification criteria for idiot or imbecile seemed reasonably clear to. An idiot may have had a physical disability as well as having, by later standards, an Intelligence Quotient (IQ) in the range of 20 to 50. An imbecile would have had an IQ of between 50 and 70, possibly not had a physical disability, but still required care and control. However, the criteria for assessing an individual as feeble-minded were vague. The individual was able to earn a living, under what were called 'favourable circumstances', what this meant is unclear. The phrase 'incapable … of competing on equal terms with their normal fellows', was clumsy and debatable in comparison with the definitions for idiot and imbecile. Contemporary commentators saw the feeble-minded as the most troublesome, because of their ability to blend in with 'normal' society. The feeble-minded did not require care like idiots and imbeciles, but rather increased control.

The Act outlined the procedure for the admission of mental defectives into mental hospitals. Under section four, the person wanting to commit a defective (the applicant) would first have to make an application for a reception order into an institution to a magistrate, stating on what grounds the person was believed to be a defective.[29] For Tokanui patients the reasons were sometimes straightforward, especially for 'low grade' defectives. Evelyn C., for example, was a 'mongolian imbecile' and committed by her brother, because '[s]he has the mind of a child. She has been like that since childhood and is not responsible for

[26] *Statutes,* 1911, No. 6, Mental Defectives Act, sec. 2.
[27] *Statutes,* 1911, No. 6, sec. 2.
[28] *Statutes,* 1911, No. 6, sec. 2.
[29] *Statutes,* 1911, No. 6, sec. 4.

what she does'.[30] However, in the case of 'high grade' defectives, the grounds for committal seemed weaker. Norman B., a social defective, exhibited 'irresponsible and erratic behaviour, anti-social tendencies and a lack of self-control'.[31] Reception orders were usually granted shortly after an application was made.

As well as families, police were able to lodge applications under certain conditions. Under section 16 of the Act constables could apply for a reception order if three criteria were met: whether they believed the person was mental defective; that the defective was dangerous, suicidal, acted 'in a manner offensive to public decency', or was being ill-treated by the person charged with their care; and was not under proper care, control or oversight.[32] Constables did successfully apply to commit a number of defectives to Tokanui. These cases will be discussed in Chapter Four.

Like the certification required for psychiatric patients, certification of defectives required an examination by two medical practitioners.[33] Medical certificates recorded the observations of the doctor; the evidence of others, often family members; the doctor's opinion of which class of mental defect the individual should be assigned; the possible causes of the defect; whether the individual was dangerous or suicidal; their physical health; and what treatments, if any, had previously been given or were recommended for the patient.[34] The medical certificate included a section for evidence of mental deficiency from another person, usually this would be provided by a family member. However, for some patients, this secondary evidence came from police, other institutions such as prisons, or another mental hospital. In some cases it seems that the certifying doctor had little contact with the patient prior to their examination and relied solely on the evidence provided by the party wanting to commit the alleged defective. Circumstances surrounding the admission of mentally defective patients provide much information not only about the background of the patient,

[30] YCBG 5904/15/481, application for a reception order, Tokanui Mental Hospital, 11 December 1925, Archives New Zealand/Te Rua Mahara o te Kawanatanga, Auckland Regional Office.
[31] YCBG 5904/55/1338, application for a reception order, 24 January 1934.
[32] *Statutes,* 1911, No. 6, sec. 16.
[33] *Statutes,* 1911, No. 6, sec. 10.
[34] *Statutes,* 1911, No. 6, sec. 11.

but also the knowledge of their certifying doctor, who often seemed to have no specialist expertise in mental deficiency or mental illness. The Appendix provides an example of a medical certificate.

For the patients discussed in this thesis, the committal process could sometimes take several days or even months, and in other cases could be completed in one or two days. Typically, committal was sparked by an incident involving questionable behaviour, or a change in family circumstances. At Tokanui, these committal documents were used by the institution for an initial assessment of patients, as well as an evaluation made by a doctor upon admission. Once examined, a decision could be made on where the patient could be housed in the hospital according gender and category of mental defect.

The Act also made provisions for leaving the institution. Discharge, probation, escape, and transfers to and from other institutions were included in the legislation. Section 80 granted leave for twelve months for patients provided they would be under proper care and control and kept to the conditions specified by the Inspector-General of the Mental Hospitals Department.[35] Superintendents of mental hospitals could give patients leave for 28 days, if proper care would be provided outside the institution. Leave could be extended for a period up to twelve months by the Inspector-General. Under section 80(5), a patient absent on leave could be discharged if a medical certificate was presented to the Superintendent stating that the patient was no longer mentally defective or no longer required care and control.[36] However, under section 80(8) any patient on leave who failed to return to the mental hospital would have their leave cancelled and would be considered an escapee. However, in any other case the patient 'shall be deemed to have been discharged as unrecovered in the date on which the leave expired, and shall continue to be liable to visitation by an Inspector or Official Visitor for such a period as the Inspector-General deems advisable'.[37] Escapes by mentally deficient patients at Tokanui were rare and not always successful. Patients that did succeed in escaping were discharged under section 79(3) of the

[35] *Statutes,* 1911, No. 6, sec. 80.
[36] *Statutes,* 1911, No. 6, sec. 80.
[37] *Statutes,* 1911, No. 6, sec. 80.

Act, if the patient was not retaken within three months. Within the three month period the escaped patient could be 'retaken by any person'. [38] The transfer of patients between mental hospitals was the responsibility of the Inspector-General under section 81. However, any patients detained under Part Four of the Act, Mental Defectives Persons under Detention for Offences, remained the responsibility of the Prisons Department, and their transfer could not be ordered by the Mental Hospitals Department.[39]

Shortly after the passage of the Act, the Superintendent of Sunnyside Mental Hospital noted its positive consequences:

> [T]he Act has widened greatly the possibilities of certification, and we must be prepared to deal with larger numbers in the near-future. I have noticed already that we are getting patients committed to our care – namely, higher grade imbeciles and epileptics – who would formerly not have been committed, and these most rightly must be provided for. It is bound to be a strain for the present, but the segregation of these types who have the power of transmission of their mental defects is sure in the future to have beneficial effects on the race.[40]

The Act was successful in extending the control of authorities to individuals previously not institutionalised, yet there were calls for wider reaching legislation that would broaden the legal definition of mental defective.

The Committee of Inquiry into Mental Defectives and Sexual Offenders (1924)

In the period 1912 to 1924 there was debate over the functions of the *Mental Defectives Act,* particularly over its perceived limitations.[41] There were concerns that there was no way of handling the more 'troublesome individuals' in society that were not covered by any section of the Act. Parliamentarians raised questions about the British category of 'moral imbecile' and the possibility of introducing a similar classification in New Zealand as an amendment to the *Mental Defectives*

[38] *Statutes,* 1911, No. 6, sec. 79.
[39] *Statutes,* 1911, No. 6, sec. 81.
[40] *AJHR,* 1912, H-7, p. 17.
[41] For a comprehensive discussion of these debates, as well as this Committee of Inquiry, refer to Robertson, 1989, pp. 37-58, 60-97.

Act. Also of concern was the introduction of new special schools and classes throughout the country. The issue was raised a number of times over the possibility for creating a school for feeble-minded girls similar to the Otekaieke Special School for Boys in the South Island, and the establishment of a special school like Otekaieke in the North Island.[42]

The 1922 Report on Venereal Diseases in New Zealand suggested that mentally defective or 'morally imbecile' girls were a 'foci of infection' for venereal disease, as they 'are easily approached, and facile victims for men'.[43] Among the recommendations of this Report was the classification and segregation, where necessary, of mentally defective adolescents.[44] The reproduction of mental and physical defectives was a concern for this Committee, who urged the government to adopt a registration and classification scheme for defective adolescents so that they could be segregated, educated and usefully employed.[45] Although this Report was not mentioned by the 1924 Committee of Inquiry, its findings were plainly a factor in its creation.

The Committee of Inquiry into Mental Defectives and Sexual Offenders (1924) was established because of public anxiety in the years before at the 'number of mental defectives becoming a charge on the State, and also the alarming increase in their numbers through the uncontrolled fecundity of this class'.[46] The Committee had two questions to consider: 'To inquire and report as to the necessity for special care and treatment of the feeble-minded and subnormal, and to propose the general means by which such care and treatment, if any, should be provided'.[47] It stressed that questions concerning the feeble-minded and sexual offenders were separate from one another. However, early in its Report the Committee suggested that 'it is true that a certain proportion of mental defectives show their lack of self-control in regard to sex instincts and

[42] *NZPD,* vol. 164, 27 August 1913, p. 124 (A.M. Myers); *NZPD*, vol. 178, 1 August 1917, p. 876 (W.T. Jennings); *NZPD,* vol. 185, 22 October 1922, p. 672 (W.T. Jennings).
[43] Venereal Diseases in New Zealand: Report of the Committee of the Board of Health, *AJHR,* 1922, H-31A, p. 11.
[44] *AJHR,* 1922, H-31A, p. 22.
[45] *AJHR,* 1922, H-31A, p. 21.
[46] *AJHR,* 1925, H-31A, p. 2.
[47] *AJHR,* 1925, H-31A, p. 3.

functions as in other respects. This is particularly the case with mentally defective girls, and constitutes one of the chief difficulties in dealing with them satisfactorily'.[48] This statement makes it clear that defective women were one of the primary concerns for authorities when they considered the problem of mental deficiency.

The seven Committee members included representatives from the Health, Education, and Prison Departments and took evidence from school medical officers, Education Department officials, special school teachers, church representatives, mental hospital superintendents, prison officers, and academics. The Committee also visited mental hospitals, including Tokanui, as well as prisons, special schools, and industrial schools, over six months before submitting their Report in 1925.[49]

With little New Zealand research at that time to consider, the Committee relied on American and British studies. Based on these international findings, the feeble-minded, who were the focus for the Committee, were characterised as a menace for New Zealand. The Committee made a number of recommendations for the Mental Hospitals Department, as well as the Prisons and Education Departments.[50] However, only the Mental Hospitals Department implemented these recommendations, although not for another two years. It suggested a register of feeble-minded and epileptics; the establishment of a Eugenics Board; that sterilisations for some defectives should be performed – at the discretion of the Eugenics Board; and that immigration be subject to tighter control. The introduction of a new category, 'social defective', modelled on the British 'moral imbecile', was perhaps the most significant proposal.[51] This category will be analysed more closely later in this chapter. All these steps were aimed at maintaining or increasing control over defectives by preventing reproduction, limiting their interactions with wider society, and trying to reduce the burden on

[48] *AJHR*, 1925, H-31A, p. 5.
[49] *AJHR,* 1925, H-31A, pp. 3-4.
[50] Robertson, 1989, p. 101.
[51] *AJHR,* 1925, H-31A, p. 15.

the State.[52] Historian Robert Metcalfe argues that the recommendations of the Committee had a strong eugenic flavour as 'the debate about eugenics was at its height in New Zealand at the time', and the subsequent Mental Defectives Amendment Bill was in the 'forefront of worldwide eugenic legislation'.[53]

Although the Committee, stated that it was concerned with what care and treatment should be provided to the 'subnormal' and the feeble-minded, the control of these groups was the real focus. The Committee's recommendations of drastic measures such as marriage restriction and sterilisation proved this. British evidence considered by the Committee argued sterilisation was not a 'practical proposition' and would have a limited effect on the prevention of mental deficiency, and that segregation would be a better solution for restricting the reproduction of mental defectives.[54] However, the Committee thought that sterilisation was, in fact, a practical option to limit the 'propagation of the feeble-minded' and would be favoured by the public as soon as they could understand how it would really affect defectives.[55] The Committee recommended that the Eugenics Board have the power to decide which cases were suitable for sterilisation, and that the operation was only performed with the permission of the parents or guardians of the person concerned.[56]

Concerns that the Committee had over the links between gender and mental deficiency were clear. It argued that 'there are many cases of mentally defective girls, liberated from other institutions in New Zealand for the purpose of engaging in domestic service or other work, returning afterwards the mothers of illegitimate children, probably also mentally defective'.[57] The Committee argued further that the numbers of these children could be reduced if segregation and sterilisation were used.[58] Segregation of the feeble-minded was acceptable, rather

[52] *AJHR*, 1925, H-31A, pp. 24-25.
[53] Metcalfe, p. 15.
[54] *AJHR,* 1925, H-31A, pp. 19-20.
[55] *AJHR*, 1925, H-31A, p. 20.
[56] *AJHR,* 1925, H-31A, p. 20, 24.
[57] *AJHR,* 1925, H-31A, p. 20.
[58] *AJHR,* 1925, H-31A, p. 20. The issue of sterilisation in New Zealand is covered in more depth by Robertson, 1989, pp. 49-58, 74-75, 94-95.

than heartless as, '[t]he real unkindness consists in allowing such unfortunates to be brought into the world'.[59]

Ultimately, segregation was deemed a better solution to restrict the reproduction of mental defectives. It was thought that segregation would therefore ease the burden that this group of individuals placed on society as well as being an effective method of control.[60] The Committee recognised that segregation of all defectives was not possible, and stated that feeble-minded individuals who received adequate care and training in their home should remain there.[61]

The suggestions made by the Committee and Dr Theodore Gray, Director-General of the Mental Hospitals Department, were typical of contemporary opinions about mental deficiency. Their main concerns were to limit the reproduction of defectives, and to provide appropriate care and treatment for defectives, according to their classification. Like his British and American counterparts Gray advocated a policy of eugenics, Gray favouring segregation, sterilisation and marriage laws as steps to control the procreation of defectives.

In the section 'Policy for the future', the Committee supported a registration scheme for mental defectives, based on policy from the British Royal Commission (1908). The three main principles maintained that: any person affected by mental defect should be given protection by the State as their condition warranted; their mental condition, not their poverty or their crime should be the grounds for help they received from the State; and that it was necessary to find out who and where defectives were if they were to be properly considered and protected.[62] This last point was the purpose of the registration scheme suggested by the Committee. Finally the British Commission recommended that whatever form 'protection' took, it should be 'continued as long as necessary for his own good'.[63] New Zealand policy for mental defectives would follow this example; in particular, the proposed long term segregation of defectives. While New Zealand followed a policy of segregation, it should be

[59] *AJHR,* 1925, H-31A, p. 21.
[60] *AJHR,* 1925, H-31A, pp. 19-20.
[61] *AJHR,* 1925, H-31A, p. 21.
[62] *AJHR,* 1925, H-31A, p. 17.
[63] *AJHR,* 1925, H-31A, p. 17.

acknowledged just how seriously sterilisation was considered by the 1924 Committee, and by Gray in his 1927 Report.

The Report into Mental Deficiency and its Treatment (1927)

Along with the 1924 Inquiry and its Report, the Report into Mental Deficiency and its Treatment (1927) signalled a shift in official attitudes towards mental defectives. The report was based on Gray's visits to mental colonies and special schools in Britain, Europe and the United States. Gray's report added momentum to the push for changes that had been recommended earlier, and his findings echoed those of the 1924 Report. The 1927 Report set out to explore the problem of mental deficiency; the possibility of a census and registration of feeble-minded persons; the social control of the feeble-minded; sterilisation, segregation, marriage laws, eugenic education of the public; and how to render all known defectives as socially adequate as possible; with specific policies for each category.[64] Also included was a plan for the establishment of a Eugenics Board, something that Gray especially desired. He argued that: '[t]he first step should be the appointment of the Eugenics Board, who would proceed at once to take stock of our present resources with the view to developing a programme in accordance with the estimated needs'.[65] Gray's overseas tour of American and European institutions impressed upon him the value of policies and the treatment different classes of defectives received at institutions. Gray thought misclassification and incorrect treatments were common at some facilities. [66]

The 1911 Act had been criticised in the previous decade for not having greater powers to place more individuals under its control. When questioned on the desirability of establishing an institution for mentally unbalanced people who could not be classified under the Act, the Minister in Charge of Mental Hospitals replied that those not classified as defectives in the meaning of the Act, 'cannot be deprived of their liberty. Though in many instances it would be advantageous …

[64] *AJHR,* 1927, H-7A, pp. 1-20.
[65] *AJHR*, 1927, H-7A, p. 20.
[66] *AJHR,* 1927, H-7A, pp. 10-12.

any legislative extension of restraint of the liberty of the subject is a dangerous proceeding'.[67] The addition of the category 'social defective' was the most important change in the *Mental Defectives Amendment Act* (1928). This highly constructed category was vague in terms of who it may have been applied to. Yet the Amendment was intended to broaden the definition of mental defective, so that institutional control could be applied to more individuals. While Gray's suggestions were typical of contemporary international ideas about mental deficiency, he objected to the English definition of 'moral imbecile' as too vague, somewhat indefinable, and stated that, 'the definition would require the infliction of punishment in order to determine its effects as a deterrent'.[68]

The 1924 Committee and Gray's report were the result of years of debate over the problem or issue of mental deficiency and what policies New Zealand should implement. The Committee and Gray stressed that 'mental deficiency should not be regarded so much as a disease entity but rather as a social problem'.[69] International influences were clear, most importantly from Britain and the United States. However, is also apparent that New Zealand did not follow the example of other countries blindly. Gray favoured assessments that were not based solely on mental testing, which had become commonplace in the United States. Gray instead argued that psychiatrists should be relied on for more thorough assessment of an individual, by recording personal and family history, physical condition and environment. As he stated:

> [N]o decisions should be made on the basis of intelligence tests, but that the presence or absence of mental deficiency should be determined by a psychiatrist. The important matter is not the pigeonholing of the cases into classes, but the mutual adjustment between the patient and his environment, so that, instead of being a social misfit, he may become a productive unit of society.[70]

At Tokanui, as Chapter Two will show, intelligence testing was not common before 1926, and even then it was not the sole factor in determining a patient's

[67] *NZPD,* Vol. 172, 14 July 1915, p. 326 (R.H. Rhodes).
[68] *AJHR,* 1927, H-7A, p. 2.
[69] *AJHR*, 1927, H-7A, p. 2.
[70] *AJHR,* 1927, H-7A, p. 4.

classification. Background information on the patient was collected upon admission, and as Gray recommended, was just as important.

Mental Defectives Amendment Act (1928)

There was pressure from legislators for the recommendations of the 1924 Committee to be introduced as legislation.[71] The new 'social defective' classification and the creation of a Eugenics Board were the two major recommendations adopted. The Eugenics Board was created in 1928 on the recommendations of the 1924 Committee and Gray. It was ineffective and short lived, eventually disintegrating in 1932 after conflict between the members.[72] Only one patient in the sampled cases, a young boy, was referred to the Board for registration.[73] The Appendix contains a copy of this letter. The social defective classification had a longer lasting effect.

The 1924 Committee had favoured the introduction of social defective, in line with the English *Mental Defectives Act* (1913), which had included 'moral imbecile' following the recommendation of the 1908 Royal Commission. The British defined a 'moral imbecile' as 'persons who from an early age display permanent mental defect, coupled with strong criminal or vicious propensities, on which punishment has little or no deterrent effect'.[74] The New Zealand category of social defective was constructed along similar lines: describing them as 'persons who suffer from mental deficiency associated with anti-social conduct, and who by reason of such mental deficiency and conduct require supervision for their own protection or in the public interest'.[75]

The introduction of the term into New Zealand was problematic. There were doubts from legislators over the possible uses for such a highly constructed

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[71] *NZPD,* Vol. 206, 16 July 1925, p. 588 (G.W. Forbes); *NZPD,* Vol. 209, 7 July 1926, p. 509 (T.K. Sidey); *NZPD,* Vol. 212, 20 July 1927, p. 727 (T.K. Sidey).
[72] *AJHR*, 1925, H-31A, pp. 17-19. Robertson, 1989, pp. 131-150, analyses the functions of the Board and the reasons for its failure.
[73] YCBG 5904/50/1240, K.M. Todd, Psychological Clinic, Auckland, to the Chairman, Eugenics Board, Wellington, 24 March 1933.
[74] *AJHR,* 1925, H-31A, p. 15.
[75] *Statutes,* 1928, No. 23, Mental Defectives Amendment Act, sec. 7.

category, which had little to do with the mental state of the individual, and could result in committal to a mental hospital. Indeed, one social defective to Tokanui after 1928 was described as '[not] lacking in ordinary intelligence … [rather] she is a social misfit'.[76]

During the second reading of the Mental Defectives Amendment Bill the Minister in Charge of Mental Hospitals Department, James Young, defended the broad definition of social defective, claiming it was necessary in order to reach the types of people that would otherwise escape 'proper statutory classification'.[77] It is particularly interesting that this category could be introduced when there were serious questions being raised in Britain over the validity and effectiveness of the 'moral imbecile' classification from its inception in 1913 and throughout the following decade. New Zealand legislators were certainly aware of this uneasiness in Britain, yet 'social defective' was included in the 1928 Amendment. There had been pressure during the period 1911 to 1928 for the powers of the *Mental Defectives Act* to be extended as legislators and the public had doubts over the people that were not able to be placed under any kind of official control. There had been debate over the limited powers authorities had over individuals who were not legally mentally defective, and could not be segregated, or kept in custodial institutions, as some wanted. Evidently, New Zealand legislators thought there was a place for a broader category that could be applied to 'troublesome' parts of the population not covered by earlier classifications.

The establishment of Tokanui Mental Hospital

The number of patients admitted to New Zealand mental hospitals had increased from the late-nineteenth century, resulting in overcrowding, unsatisfactory conditions and difficulty in patient management. Land had been taken from local Māori in 1896, for the purpose of establishing an institution, but it was not until

[76] YCBG 5904/36/1005, preliminary statement as to mental and bodily condition, 2 January 1931.
[77] *NZPD,* Vol. 217, 19 July 1928, p. 612 (James Young).

1908 that building began.[78] In 1912 Tokanui became the first new mental hospital in New Zealand for 20 years, and the first in the central North Island. The new hospital was intended to alleviate the pressure on Auckland and Porirua mental hospitals and it was noted that:

> The mission of the Tokanui Hospital for some years to come will be the absorbing of the yearly increment, leaving the other hospitals much the same size as they are at present, by providing for the reception by transfer of numbers of patients who as a class can be managed in less expensive institutions than the ordinary mental hospital. This class compromises for the most part patients who keep fairly well under skilled supervision, but are quite unable to adjust themselves to the larger environment of the world outside institution.[79]

Indeed, from its first year of operation, until 1923, the only patients were those transferred from other mental hospitals. Set in a quiet rural environment, near the small town of Te Awamutu, Tokanui exemplified contemporary ideology on the location, and benefits, of villa style mental hospitals. The first patients, all male, assisted in the construction of the first buildings, and clearing the land for the hospital farm, which spread out over about 5000 acres.[80] Female patients were not admitted until 1915 after wards had been built to house them. See Appendix for a proposed plan for a female admission building.[81] More wards were added from the 1920s and in the 1930s a bakehouse, nurses' home, fire station, and dental surgery were built.[82]

Historian Warwick Brunton argues that Tokanui was the brainchild of Frank Hay, the Inspector-General of the Mental Hospitals Department from 1907 to 1925. Hay intended Tokanui to be the national asylum for chronic and

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[78] *AJHR*, 1910, H-7, p. 7.
[79] *AJHR,* 1910, H-7, p. 7.
[80] *AJHR,* 1912, H-7, p. 7. As the hospital estate proved too large for Tokanui staff and patients to clear and farm effectively, much of the land was transferred to the neighbouring Waikeria Reformatory in 1916 and the remaining 1000 acres continued to be farmed by the hospital.
[81] YCBG 5929/20/a, Sir Truby King, Inspector-General, Mental Hospitals, Wellington, to Dr Henry Prins, Superintendent Tokanui Mental Hospital, 22 December 1930. The plan was sketched by Prins, and included in a letter to King, who later replied, 'there is no chance of an appropriation for this purpose this year.'
[82] McLaren, pp. 20-21.

incurable patients.[83] Brunton states that, 'according to Sir Truby King, who was never enamoured of Hay's scheme, Tokanui was supposed to serve for all time as a "great farm colony for all those chronic patients from throughout New Zealand who could not work outside and whose relatives did not object to the transfer"'.[84] Hay had great hopes for Tokanui: he imagined that 'each 25 – 100 bed ward block at Tokanui would be a "separate house in a garden city" linked by a light rail system'.[85] Although Hay's grand vision for Tokanui did not materialise, by the 1960s, over 1000 patients were housed there, making Tokanui one of the largest mental hospitals in the country.[86]

There is little information about the patients or the impact of legislation on Tokanui during its first ten years of operation. There are only brief mentions of patient labour and some recreational activities in inspectors' and superintendents' reports from the *AJHRs* during this period, which focused on building progress and the development of basic services at the hospital.[87] This study considers the ways in which legislation and policies operated in practice, and particularly in the lives of patients who resided there.

Conclusion

This chapter has argued that legislation and policy introduced in New Zealand during the early twentieth century had a significant impact on those categorised as mental defectives and the operation of mental hospitals. The 1911 Act laid the ground work for New Zealand's responses to mental deficiency. Throughout the rest of the decade it was critiqued by institutional doctors, government officials, and legislators. The 1924 Committee and its report were thorough and considered a range of options available to better control defectives. Gray's 1927 Report

[83] Brunton, 2001, p. 267.
[84] Inspector-General to Minister (confidential), 4 March 1926, H31/6 (41885), Wellington Branch, National Archives, as cited in Brunton, 2001, p. 267.
[85] Inspector-General to Minister, 11 April 1910, HMH 1910/345, Wellington Branch, National Archives, as cited in Brunton, 2001, p. 256.
[86] Midland Health, *From institution to independence: The movement of people with an intellectual disability from Tokanui Hospital into the community* (Hamilton: Midland Health, 1996), p. 2.
[87] *AJHR*, 1914 – 1920, H-7.

maintained the momentum, pushing for action on the recommendations made a few years earlier. The 1928 Act seemed to at last provide each of the concerned parties with adequate, effective solutions to the 'problem'. Segregation was a less severe, but still effective, mode of control, and was official policy for the Mental Hospitals Department for much of the twentieth century. It also had different implications for all defectives institutionalised at Tokanui during the period 1911 to 1935.

Tokanui's response to legislation was influenced by the gender, age, category, year of admission, and circumstances surrounding the committal, of patients. The slow establishment of Tokanui during its first ten years of operation restricted the implementation of some policies. However, from 1925 Tokanui's practices became refined and distinctive. Its interpretation of some aspects of legislation, particularly classificatory criteria, was unique from other mental hospitals. The next chapter analyses the patient sample for this study, and considers the committal process, the factors considered in patient categorisation, and how Tokanui's doctors classified patients.

Chapter Two

Patients in Tokanui: committal, classification and hospital life

Muriel C. was 19 when she was admitted to Tokanui Mental Hospital in 1915. She had previously been a patient in Porirua Mental Hospital for three years. Before her committal to Porirua she had been in the care of the Home of Compassion in Wellington since she was a small child.[1] The sisters at the Home committed Muriel mainly due to her increasingly violent behaviour towards the other children in the Home. Yet at other times she was 'quiet and gentle', and was unable 'to converse or behave in a rational manner … [with the] General appearance and demeanour of an Idiot'.[2] She was classified as a low grade imbecile in Tokanui and did some light ward work such as sweeping and dusting. Muriel was a patient at Tokanui for 39 years, and had little contact with her family during this time. Little is known about Muriel other than what is contained in her file, which consists of committal documents, very brief doctor's notes and a few letters from family enquiring about her condition. Muriel's patient file is typical among the Tokanui patient files for mental defectives during its first years of operation, for the type of information that was recorded, the circumstances surrounding her committal, and Tokanui's response to mental defectives.

This chapter will use patient case files to describe mentally defective patients in Tokanui between 1912 and 1935. The mentally defective population at Tokanui in its early years of operation, from 1912 to 1923 was small, but significant. There was increased interest from government departments from 1911, as the previous chapter demonstrated, about the management of mental defectives. It is worthwhile considering the possibility that as a new mental hospital Tokanui was more able to adapt to changing interpretations of mental deficiency. Tokanui's responses to mental deficiency from 1912 to 1935 will be considered in the first section of this chapter through an analysis of the defective

[1] The year of Muriel's admission to the Home of Compassion is unknown.
[2] YCBG 5904/3/117, medical certificate, 7 September 1912.

population using categories of gender, classification, and age. The second section of the chapter will provide a more detailed analysis of these patient statistics by discussing rates of admission, length of stay, outcomes, and circumstances of committal. Some aspects of life within Tokanui will also be explored briefly here, including work, education and recreation, and the effects of legislation and policy on patients. Finally, the language used by Tokanui's doctors in patient files will be analysed for what it can tell historians about medical knowledge surrounding mental deficiency in New Zealand during the early-twentieth century. This chapter will argue that gender played a key part in committal and subsequent categorisation and treatment within Tokanui.

Mental defectives at Tokanui

The sample for this study includes all mental defectives admitted to Tokanui between 1912 and 1935. This numbered 111 patients: 69 males and 42 females. The selection process of the patient sample was outlined in the Introduction to this thesis. Males made up 62 per cent of mental defectives throughout the period. Of this group, the feeble-minded were the largest category, and approximately half of the male patients could be further classified as 'control' or 'criminal' patients. This group of patients will be discussed further in Chapter Four. However, control of female patients was more important to authorities, and underscored by contemporary concerns about limiting the reproduction of mental defectives. As Chapter Three will argue, female defectives were more likely than male defectives to be long term patients at Tokanui.

Female patients were first admitted to Tokanui in 1915, and all were transferred from Porirua. Typically, female defectives were low grades, that is, idiots or imbeciles, and were committed by family members, usually their parents. They were more likely to be 21 years or older on admission. Nearly half of all female patients had hospital stays of less than 15 years, with the briefest stay being just 6 weeks, the shortest stay at Tokanui of all these defectives, while the longest was 54 years, also the longest stay of all defectives. Of the total number of patients, 70 per cent had stays of less than 15 years, of which nearly two thirds were male.

The most common classification was imbecile: 50 patients, or 45 per cent of defectives. Of these, 20 were female: more female patients were classed as imbecile than any of the other categories. Just 7 per cent of all defectives were idiots, most of whom were female. Of the 33 feeble-minded patients, the majority were male. The smallest group were the social defectives, 1 male and 2 females, or 3 per cent of the sample. The category 'other' was the third largest group with 17 patients, or 15 per cent, evenly split between male and female patients.

Table 2.1 Category of mental defectives admitted to Tokanui, 1912-1935 (number of admissions and percentage of total sample)

	Males	***%***	***Females***	***%***	**Total**	**%**
Idiot	2	2	6	5	**8**	**7**
Imbecile	30	27	20	18	**50**	**45**
Feeble-minded	26	23	7	6	**33**	**30**
Social defective	1	1	2	2	**3**	**3**
Other	10	9	7	6	**17**	**15**
Total	**69**	**62**	**42**	**37**	**111**	**100**

(Source: YCBG 5904, patient files, 1912-1935)

Nearly half Tokanui's defective patients, or 54 inmates, were admitted after the age of 21, and 36 of them after the age of 31. This is significant because it shows that there were mental defectives that remained under the care and control of their families well into their adulthood. Typically these individuals were admitted because their family, usually a parent, had died, or had become ill, and was unable to provide sufficient care and/or control any longer. However, most of the women that were admitted to Tokanui over the age of 41 had been transferred from another mental hospital. These women had usually been patients for 10 years or more before admission to Tokanui, and all remained in Tokanui until their death.

Table 2.2 Ages of mental defectives upon admission to Tokanui, 1912-1935

	Male	***Female***	**Total**
0-10	8	3	**11**
11-20	18	10	**28**
21-30	10	8	**18**
31-40	9	9	**18**
41-50	6	8	**14**
51-60	2	1	**3**
61-70	-	2	**2**
Unknown	16	1	**17**
Total	**69**	**42**	**111**

(Source: YCBG 5904, patient files, 1912-1935)

The number of minors, those under 21, admitted to Tokanui was 31, or 28 per cent of mental defectives. Of this group, 21 were boys and young men which equalled 19 per cent of all defectives, while 10 girls and young women only constituted 9 per cent. Although Tokanui did not have responsibility for committing minors during the early years of its operation, some children were admitted there in the period 1912 to 1935.[3] James O., admitted aged nearly three years, was a patient at Tokanui for only two months before he was transferred to the Stoke Villa at Nelson Mental Hospital.[4] However, not all children admitted to Tokanui were transferred to a mental hospital specialising in the care of mentally defective children, four-year old Myrtle H. and seven-year old Mavis L. were long term patients.[5] Mavis, an idiot, died at 16, and Myrtle, an imbecile, was recommitted at 21.[6]

Most minors were low grade defectives admitted when their parents were unable to care for them any longer; these children often had serious physical disabilities as well as being mentally deficient. Parents were usually reluctant to commit children, and when children were institutionalised most parents visited as often as possible. Typically they did not live long after committal to Tokanui,

[3] 'Educable' or high grade defective children could be admitted to Otekaieke Special School for Boys or Richmond Special School for girls, both in the South Island. Idiot or imbecile children could be admitted to Stoke, near Nelson, a mental institution set aside specifically for mentally deficient children, particularly those who would not benefit from special schools or classes.
[4] YCBG 5904/56/1367, transfer warrant, 23 April 1935.
[5] YCBG 5904/20/623, application for reception and detention of minor in an institution, 8 November 1927; YCBG 5904/23/706, application for a reception order, 15 September 1928.
[6] Myrtle's file for the years after that was not available.

perhaps indicating that parents were only willing to commit their child when they could no longer provide adequate care. For example, James R. spent 18 months in Tokanui before his death. His case notes made little reference to his mental condition: '[James is] unable to speak, laugh or cry, with no knowledge of his parents & surroundings. … he is an imbecile whose mental age is that of a child of about 10 months old'.[7] Much of James' file is concerned with his physical health, particularly his eating habits, weight, and then his gradual deterioration until his death. In James' case, and for other defectives who also had severe physical disabilities, bodily health was a greater concern than intellectual abilities. This will be examined further in Chapter Three.

Analysis of the rate of admissions over a five yearly period shows that admissions of defectives increased from 1921 onward. At Tokanui, only 17 per cent of the all defectives were admitted in the first eight years of operation, of whom just 6 per cent were male. Both male and female rates of admission increased; in the period 1926 to 1930 the rates increased from 12 to 23 per cent for males, while for females it jumped from 4 to 15 per cent. However, the rate of female admissions decreased again, to 7 per cent during the period 1930 to 1935.

Table 2.3 Number of mental defectives admitted to Tokanui, 1912-1935 (number and percentage of total sample)

	Male	***%***	***Female***	***%***	**Total**	**%**
1912-1915	2	2	11	10	**13**	**12**
1916-1920	5	4	1	1	**6**	**5**
1921-1925	13	12	5	4	**18**	**16**
1926-1930	25	23	17	15	**42**	**38**
1930-1935	24	22	8	7	**32**	**29**

(Source: YCBG 5904, patient files, 1912-1935)

It is important to consider length of stay for all patients. The majority of male and female patients, 70 per cent, stayed less than 15 years, and of these, 11 patients, or 10 per cent stayed less than one year. The briefest stay was 6 weeks. Irene F. was admitted by her father from Waikato Hospital, and diagnosed in Tokanui as an imbecile with a 'bad prognosis', and who '[h]as been feeble-

[7] YCBG 5904/21/645, preliminary statement as to mental and bodily condition, 10 March 1928.

minded since birth and has never got beyond the II standard at school'.[8] However, Irene was released from Tokanui on probation after two weeks and discharged 'unrecovered' four weeks later. The reasons for Irene's discharge are unknown and unclear, particularly as her father had stated that 'I cannot give her proper attention', although both her parents were alive.[9] In her case notes Dr MacPherson wrote: 'she seems to be a case more suited for Richmond than for this institution'.[10] It is possible that Irene was transferred to Richmond Special School for Girls, although this is not recorded in her file. Feeble-minded Catherine S. was segregated for 54 years, the longest stay of these defectives. Some historians have argued that more female patients tended to be in institutions for long stays than male patients, attributing this to the greater control female defectives were supposed to require during their child bearing years, as well as their moral worth, respectability and employability.[11] Indeed, as Chapter Three will show, fears over uncontrolled sexuality and reproduction were often reasons for committal of female defectives to Tokanui.

Just over half of all defectives admitted died in Tokanui, about the same number of males and females. Many defectives suffered poor physical health. Because of this, deaths were not unusual. Old age was also cited as a reason for patients' deaths. Males were more likely to be discharged than females, particularly if they were higher grades. Their capacity as workers was often cited as the reason for their discharge. Similarly, the five females that were discharged were also considered good workers, and released to the control of family.

[8] YCBG 5904/11/359, preliminary statement as to mental and bodily condition, 1 September 1923.
[9] YCBG 5904/11/359, application for a reception order, 1 September 1923.
[10] YCBG 5904/11/359, patient case notes, 5 September 1923.
[11] Walmsley, pp. 65-70.

Table 2.4 Outcomes for mental defectives at Tokanui 1912-1935 (number and percentage of total sample)

	Males	***%***	***Females***	***%***	**Total**	**%**
Died	28	25	30	27	**58**	**52**
Discharged	17	15	5	5	**22**	**20**
Transferred	18	16	1	1	**19**	**17**
Escaped	4	4	-	-	**4**	**4**
Recommitted	2	2	6	5	**8**	**7**
Total	**69**	**62**	**42**	**38**	**111**	**100**

(Source: YCBG 5904, patient files, 1912-1935)

The committal process, outlined in Chapter One, sheds light on how much significance mental hospitals gave to family and certifying doctors' opinion or assessment of the patient's mental state and prognosis, and whether information provided by families did in some cases provide the basis of medical knowledge of mental deficiency in Tokanui. This is important because historians have argued that families played a significant role in the categorisation of mental defectives.[12] David Wright states that during the nineteenth century, family ideas about idiocy were distinct from medical discourse and were derived from practical aspects of household life, the 'domestic economy, concerns over household safety, individual responsibilities and duties'. [13]

Reasons for admission of mental defectives to Tokanui were varied. In the cases of low grade defectives and children, usually the level of care required had become too much for their family to provide. For defectives committed as adults, often the parent with the main carer responsibilities had become ill, or died, and the remaining family did not assume responsibility for their mentally defective family member. In the case of high grade defectives, the primary concern for family, the police, and authorities, was control. Mental defectives were transferred from the Prisons Department, an industrial school for example, because those institutions were not equipped to deal with defectives. Transferred patients were a significant number of all patients admitted to Tokanui between 1912 and 1935, and as stated earlier in this thesis, all patients admitted between 1912 and 1923 were transfers.

[12] David Wright, '"Childlike in his innocence": Lay attitudes to "idiots" and "imbeciles" in Victorian England', in Wright and Digby, pp. 118-133.
[13] Wright, 1996, p. 119.

As international literature suggests, patients were most likely to be admitted by their parents, or in the cases of 12 female patients, a sibling or other family member. It seems that patients that were admitted by a sibling had been under the care of their parents, but upon the parent's death the sibling was unwilling or unable to care for their mentally defective sibling. For example, Eleanor C. was committed by her sister not long after their mother's death because Eleanor was 'unable to look after herself & requiring attention has no one able to give it to her & needs to be placed under restraint'.[14] Evelyn C. lived with her brother and sister-in-law but was committed as her brother had 'no fit person to look after her'.[15] Ernest S. also lived with his brother and sister-in-law, but was committed by his brother as '[h]e has become dangerous and has threatened to murder me on several occasions. He believes he should have the same right to my wife as myself'.[16] Lucy D.'s sister, who cared for her sister after their parents died, found 'the care of the said person involving constant watchfulness of her habits & welfare very arduous. Her simple and usually stupid mind too not good for the young children of the household'.[17] These patients were in their mid-thirties or older on committal, and had apparently been under proper care and control in their homes until a change in their family circumstances.

However, following admission and closer examination, Tokanui doctors sometimes found that evidence of mental deficiency provided during the certification process had been exaggerated. One patient, Moana H., had lived with her father, stepmother and half siblings before her committal to Tokanui in December 1935. Her stepmother stated in one medical certificate that, 'she is unclean in her habits … Becomes sulky & obstructs other members of the family in moving around the house. Has struck the other children & also her stepmother when in a sudden rage. Could not get past standard 2 at school. Father corroborates above'.[18] But Moana's assessment upon admission to Tokanui revealed a different and probably more accurate description of her relationship with her family. This examination noted that Moana was, 'dull, apathetic & awkward in manner. … With patient questioning she becomes less reserved &

[14] YCBG 5904/17/528, application for a reception order, 21 July 1926.
[15] YCBG 5904/15/481, application for a reception order, 11 December 1925.
[16] YCBG/10/341, application for a reception order, 24 February 1923.
[17] YCBG 5904/46/1169, medical certificate, 2 November 1932.
[18] YCBG 5904/58/1430, medical certificate, 21 December 1935.

gives a version suggesting friction at home'.[19] It became apparent that her relationship with her stepmother and younger half siblings had been strained; Moana's housework was considered below standard, she was excluded from family outings and was sometimes restricted to one meal a day by her stepmother if there had been 'trouble', which resulted in Moana hiding food under her mattress.[20]

However, in Tokanui, feeble-minded Moana was a willing worker in the sewing room, cheerful, sociable with other patients, and wrote affectionate letters to her grandmother.[21] After Moana had been at Tokanui a few weeks, one doctor noted, 'She has turned out to be a better patient than at first seemed likely'.[22] Consequently, in March 1936, because Moana, 'now appears to be as well as she is ever likely to be', the hospital began to make arrangements for her release on probation to her sister with the conditions that Moana not be left alone, and 'that she will not go back to her step mother, who treated her badly'.[23] Hospital staff acknowledged that there was little reason for Moana to remain at Tokanui, although she was 'simple & childish – [and] will always need sympathetic supervision'.[24] Moana's stepmother appeared to be the instigator behind her committal and that she had been determined that Moana would leave the family home. While Tokanui staff agreed that Moana was mentally defective, the care and supervision that was available to her from her sister meant that she did not require institutional control. Evidence presented during the committal procedure was often useful in diagnosis and classification, although there was the possibility that facts could be misrepresented or exaggerated so that the alleged defective's committal was assured.

[19] YCBG 5904/58/1430, preliminary statement as to mental and bodily condition, 21 December 1935.
[20] YCBG 5904/58/1430, preliminary statement as to mental and bodily condition, 21 December 1935.
[21] YCBG 5904/58/1430, patient case notes.
[22] YCBG 5904/58/1430, patient case note, 12 January 1936.
[23] YCBG 5904/58/1430, patient case notes, 21 March 1936; 24 May 1936.
[24] YCBG 5904/58/1430, patient case notes, 22 May 1936.

Hospital life

For patients, life within Tokanui centred on work, considered an important part in their treatment, and which also contributed to the cost of their institutionalisation, and in the cases of some patients provided them with skills that would help them find employment if they were discharged from Tokanui. For mental defectives, 'work was also considered important to control people who were seen as children inhabiting adult bodies, to keep them fit and diverted'.[25] The feeble-minded, apparently dependent on routine, once trained in the 'regular performance of simple duties … find difficulty in breaking their methodical programme. In this way their lack of initiative is really protective, as it tends to keep them steadfastly at their labours'.[26] Most patients at Tokanui were employed in the hospital. Higher grade patients made significant contributions to the operation and maintenance of Tokanui, through their work on the farm, in the hospital gardens, with the farm animals, in the kitchen, the bakehouse, and the laundry. Tokanui staff expected that when they were well or capable enough, some patients would return to the community to be productive citizens, under appropriate supervision. Some patients had proved themselves to be capable of holding a job before their committal to Tokanui, and were keen to return to work outside the institution, but were refused their discharge. For example, a small number of male patients had worked on their family farms prior to their committal.

However, not all patients at Tokanui were part of the work programme regimen. Lower grade patients were often unable to participate in work beyond 'simple ward work'. This was usually floor rubbing, sweeping, or other chores that required few skills. There were lower grade patients, who also felt that they would be able to be employed outside the institution if given the opportunity, but had little idea of how this would be achieved. William M. wanted his discharge, but owing to 'his general "makeup" … it would be with difficulty that he would settle down outside'.[27] There were different expectations of low and high grade patients at Tokanui. Low grade patients were unable to do more than simple ward work under supervision, while higher grade patients were given more

[25] Patricia Potts, 'Medicine, Morals and Mental Deficiency: the contribution of doctors to the development of special education in England', *Oxford Review of Education*, 9, 3, (1983), p. 184.
[26] *AJHR*, 1925, H-31A, p. 11.
[27] YCBG 5904/4/178, patient case notes, 11 February 1931.

responsibility. If patients were able to contribute to the running of the hospital and to contribute to their maintenance then they were encouraged to do so. Social defectives and feeble-minded patients were usually given jobs in the hospital that required more responsibility, ability and skill. Their capabilities highlight the construction of these two categories in contrast to a strong emphasis on the inability of idiot and imbecile patients to work due to their mental and physical impairments.

But there were also some patients who did not want to return to life outside Tokanui. William W.'s committal, after his arrest, seems not to have troubled him greatly. He was transferred to Tokanui from Avondale in 1925 at age 43. William's case notes report: 'Patient says he was admitted from Avondale M.H. because "I was feeble-minded and could not make a living outside" says he has no wish to be discharged'.[28] Indeed, William did not press for his discharge and remained in Tokanui, working in the kitchen and on the farm, until his death in 1944. The insight in William's statement that he 'was' feeble-minded and unable to support himself 'outside', is unusual among these patients. The fact that he was 40 years old when first committed to Avondale suggests that William had in fact been employed prior to his committal, or that he had earlier had support from family, although neither is mentioned in his file. At age 35 George M. was admitted to Tokanui in 1932, after 14 years at a Timaru school for mental defectives.[29] George was described as a cheerful imbecile, who was happy in his surroundings. His family stated he had learned nothing during his time at school, and that '[h]e is unable to look after himself'.[30] Despite having parole and being regularly allowed home for short visits George 'does not relish any suggestion of going home, as he would miss the pictures & dances'.[31]

Recreational activities were provided for patients, and Tokanui's annual reports to the Mental Hospitals Department noted the increased number of activities that were available to patients, particularly after 1920. For example in 1921, '[a] tennis court for the use of the patients and staff has been laid out, and a

[28] YCBG 5904/14/438, patient case notes, 24 June 1925.
[29] YCBG 5904/40/1091, medical certificate, 4 January 1932. This was Elmsdale School, a private school established in 1917 by George Benstead, the first principal of Otekaieke Special School; see P.G. Aspden, *75 years service* (Oamaru: P.G. Aspden, 1983). Benstead was also a member of the Eugenics Education Society; see Fleming, p. 35.
[30] YCBG 5904/40/1091, medical certificate, 4 January 1932.
[31] YCBG 5904/40/1091, patient case note, 6 July 1932.

bowling green is in the course of construction'.[32] Tokanui's official visitors were often responsible for additional entertainment and gifts for the patients, 'Mrs Wood of Te Awamutu [has provided] parcels of magazines and sweets'.[33] In 1928 a radio was set up, with loud speaker extensions into the wards, and weekly 'picture entertainment' was attended regularly by patients.[34] The following year Dr Childs wrote:

> Recreation has formed a considerable part of the Hospital life, fortnightly dances in the winter, occasional concerts, and weekly picture being held. … Outdoor games such as bowls, croquet, and cricket were indulged in, while swimming and picnic parties were held when the weather allowed. The patients also attend any outside entertainment that is suitable. A fancy-dress ball was held during the year, and proved very popular, while the annual picnic was also a success.[35]

However, recreation seldom featured in patient case notes. One exception was Charles H., a 20-year old imbecile, who had 'no interest in intellectual pursuit of an advanced order, but [was] enthusiastic over wrestling & cricket, participating in recreations here & listening to wrestling & test cricket over the radio'.[36] Patients' recreational pastimes were usually not significant for doctors to record in case notes, as they were mainly interested in the patient's mental progress.

Education was minimal during the first twenty-five years of Tokanui's operation.[37] As stated earlier in this chapter, children admitted during this early period were usually severely intellectually and physically disabled and needed constant care. Few of these children lived longer than five years after committal to Tokanui. In addition, Tokanui was not originally intended to admit children. The growing number of mentally defective children in mental hospitals in New Zealand had been noted since the late-nineteenth century. The Mental Hospital Department considered it inappropriate for children to be segregated with defective adults.[38] The first mental hospital established solely for children was Stoke near Nelson in 1922, and admitted boys who were considered unsuitable for

[32] *AJHR*, 1921, H-7, p. 6.
[33] *AJHR*, 1927, H-7, p. 10.
[34] *AJHR*, 1928, H-7, p. 6.
[35] *AJHR*, 1929, H-7, p. 6.
[36] YCBG 5904/50/1246, patient case note, 3 February 1937.
[37] A school was not established for children at Tokanui Mental Hospital until the 1970s.
[38] *AJHR*, 1919, H-7, p. 2; 1921, H-7, p. 2; 1926, H-7, p. 5.

mental hospitals and the Otekaieke Special School.[39] Boys admitted to Stoke were 'care' cases, and places in the hospital's villas filled fast.[40]

Assessment of defective's intellectual ability began at Tokanui from about 1926, when Dr Corban Assid Corban, medical officer at Tokanui from 1926 to 1941, engaged in mental testing of some defective patients.[41] Even here, testing was limited, and emphasised what the patient did not know, and usually reinforced what Corban, and other Tokanui staff, already suspected. The testing coincided with an appeal from Gray, for better classification of patients, although he did not favour mental testing as a way of assessing mental defectives.[42] Corban used some informal mental testing in his examination of patients upon their admission to Tokanui. Not all mental defectives committed after 1926 were subject to this testing, and it is unclear what guidelines, if any, Corban followed. It is likely that he developed and expanded his own knowledge of mental deficiency, and its features, based on his own experiences and the advice of colleagues at Tokanui. Patients were seldom 're-tested'. Patient files show Corban had a particular interest in Tokanui's patients for several years, culminating in a two part article published in the *New Zealand Medical Journal* on the topic of occupational therapy.[43] Corban's article focused on the benefits of occupational therapy for psychiatric patients. However, case notes made by Corban show that he was just concerned with the progress of mentally deficient patients during this time.

Corban's mental testing was based on the patient's understanding of the world, and how well, if at all, the patient would be able to manage their own affairs or guard themselves against common dangers. For low grade defectives, testing often seemed to be based on physical as much as intellectual ability. Testing focused on arithmetic, currency, the alphabet and reading, and some general knowledge. For example, upon admission, imbecile Elvery A. was tested by Corban wrote, '[h]e is unable to repeat the alphabet or to add simple numbers,

[39] *AJHR*, 1919, H-7, p. 9; 1921, H-7, p. 2; 1923, H-7, p. 2.
[40] *AJHR*, 1926, H-7, p. 5, 10.
[41] Rex Wright-St Clair, *Medical Practitioners in New Zealand, From 1840 to 1930* (Hamilton: R.E. Wright St-Clair, 2003), p. 95.
[42] *AJHR*, 1927, H-7A, p. 4.
[43] Corban Assid Corban, 'Reflections of Occupational Therapy in Mental Treatment Part I', *New Zealand Medical Journal* (*NZMJ)*, 31, 163, (1932), pp. 191-198; Corban, 'Reflections of Occupational Therapy in Mental Treatment Part II', *NZMJ*, 31, 165, (1932), pp. 334-340.

e.g. he says 1 + 1 = 4'.[44] A few years later when Elvery was tested again, Corban noted:

> Mentally unaltered, & has little comprehension. When shown a sixpence, replies "shilling" then "threepence"'; 'Asked the date replies "dunno". Asked the month says "Monday". Asked the year says "May"' and 'Correctly points out a watch, knife, pencil. Very poor at simple arithmetic, thus 1 + 1 are 2, 2 +2 are 3, 3 + 3 are 5, 10 + 10 are 11.[45]

After examining Christina B. Corban concluded that she: '[c]an give correct answers to simple questions but cerebration is very slow. … Cannot tell the time nor the date nor even what day it is. Mentality is that of a child of 5 years'.[46] In contrast, Elizabeth T., a social defective, who was not admitted on the basis of mental impairment, was not subject to any form of mental testing. Corban wrote: 'she passed Std 6 at 13 ½ years … she does not seem to be lacking in ordinary intelligence'.[47]

The Education Department noted the increased use of 'psychological testing of educable capacity' in the United Kingdom and the United States from about 1915, and decided in early 1924 to 'make an experiment in their use, partly with the object of bringing newer methods under the notice of teachers, and partly to obtain Dominion data of a nature not otherwise easily obtainable'.[48] All students at secondary schools, technical schools, and district high schools were tested, and their results compared with American results. While the Education Department did not test mental defectives specifically, placing these tests within the context of the increased debate over mental deficiency, highlights the contemporary anxieties over the 'fitness' of individuals and their contributions to New Zealand society.

In New Zealand, and overseas, mental defectives were considered to be incurable, or any improvements to their condition would be limited, so usually the only treatment that was offered for defectives in institutions was hospital work. Occasionally, defectives had received treatment prior to committal. Christina B.'s examination upon committal noted that, 'cerebration is very slow in spite of the

[44] YCBG 5904/26/796, preliminary statement as to mental and bodily condition, 30 July 1929.
[45] YCBG 5904/26/796, patient notes, 29 January 1930; 29 July 1930; 29 July 1931.
[46] YCBG 5904/28/841, preliminary statement as to mental and bodily condition, 3 February 1930.
[47] YCBG 5904/36/1005, preliminary statement as to mental and bodily condition, 2 January 1931, 2 January 1931.
[48] *NZOYB 1925*, p. 823.

fact that she was "given thyroid 2 years ago to hasten cerebration"'.[49] However, one feeble-minded patient, Sydney J., was discharged from Tokanui in 1924 to undergo the 'Hickson faith-healing treatment'.[50] James Moore Hickson, an Anglican healer, bought his spiritual healing mission to New Zealand in 1923.[51] One New Zealand doctor stated that Hickson's treatment would likely help people who were 'mentally afflicted, and whose physical processes were thereby vitiated. In cases of that type, that healing mission would undoubtedly bring benefit'.[52] However, Sydney was re-committed to Tokanui in 1927, his mental condition apparently unimproved by this treatment.

Medical language

Analysis of medical language in Tokanui's patient files can provide historians with an insight into what constituted mental deficiency in one New Zealand mental hospital. Historian Margaret Tennant argues that the language used during this period provides 'important clues to the mindset of our forebears'.[53] This last section of the chapter will show that from the mid-1920s at Tokanui, there was improved institutional knowledge of mental deficiency and confidence in classification.

The effect of legislation enacted during the period 1911 to 1928 on patients at Tokanui, is a significant issue. Early patients at Tokanui showed that understandings of mental deficiency differed between New Zealand mental hospitals from the late nineteenth century to the 1930s. Any re-classification of patients admitted earlier than 1911 reflected the new *Mental Defectives Act*. This re-categorisation did not mean that the original classification was wrong; doctors were working within the nineteenth century legislative criteria. However re-categorisation proves that a more accurate classification system was needed. Interestingly, thirteen of these patients retained the classifications they were assigned during their committal to Porirua or Auckland in the late-nineteenth

[49] YCBG 5904/28/841, preliminary statement as to mental and bodily condition, 3 February 1930.
[50] YCBG 5904/20/608, preliminary statement as to mental and bodily condition, 27 August 1927.
[51] Douglas E. Ireton, 'A time to heal: The appeal of Smith Wigglesworth in New Zealand 1922-1924', BA (Hons) essay, Massey University, 1984, p. 24.
[52] Editorial, *NZMJ*, 22, 111, (1923), p. 289.
[53] Margaret Tennant, 'Disability in New Zealand: An Historical Survey', *New Zealand Journal of Disability Studies*, 2, (1996), p. 5.

century. This group of patients were simply categorised as 'imbecile' in accordance with the *Lunatics Act* (1882). Some later patients transferred to Tokanui were also re-classified upon admission.

The opinions of doctors at Porirua or Auckland did not always correspond with those of Tokanui's doctors. This demonstrates that although the new legislation was intended to provide consistency in classification, hospital practices did not always reflect this. For example, a patient diagnosed as feeble-minded at Porirua might be re-diagnosed as being of unsound mind at Tokanui, or vice versa. Theoplius Y. was transferred from Avondale to Tokanui in 1925. The notes that accompanied Theoplius from Avondale's medical superintendent described him as an imbecile.[54] His medical certificates diagnosed him as being of 'unsound mind'.[55] However, in his case notes, written at Tokanui, staff described Theoplius as feeble-minded.[56] The 1924 Committee had an effect on improved medical knowledge and classification procedures, as there was increased debate about defectives and the most effective methods of providing care and control. The *Mental Defectives Amendment Act* (1928) utilised developments in New Zealand, and overseas, in the period between 1911 and 1924.

Contemporary ideas about mental deficiency were varied; it was not until the 1950s that there was a unified international agreement of what constituted mental deficiency. Patient files analysed in this chapter typically contained certification documents, case notes made by Tokanui's doctors and for transferred patients, the notes from their previous institution. The language used in certification, transfer notes, and case notes, provides valuable information about patients' lives prior to committal, the reasons for their committal, and a broader understanding of mental deficiency in New Zealand. This will show what information the hospital's doctors used to categorise patients upon admission, and if there was a distinct institutional, or 'Tokanui', knowledge of mental deficiency, as the hospital established itself.

Between 1912 and 1921 there were few notes made in the patient files. Typically the only information available for patients during this early period of Tokanui's operation was brief notes made by the Superintendent of the previous

[54] YCBG 5904/14/439, Medical Superintendent, Auckland Mental Hospital, to the Medical Superintendent, Tokanui Mental Hospital, 12 May 1925.
[55] YCBG 5904/14/439, medical certificates, 14 April 1920; 14 April 1920.
[56] YCBG 5904/14/439, patient case notes.

institution. It is unclear why no new information was added. Perhaps it was because there were few opportunities for Tokanui's doctors to assess the patients, possibly due to the ongoing difficulties in establishing the hospital during the early years.[57] Staff at this time may have had other priorities than the re-assessment of mentally defective patients that they considered to be incurable. However, from 1921 onward, staff began to update patient files.

In 1923 Tokanui began taking direct admissions and around this time regular notes started to appear in patient files, usually every six months or annually. Typically, these were only one or two sentences and repetitive, usually providing little new information on the patient from the previous note, particularly for idiots and imbeciles, from whom little improvement was expected. This was common for mental defectives' files and casebook entries.[58] There was often no prospect of discharge, and the same phrases were used over many years. For high grade patients, notes were usually longer, contained new information on the patient, and were sometimes more regular, sometimes monthly during the first year of their stay. Notes described any improvements, physical health, and a doctor's opinion on the patient. From the mid-1920s the case notes of defectives show that knowledge of mental deficiency at Tokanui had generally became more refined and consistent. Although it seems that Tokanui's medical language is distinct from other mental hospitals in New Zealand at this time, it is important to point out that mental hospital staff moved between institutions fairly regularly.

Tokanui also developed its own criteria for diagnosis and classification of mental deficiency. Although it is difficult to be sure what this knowledge was based on, it likely drew on medical training, doctors' previous experience, and advice from colleagues, observation of patients' behaviour, mental ability and physical characteristics. Individual doctors, such as Corban, were also creating their own expertise simultaneously. From the late-nineteenth century, in Britain, defectives were believed to be part of a 'physically distinct sub-section of the population', and medical texts began to use photographs and drawings to aid accurate classification.[59] These illustrations were especially useful in the

[57] McLaren, p. 5.
[58] Charles Fox, '"Forehead low, aspect idiotic": intellectual disability in Victorian asylums, 1870-1887', in *Madness in Australia*, edited by Catharine Coleborne and Dolly MacKinnon (St Lucia: University of Queensland Press, 2003), p. 148.
[59] Jackson, 2000, pp. 89-90.

categorisation of the feeble-minded, who were particularly difficult to detect in the general population; 'mental defectives were arranged on an axis of visibility, in which the least visible were construed as the most menacing, a process which placed a premium on the precise recognition of the physical signs of deficiency'.[60] It is likely that doctors at Tokanui used or were aware of medical textbooks that provided photographs depicting typical physical characteristics of defectives, but it is difficult to know for certain if they were used to assist in classification.

Photographs of patients were not part of the Tokanui files during the period 1912 to 1935. The only photograph included in the mental defective's files is of the feet of Ernest S., who had six toes on each foot and required special boots to be made before he could begin work on the hospital farm.[61] Ernest was described as 'a well developed man … His facial expression is fatuous and he has many stigmata of degeneration. … He has two great toes on each foot, webbed with separate nails and a flexor and a tendon to each'.[62] The phrase 'stigmata of degeneration' regularly appeared in mental defective's case notes from the mid-1920s on. Although there is no definition of this term provided in the Tokanui archival material, or in official sources, according to Jackson, early-twentieth century medical texts used it to describe a number of physical anomalies exhibited by defectives. These included cranial abnormalities, deformities of the eyes, ears, teeth and jaw, lower heights and weights, as well as other physical disorders that seemed to be commonplace among mental defectives.[63] There were similar criteria for the classification of idiots and imbeciles in Australian asylums during the late-nineteenth century.[64]

The physical characteristics of Tokanui mental defectives were described in detail in their committal documents, and in their initial examination upon admission to Tokanui. Usually, the committal documents provided vaguer descriptions of defective appearance, reflecting the certifying doctor's lack of expertise in dealing with defectives, and their reliance on the evidence of families. For example, in his medical certificate William M. 'has the appearance of idiocy

[60] Jackson, 2000 p. 96.
[61] YCBG 5904/10/341, patient file. The photograph was most likely taken for the boot maker to use and a copy was kept on Ernest's file as it was also an unusual condition.
[62] YCBG 5904/10/341, patient case notes, [no date].
[63] Jackson, 2000, p. 103.
[64] Fox, p. 148-149.

… deficient in general appearance'.[65] However, on examination in Tokanui, William was found to have stigmata of degeneration, including a 'highly arched palate'.[66] The expertise of Tokanui's doctors and their recognition of conditions particular to defectives can be seen in the following examples. Irene F., a 14 year old imbecile, was found on admission to Tokanui to be 'poorly developed weighing but 4 ½ stone. She presents degenerate stigmata, e.g. a well marked Simian thumb and deformed ears with adherent lobules'.[67] Similarly, feeble-minded John W. had a cleft palate and a speech impediment, a typical characteristic of defectives, which was 'accentuated by stereotyped actions which accompany his utterance, gives him the appearance of a formidable customer at close quarters, especially as what he says is gibberish & unintelligible'.[68] Evelyn C. was described as 'undersized & shows stigmata of degeneration of a mongol type e.g. eyes, short, spade like hands, head', as well as showing the 'typical response of the very simple minded – easily pleased & easily upset, and very amenable to a little praise'.[69] In the case of Carl O. his physical disability was the key factor in his classification. Carl had never been able to walk, talk, or feed himself, and required the constant care of his mother, and was thus categorised as an idiot.[70] Eleven-year old Ivanhoe A. was undersized and had 'a tendency to achondroplasia. Head is normally sized but of an abnormal globoid shape'.[71] George M. had 'mongoloid characteristics' and was described as having the 'simplicity & good nature of individuals of his type'.[72] Indeed, as he approached his forties it was noted George was beginning to reach the 'phase where cases of his type commence to deteriorate & disintegrate'.[73] Finally, William L. displayed the 'mannerisms & the typical curiosity of an imbecile'.[74]

Facial expressions were also a factor in classification. In the case of Christina B., 'her facial appearance shows a lack of mental development'.[75] Imbecile Eleanor C. showed 'no sign of animation in the face, which remains

[65] YCBG 5904/4/178, medical certificate, 10 February 1908.
[66] YCBG 5904/4/178, patient case notes, 14 April 1921.
[67] YCBG 5904/11/359, preliminary statement as to mental and bodily health, 3 September 1923.
[68] YCBG 5904/14/437, patient case note, 30 July 1930.
[69] YCBG 5904/15/481, patient case notes, 17 June 1928; 17 July 1932.
[70] YCBG 5904/17/551, medical certificate, 29 October 1926.
[71] YCBG 5904/22/685, preliminary statement as to mental and bodily condition, 11 June 1928.
[72] YCBG 5904/40/1091, patient case note, 6 January 1934.
[73] YCBG 5904/40/1091, patient case note, 6 July 1935.
[74] YCBG 5904/51/1252, patient case notes, 4 September 1933.
[75] YCBG 5904/28/841, medical certificate, 26 September 1928.

without expression & is vacant'.[76] Richard B. had 'an expression of imbecility' and 'the appearance of an imbecile & degenerate' according to both medical certificates.[77] Hazel L. 'makes unintelligible weird chuckling noises & grimaces grotesquely'.[78] More vaguely, James L. had 'a queer look of weak intellect'.[79] However, the typical features of feeble-mindedness were indistinct. Richard W., for example, had the 'general posture and restlessness … of the mentally deficient', and would never hold a job 'having insufficient concentration or innate ability'.[80]

In contrast to the physical features of mental deficiency, there were more general signs of defectiveness, especially behaviour, that were shown by patients, particularly lower grades. Poor conversation, facile, fatuous, simple, unable to provide an account of one's life, poor memory, apathetic, incoherent speech, childish manner, needs supervision, noisy, lack of initiative and little interest in the surrounding environment, were all common phrases in the patient files. Not all patients displayed these characteristics of mental deficiency, but these terms were used often in case notes. These general phrases seem to demonstrate that there was an institutional knowledge of what constituted mental deficiency, as they are used more frequently than specific medical terms. From these examples it is clear that Tokanui doctors were drawing on specific knowledge of mental deficiency, in some cases it seems that classification and medical opinion were based on previous experience with defectives, rather than medical texts.

Conclusion

As a new mental hospital, Tokanui was in some respects, in a better position to use the new legislative categories, but during its first ten years of operation this was limited. The only patients admitted at this time were transfers, and as the hospital estate and buildings were also being developed during this period, there were restrictions on the evolution of institutional practices. However, between 1925 and 1935 Tokanui had firmly established its institutional procedures. This

[76] YCBG 5904/17/528, medical certificate, 21 July 1926.
[77] YCBG 5904/4/164, medical certificate, 8 July 1914; medical certificate, 8 July 1914.
[78] YCBG 5904/28/833, patient case note, 22 December 1936.
[79] YCBG 5904/5/225, medical certificate, 1 February 1912.
[80] YCBG 5904/51/1256, application for reception and detention of a minor, 9 September 1933.

chapter has also shown that gender was important in categorisation, and in determining the length of stay for a defective patient. Female defectives were thought to require long term segregation in order to control their reproduction. Male defectives, although linked with crime, were not subject to these same controls. Committal was often initiated by families, factors such as age, a defective's life prior to admission, and a family's ability to provide care and control, were just as important as gender and category to committal. The themes of gender and categorisation are expanded on in Chapters Three and Four as the concepts of 'care' and 'control' are explored.

Chapter Three

‘She cannot guard herself from ordinary physical dangers’: The care and control of patients at Tokanui

Hilda B., an imbecile, was admitted to Tokanui in 1930 at the age of 42, after she had spent the previous ten years in Porirua Mental Hospital. Hilda had two children, and was the only patient in the sample who was a parent. According to her family, the paternity of both her children was unknown.[1] Hilda’s family stated that her father had been able to control her, but that since his death, Hilda had become pregnant again. It appears the main reason for her committal was that her family was no longer able to control her, but also because she could not care for herself. The application for a reception order noted that ‘she cannot guard herself from ordinary physical dangers’, a typical characteristic of imbeciles according to the legislation.[2] She was unable to read or write, or perform domestic chores, and it would have been unlikely she could have held a job, although at Tokanui she was employed in some ward work.[3] Her case notes state that she was ‘impulsive’, ‘destructive’, and ‘requires considerable supervision’.[4] Hilda’s case provides a good example of the tension between the concepts of care and control in Tokanui and other New Zealand mental hospitals as this chapter explores, and her story is revisited later in this chapter.

The need to care for, and/or control, defectives was identified when mental deficiency was first recognised as a social problem in the late-nineteenth century. The methods for providing or maintaining either care or control, or both, in the cases of some patients, were varied in the international context, but in New Zealand segregation was considered the most practical and effective method. Typically, ‘care’ patients were children, that is, young idiots or imbeciles, who also tended to have physical disabilities or health problems, and

[1] YCBG 5904/29/845, preliminary statement as to mental state and bodily condition, 3 February 1930; application for a reception order, 10 June 1920.
[2] YCBG 5904/29/845, application for a reception order, 10 June 1920.
[3] YCBG 5904/29/845, patient case notes, 14 December 1932.
[4] YCBG 5904/29/845, patient case notes, 14 June 1939; 15 December 1934; 14 June 1940.

had previously been cared for by their family or in another mental hospital. 'Control' patients at Tokanui, on the other hand, were more likely to be feeble-minded or socially defective, although some imbeciles could be included in this group. A significant group among control patients were criminal males, usually adolescents or in their twenties. This latter patient group will be the focus of Chapter Four. However, there was not always a clear division between care and control, and among patients at Tokanui, there was a blurring of these groups.

This chapter argues that most female patients were admitted to Tokanui in order to be controlled. Some female patients were also admitted for care reasons. Usually they were low grade defectives or female children. However, families often committed women because they wanted to control the actions of the patient, which may have been sexually inappropriate, whether real or perceived; or other behaviour, including violence against family members or strangers. These women were usually described as somehow dangerous in their certification documents, and termed destructive, 'over-sexed', or violent. Contemporary authorities also considered that segregation protected these 'sexually vulnerable' female patients, as well as protecting society from promiscuous, 'hypersexual' feeble-minded women.[5] It is clear though that both male and female defectives required segregation to limit the effects that mental deficiency could have on New Zealand society, through crime, illegitimacy, reproduction and the spread of mental deficiency, and anti-social behaviour. For some patients, their family history reinforced the value of institutional control. In some instances, authorities noted there was a defective 'taint' in the patient's family that needed to be controlled, regardless of the individual cases. This chapter examines the role of gender in Tokanui's responses to female mental defectives in the light of international and New Zealand literature, and highlight cases of care, cases of control, and overlaps between the two. This chapter also considers the reasons why government departments wanted these measures in place, and how Tokanui responded to these policies from 1911 to 1935 through individual case studies.

As the Introduction discussed, social control theory and its influence on histories of institutions, including the asylum, are central to this concept of care

[5] Robertson, 1989, p. 27.

and control. In institutions for the mentally deficient there was a tension between the provision of care and the desire to protect defectives, and including the need to control defectives and protect society from them. The concept of the 'care/control paradox' has been raised by Pamela Dale. According to Dale, this paradox was an implicit tension in the nineteenth-century asylum in Britain.[6] Dale argues that several British historians in the last decade have emphasised this concept in relation to policies and the practices of the British *Mental Defectives Act* (1913).[7] During the nineteenth century the idea of care was central to the provision of services for the mentally defective. However, the emergence of the feeble-minded as a menace from the early-twentieth century, led to a new ideology for mental deficiency work, and the creation of new institutions, community care, and the medical model of care.[8] Although Dale argues, 'there is no evidence to suggest widespread acceptance of specifically eugenic policies or the complete abandonment of earlier ideologies of care'.[9] Dale agrees with Thomson's assessment of the British Act as 'paternalistic, even authoritarian', yet it also 'embraced humanitarian ideas' and she adds, '[t]here were real people whose problems were not simply the product of eugenic discourses, although the way that individual cases were presented had as much to do with prevailing ideologies'.[10]

The concept of a care and control 'paradox', as Dale describes it, is less evident in the analysis of Tokanui or other New Zealand mental hospitals. There was simply not the same extensive debate over mental deficiency and the feeble-minded that culminated in the Commission on the Care and Control of the Feebleminded (1908) in Britain. However, the New Zealand debate was largely informed by the findings of this British Commission. New Zealand's smaller society also meant the number of mental defectives was much lower. There was no need for the specialised idiot asylums that had been established in Britain and the United States during the mid-nineteenth century. Idiots who had been institutionalised in New Zealand were placed in mental asylums alongside

[6] Pamela Dale, 'Implementing the 1913 Mental Deficiency Act: Competing Priorities and Resource Constraint Evident in the South West of England before 1948', *Social History of Medicine* ,16, 3, (2003), pp. 403-404.
[7] These are Thomson, Jackson and Wright.
[8] Dale, p. 404.
[9] Dale, p. 405.
[10] Dale, p. 404.

lunatics; little distinction was made between the two. The eugenics movement was stronger in Britain and United States than in New Zealand. In New Zealand its influence was short lived. While there were campaigns in Britain for improved care and control of mental defectives, there was not the same level of activism in New Zealand in the early-twentieth century. In addition, medical knowledge of mental deficiency was chiefly informed by international research rather than studies done on New Zealand cases. There were fewer participants in the New Zealand debate other than doctors, legislators, and some educators.[11]

The concept of care and control in New Zealand was simplified to providing care for those who needed it, such as care from neglect, but also to protect and control society, to limit the spread of mental deficiency, and the impact of defectives on the society. Mentally defective children and women were a particular concern to authorities, and a number of the steps taken by both the Mental Hospitals and Education Departments were to provide care and control. The remainder of this chapter will analyse official discourses and patient cases to explore the themes of children and care, care, control, feeble-mindedness and social defectives, and argue that segregation was considered the most effective means of control in New Zealand.

Official discourses around care and control

The aim of legislation introduced between 1911 and 1928 was primarily to improve the ways that New Zealand mental hospitals provided care, control and oversight of mental defectives and the mentally ill. Improvements to the provision of services for the mentally deficient were not strictly concerned with meeting the needs of defectives and their families, but providing authority in law of officials to intervene. Proper control of these individuals was required. Internationally a number of responses were considered and used in order to establish and maintain control of mental defectives.

New Zealand was largely following Britain's example when the *Mental Deficiency Act* was introduced. However, it was not until the 1924 Committee

[11] For further discussion of the lack of public debate over the *Mental Defectives Act* (1911), the Committee of Inquiry into Mental Defectives (1924), and the *Mental Defectives Amendment Act* (1928), see Fleming and Metcalfe.

was formed, that some assessment of the Act's policies and practices could be made. Parliamentarians had earlier debated the merits of segregation, the efficacy of the Act, and the possible introduction of further reaching legislation to include 'moral imbeciles'.

Official discourse in New Zealand did consider in broad terms the ideas of care, control and oversight in relation to mental deficiency. The 1924 Committee considered that the State should have the power to control mental defectives, even if they were not institutionalised, and recommended that 'whether with relatives or otherwise, the State should, in the interest of both such feeble-minded individuals and of society, have the ultimate right of supervision'.[12] The distinction between those who required care, and those who needed control, was often blurred, as this statement from the 1924 Committee shows:

> Surely it is a kind act to give the protective care of the State to those unfortunate persons who are unable to hold their own in the struggle for existence, and who, if left to their own devices, will fall miserably by the way and in many cases become a menace to society.[13]

The 1927 Report also made recommendations on the measures that should be taken to ensure mental defectives were under proper care and or control. This report on Gray's visits to overseas institutions meant that his recommendations were also influenced by what he had seen in Britain, Europe and the United States. There were changes made to these recommendations for the New Zealand mental hospitals system.

For Gray, institutional care was the only suitable place for idiots and low grade imbeciles, where 'their simple requirements as to diet and cleanliness can be adequately met, and not in private houses where their helplessness imposes a serious burden upon their parents and other members of the household'.[14] Higher grade imbeciles, the feeble-minded and social defectives all needed 'some degree of State supervision'. Whether these mental defectives lived in an institution or under proper supervision in the community, the 'rationale of any State scheme for the social control of the feeble-minded should be to bring each

[12] *AJHR*, 1925, H-31A, p. 12.
[13] *AJHR*, 1925, H-31A, p. 21.
[14] *AJHR*, 1927, H-7A, p. 11.

defective to his maximal efficiency'.[15] Control of defectives, especially females, through segregation, was the best way to ensure that the fitness of the race could be preserved, and that problems such as alcoholism, promiscuity, prostitution, illegitimacy and criminality, attributed to mental defectives, could be diminished.

Children and care

Children admitted to Tokanui were typically care patients. Often they had been in the care of their parents before being committed, although some had been in the care of the Child Welfare Department. The reasons for admission were generally the same: the child had become difficult to care for and parents were unable to cope with the increasing demands as the child got older, as well as caring for other children or working. Some children had been to school, most had made little progress, and there was little point in continuing to attend. It is possible that parents whose children had left school found it more difficult to cope with having their son or daughter at home all the time and were therefore more likely to admit their child to an institution. In most cases parents were encouraged to place their child into the care of a mental hospital by doctors and government officials.

During the second reading of the Mental Defectives Bill in 1911, Attorney-General Sir John Findlay argued that parents should not be judged harshly by society for admitting their child to a mental hospital. He stressed that 'it is not only the right thing for the child, but eminently fair to the parents, that the State should provide some means under which the child should be properly and scientifically treated'.[16] The 1926 Annual Report considered the removal of a child to a mental hospital beneficial for the child because, such an 'environment is less complex and exacting than that outside, and in which he will never be made to realise his inferiority'.[17] Parents would give their support

[15] *AJHR*, 1927, H-7A, p. 11.
[16] *NZPD*, Vol. 155, 6 September 1911, p. 303 (J.G. Findlay).
[17] *AJHR*, 1926, H-7, p. 5.

for early segregation once they realised 'everything possible is being done in the matter of classification, education, care and treatment'.[18]

Tokanui, as the previous chapter argued, was not specifically equipped to handle defective children. However, the few children who were admitted to Tokanui in its first decades of operation were transferred elsewhere to specialist children's mental institutions. This was most likely because these facilities were in high demand, and places at children's institutions filled quickly.[19] There were calls throughout the early-twentieth century to increase the number of institutions for the care and education of mentally defective children. Only one child, James O., aged two years, was transferred to Stoke Villas at Nelson Hospital in 1935 after two months in Tokanui.[20] This was not uncommon; it was thought to be unsuitable for very young children to be housed with older children or adults. Defectives who were admitted to Tokanui as children seldom returned home. Usually they would be recommitted after their twenty-first birthday, transferred to another mental hospital, or they later died in Tokanui.

In July 1933, nine-year old Allen M. was committed to Tokanui by a Child Welfare Officer. The Child Welfare Department had been responsible for Allen since the death of his mother and father.[21] Allen's imbecility was attributed to congenital syphilis; both his parents had the disease. Both were patients at Tokanui and died as a result of dementia paralytica, his father in 1929 and his mother in 1931.[22] Of Allen's three siblings, he was the only child that was affected, although the psychologist who assessed Allen for registration with Eugenics Board advised that his brother and sisters also be tested for syphilis.[23] Allen was the only defective who was referred to the Eugenics Board. It appears that on the basis of the evidence presented to doctors and the welfare officer concerned with Allen's case, his family were identified as possible 'carriers' of mental deficiency. Evidence given to the Committee on Venereal Diseases (1922) showed that 'children with mental and physical defects due to venereal

[18] *AJHR*, 1926, H-7, p. 5.
[19] *AJHR*, 1926, H-7, p. 5, 10.
[20] YCBG 5904/56/1367, transfer warrant, 23 April 1935.
[21] YCBG 5094/50/1240, K.M. Todd, Psychological Clinic, Auckland, to the Chairman, Eugenics Board, Wellington, 24 July 1933.
[22] YCBG 5094/50/1240, preliminary statement as to mental and bodily health, 17 July 1933.
[23] YCBG 5094/50/1240, K.M. Todd, to the Chairman, Eugenics Board.

diseases may become a charge on the State'.[24] With his imbecility diagnosed, a course of action was needed in order to limit any further effects that Allen's family could have on society.

The doctor who had been treating Allen at Waikato Hospital prior to his committal wrote to Tokanui's superintendent Dr Prins: '[Allen] has had a good deal of anti-syphilitic treatment and has improved greatly but is still very dangerous to other children and attacks them on the slightest provocation'.[25] Allen's case notes initially describe him as a relatively harmless patient: 'he has given no real trouble so far, or taken any of his alleged periodic "turns". … Needs general oversight, & is not allowed to wander away from the ward or from supervision'.[26] Over the course of the following year Allen was described as 'noisy & destructive, tearing up shirts & trousers', 'a troublesome imbecile' and 'easily upset & annoyed by others'.[27] A year after his committal, Allen became increasingly weak in his legs, unable to stand and was 'put to bed'.[28] He gradually deteriorated, to the point where he was unable to do anything for himself, and died in 1937. While his committal documents portray a boy difficult to control and in need of supervision, those responsible for Allen before his admission to Tokanui must have realised from his family history that he was likely to become paralytic as his parents had, and would require constant care.

As an individual, Allen seemed to pose little danger to society, but as the son of two syphilis sufferers, he was a cause for concern for authorities. Allen's parents, apparently both defectives, had contracted syphilis and had reproduced, passing on not just the disease, but according to contemporary ideology, their mental deficiency, to their son, resulting in another admission to a mental hospital. It is little wonder then that authorities submitted a report on Allen to the Eugenics Board. Despite the concerns raised over Allen's case the reality was that he required constant care rather than control at Tokanui.

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[24] *AJHR*, 1922, H-31A, p. 21.
[25] YCBG 5904/50/1240, [writer unknown], Waikato Hospital, Hamilton, to Dr Prins, Tokanui Mental Hospital, 17 July 1933.
[26] YCBG 5904/50/1240, patient case notes, 7 August 1933.
[27] YCBG 5904/50/1240, patient case notes, 17 April 1934; 17 July 1934; 17 January 1934.
[28] YCBG 5904/50/1240, patient case note, 28 October 1934.

Care

Care for adult defectives differed from care given to children. These adult defectives did not have severe physical disabilities, although they could have difficulty in performing simple tasks such as feeding or dressing themselves, and were usually unable to work. The women discussed below were patients in a mental hospital for most of their adult lives. While each woman was a low grade defective, therefore requiring long term care, control was also a factor in their committal. Margaret S. was committed in 1893 to Mount View Hospital at the age of 15 by her mother. An imbecile, Margaret 'had shown a want of intelligence from her early childhood', and 'has to be managed as a baby in every respect (except food)'.[29] 'She plays with things around her like a young child, plays with dolls, and she appears to have neither will nor any moral self-control. She is certainly quite unable to take care of herself'.[30] In 1915 Margaret was transferred to Tokanui. Altogether she spent 53 years in mental hospitals, including 31 years in Tokanui. Her hospital employment was restricted to floor rubbing while at Porirua, but was considered 'unemployable' by staff at Tokanui.[31] Margaret's notes indicate that her mental and physical condition deteriorated over time, a possible reason why she was able to be employed when she was younger, but not during her time in Tokanui. However, Margaret was also the only patient in the sample that had to be placed in restraints. For a 15 month period from late 1926 Margaret wore a canvas coat: 'For the last three months she has taken to destroying stock, frequently necessitating in her wearing a loose canvas coat'.[32] Like most care patients Margaret was committed by her family as she became more difficult to care for. Margaret was manageable within the institution, although as she grew older her mental and physical condition worsened.

Eliza B., an imbecile, was admitted to Tokanui in 1915 at the age of 63 after spending the previous 15 years in Porirua Hospital. Eliza had lived with her mother her entire life until her mother's death and then with her brother,

[29] YCBG 5904/4/152, medical certificate, 1 August 1893; medical certificate, 3 August 1893.
[30] YCBG 5904/4/152, medical certificate, 1 August 1893.
[31] YCBG 5904/4/152, memo from the Superintendent Mental Hospital, Porirua to Medical Superintendent, Tokanui Mental Hospital, December 1915; patient case notes, 20 June 1927.
[32] YCBG 5904/4/152, patient case notes, 30 November 1927; YCBG 5922/1a, Register of Mechanical Restraint and Seclusion, Tokanui Mental Hospital.

who committed her to Porirua 18 months later. The information that Eliza's brother and sister-in-law provided in her medical certificates, indicates that she had become too difficult for them to manage. Her brother stated that Eliza '[s]ays she is going to marry an old man Tom McShane – when no such intention is entertained by him. Could not be trusted to take care of herself. Not entirely responsible for her actions. Has no sense of shame. Will undress without any idea of its not being decent to do so when men are about'.[33] According to the medical certificate Eliza also 'laughs and cries alternately for no reason, [is] incoherent in her speech and generally imbecile, unclean in habits … is generally idiotic in behaviour, [and] unable to carry out ordinary simple duties of a household washing, needlework, cleaning'.[34] Upon her transfer to Tokanui, the Superintendent of Porirua wrote in a memo regarding Eliza that she '[i]s able to answer simple question & is obedient. She usually works in the ward at washing etc'.[35] However, in Tokanui Eliza was not employed due to her deteriorating physical health. Eliza's behaviour around men, her inability to do any household chores, and her 'generally idiotic' behaviour combined with her family's inability to provide the level of care attention she required, were the reasons for Eliza's committal. She did live most of her life outside an institution, which seems to indicate that Eliza had lived in her community with few problems and received appropriate care and control from her mother, unlike Margaret.

In 1901, Clara H., an idiot, was committed to Mount View Hospital. Her aunt and grandfather stated on her medical certificates that she 'exhibits entire want of intelligence … she is quite helpless and needs constant care'.[36] At age 25 she was transferred to Tokanui in 1915 and the Superintendent of Porirua wrote that she was 'an imbecile and too stupid to work, her intelligence is of very low grade'.[37] In her case notes Tokanui doctors made similar comments noting that '[s]he is very dull and apathetic and sits in one position for hours swaying her body and muttering to herself' and that her '[c]ondition is one of

[33] YCBG 5904/3/109, medical certificate, 3 December 1901.
[34] YCBG 5904/3/109, medical certificate, 3 December 1901.
[35] YCBG 5904/3/109, memo from Superintendent Mental Hospital, Porirua, to Medical Superintendent, Tokanui Mental Hospital, December 1915.
[36] YCBG 5904/3/129, medical certificate, 23 July 1901.
[37] YCBG 5904/3/129, memo from Superintendent Mental Hospital, Porirua, to Medical Superintendent, Tokanui Mental Hospital, December 1915.

dementia [and] complete apathy to surroundings' and finally that she was '[a] feebleminded defective who is very helpless, wet & dirty, unemployable'.[38] Even though Clara was a low grade defective unable to care for herself, and who surely posed little risk to society, she seemed to frustrate at least one doctor, who described as 'a degenerate, degraded & demented epileptic who requires much supervision. She has vicious habits such as grinding her teeth loudly; and auto-eroticism is suggested in the frequent rhythmical oscillation of her body as she sits with herself propped up on the floor'.[39] The tone and wording of this note suggests that despite Clara's obvious mental deficiency, her behaviour was unacceptable and still subject to judgement. Clara's case demonstrates how ideas of care and control could be blurred. Her case notes reveal that the doctors involved with her considered Clara largely incapable and unaware of her environment, yet the factors in her diagnosis reinforced the idea that she also needed institutional control. It seems that anxieties about mental deficiency during this period meant that even seemingly innocent behaviour or actions could be interpreted as dangerous or 'degenerate' by some.

Control

For high grade defective females, control, rather than care, was the main reason for their committal. Their actions and behaviour prior to admission to Tokanui, as well as the concerns of families and doctors, provided enough evidence that these women needed to be removed to a more controlled environment. These women made officials uneasy, as the 1924 Committee noted, 'a certain proportion of mental defectives show their lack of self-control in regard to sex instincts. …This is especially the case for mentally defective girls, and constitutes one of the chief difficulties in dealing with them satisfactorily.'[40] Australian historian Charles Fox asserts that based on his analysis of late-nineteenth century casebooks, breaking social or moral codes affected the categorisation of defectives. Fox argues that contemporary ideals of 'femininity and feminine sexuality were clearly linked to the committal of women with

[38] YCBG 5904/3/129, patient case notes, 23 January 1922; 23 January 1925; 23 July 1929.
[39] YCBG 5904/3/129, patient case notes, 23 January 1931.
[40] *AJHR*, 1925, H-31A, p. 5.

intellectual disabilities and the way medical officers constructed them as patients'.[41] This was also true for female defectives admitted to Tokanui, as the following cases will show.

Indeed, Catherine S. was characterised throughout her file as emotional, destructive, demented, and a nymphomaniac. As Catherine was apparently feeble-minded, she required segregation. She was committed in 1898 to Mount View aged 25, and had the longest stay of all the patients in the sample, 54 years. The evidence for her committal included this statement:

> Mrs Morgan – the woman in her attendance – states that she wanders thro the house in her night dress & without any shame. Exposes herself at the window. She sleeps very little & is succeedly [sic] useless. When outside she goes & talks to men that she has no acquaintance with. That she gesticulated to Mr Barton calling him by endearing names, that she ran into a shop and threw her arms round a Mr Stuart's neck.[42]

The supporting medical certificate added further that 'she is continually stopping him in the street & and asking him to go for walks with her & uses disgusting language'.[43] Interestingly, her medical certificate also stated that, 'her behaviour with regard to men to be such as a girl of her training and upbringing with proper mental control should not carry out'.[44] There is no hint at what Catherine's training and upbringing was, but her behaviour was considered inappropriate given her family's background. Yet, there are no details of her family, education, or her mental state prior to her admission to Mount View. The notes that accompanied her upon transfer to Tokanui in 1915 stated that she had nymphomania and was 'erotic & filthy in conversation'.[45]

However, there is no other evidence apart from comments in her medical certificates that would suggest that Catherine had particularly close relationships with men or was promiscuous. At Tokanui, Catherine was described as 'very childish. Speaks of herself as "she" says "she can't read"', and although 'capable of routine work', also 'requires supervision' and 'can give no coherent

[41] Fox, p. 151.
[42] YCBG 5904/3/147, medical certificate, 23 November 1898.
[43] YCBG 5904/3/147, medical certificate, 23 November 1898.
[44] YCBG 5904/3/147, medical certificate, 23 November 1898.
[45] YCBG 5904/3/147, memo from Superintendent, Porirua Mental Hospital, to Medical Superintendent, Tokanui Mental Hospital, December 1915.

account of herself'.[46] These notes do not mention sexually inappropriate conduct or language, are brief, repetitive and noted little in Catherine's condition during her 37 years at Tokanui. As Fox suggests, Catherine's case was constructed by doctors, particularly at Porirua, after she had broken moral codes prior to committal. It seems that her behaviour was curbed by segregation, although she was still considered a nymphomaniac.

The consequences of inadequate control of female defectives, that is, illegitimate, and probably defective, children, were proved to Tokanui by Hilda's case. Hilda was difficult for her family to manage, particularly after the death of her father. She had become pregnant in 1915 and again in 1919. Aside from the fact that the father of each child was unknown, Hilda 'does not appreciate that she has committed any moral wrong whatever. She is quite irresponsible and has to be watched or she will wander away from home'.[47] Despite Hilda's feeble-mindedness it appears that her family thought she was solely to blame for her pregnancies.[48] Hilda's second pregnancy and fears that she would fall pregnant again appear to have been the major motivation for her family's to have Hilda committed. Their primary concern was seemingly to ensure her safety. Hilda's habit of wandering from home left them with little choice; segregation was the only way to assure she was under proper control. Indeed, her mother seemed to be unable to cope after her husband's death, and it appears that her other children could offer little support in care-giving, although Hilda's maintenance was claimed from them.[49]

Other imbecile women were also committed by their families because of inappropriate sexual behaviour. Eva D., aged 34 on her admission to Tokanui, was committed by her brother-in-law and sister, whom she lived with. They reported that Eva had 'a tendency to run after men and has improper approaches to their sons (boys) in their bedrooms. She also has shown ridiculous sexual approaches to Mr Burns and a tendency to abuse her sister Mrs Burns, apparent

[46] YCBG 5904/3/147, patient case notes, 24 November 1921; 24 May 1928; 4 May 1934; 22 November 1943.
[47] YCBG 5904/29/845, preliminary statement as to mental state and bodily condition, 3 February 1930.
[48] YCBG 5904/29/845, application for a reception order, 10 June 1920; medical certificate, 10 June 1920.
[49] YCBG 5904/29/845, application for a reception order, 10 June 1920.

evidences of insanity of a sexual type'.[50] Eva's brother-in-law stated that because of her persistence in going after young men, the family had to lock her in the house whenever they went out.[51] As the certifying doctor commented, she '[a]ppeared harmless enough but [Eva is] an encumbrance undesirable in [the] household'.[52] Another imbecile woman, Annie H., was transferred to Porirua from Tokanui in 1920, and exhibited improper behaviour while a patient at Tokanui. The notes that accompanied her transfer reported on her mental condition, and that '[s]he is also erotic, and constantly exposes herself to the Public Works men when they pass by near her'.[53] While Eva's case again demonstrates that families were most instrumental in the committal of defective women who were 'uncontrollable', Annie shows that segregation did not necessarily curb all inappropriate behaviour. The value of segregation was illustrated to Tokanui's doctors by Annie's actions. While her inappropriate behaviour continued, its effects on society were minimal.

Feeble-minded women

In 1922, the dangers of female defectives, particularly feeble-minded women, were noted: despite having a 'degree of mental or moral defect they may be physically attractive'.[54] The ability of the feeble-minded to blend in with the rest of society had been acknowledged as one of the major difficulties in their successful identification.

Gwendoline P. was committed to Auckland Mental Hospital in 1920 and later transferred to Tokanui. One of the doctors who committed Gwendoline, wrote, '[s]he is in my opinion feeble-minded (in the meaning of the act) and requires to be under observation'.[55] Gwendoline's family committed her because she had become increasingly violent towards them, and believed that the family was 'against her and she thinks it is her duty to injure some member of the family. She has thrown several articles at her mother and has inflicted

[50] YCBG 5904/3/119, medical certificate, 28 June 1915.
[51] YCBG 5904/3/119, application for a reception order.
[52] YCBG 5904/3/119, medical certificate, 28 June 1915.
[53] YCBG 5904/30/880, memo from Medical Superintendent, Tokanui Mental Hospital, to Medical Superintendent, Porirua Mental Hospital, 16 February 1920.
[54] *AJHR*, 1922, H-31A, p. 11.
[55] YCBG 5904/10/353, medical certificate, 16 August 1920.

several beatings to her mother'.[56] By the time of her transfer to Tokanui in1923, Gwendoline was described as 'a high grade imbecile, but is bad tempered and at times immoral and indecent in behaviour. She is seldom violent'.[57] Gwendoline's case notes reveal that was little change in her condition for the rest of her stay in Tokanui, 29 years, until her death in 1952. Her family apparently had little or no contact with her during that time. Four years after her death, one of Gwendoline's sisters wrote to the Superintendent inquiring why none of their family had been informed of her death. The Superintendent wrote back, stating that the staff had attempted to, but the family could not be traced through the addresses in their records.[58] Gwendoline's committal appeared to be a relief to her family, understandable given her increasingly violent behaviour, and that they made little attempt to maintain regular contact with her. Possibly this was even more the case when it was her siblings who became responsible for her, as her parents grew older, or had died.

It was not uncommon for patients at Tokanui to lose contact with their families; particularly for idiots and imbeciles, and male, rather than female, defectives. The amount of care that low grade defectives required, combined with there being little hope of improvement, meant that some families may have seen little point in maintaining contact with a family member who was troublesome or who probably had little idea of the change in their circumstances. Indeed, as Chapter Four will argue, high grade males were usually more mobile than female defectives, and were more likely to be living away from their families, and therefore no one person was responsible for their control.

Defectives who were good workers during their segregation were more likely to be released on probation back to their families or into employment. The medical superintendent's assessment of a family's or employer's ability to provide a reasonable level of supervision, care, and control, was also a factor in granting probation. Nineteen-year old Nora P., feeble-minded, was committed to Porirua in 1918 by her aunt after 'constantly getting away at night in her night

[56] YCBG 5904/10/353, application for a reception order, 16 August 1920.
[57] YCBG 5904/10/353, memo from the Superintendent, Auckland Mental Hospital, to Medical Superintendent, Tokanui Mental Hospital, 26 July 1923.
[58] YCBG 5904/10/353, [patient's sister] to Malcolm Brown, Medical Superintendent, Tokanui Mental Hospital, 21 October 1956; Malcolm Brown, Medical Superintendent, Tokanui to [patient's sister], 25 October 1956.

clothes through the windows' and going to the 'local schoolmaster's house being acquainted with him. She went & had a bath in his house & discarding her clothes put on those of the schoolmaster's wife'.[59] Nora's occupation was listed as domestic duties, although her aunt gave no evidence that Nora was employed about their house. However, at Porirua, however she proved to be a good ward worker, and after her transfer to Tokanui in 1920 it was noted that '[s]he is quiet well behaved and a good worker in the Laundry. She … might be discharged to the care and supervision of a friend'.[60] In 1921, Nora was discharged to the care of another aunt, after a request from Dr MacPherson, the Medical Superintendent, who wrote that 'she is, and will always be feeble-minded. She is an excellent worker and you would find her useful if you require any domestic help'.[61] Despite the concerns of authorities, mental hospitals could approve the release of defectives if they had proved to be good workers and would be properly supervised if given probation.

Social defectives

Social defectives were segregated for 'their own protection or in the public interest' because of their 'anti-social conduct'.[62] They were typically teenagers or in their early twenties, were sometimes in paid employment, and were of average or above average intelligence, in contrast to the legal characteristics of the other classes of defectives. At Tokanui only three patients, two females and one male, were classified as social defectives. Another female patient, whom I have classified as 'other', seems to fit the criteria that Tokanui employed for social defectives, but was given no formal category by Tokanui doctors. This patient, Jessie S., will be included in this discussion of social defectives. Usually they were described in their case notes as promiscuous, delinquent or troublesome, and anti-social. The use of these terms reflected Tokanui's adherence to policy.

[59] YCBG 5904/8/278, medical certificate, 12 August 1918.
[60] YCBG 5904/8/278, memo from the Superintendent Porirua Mental Hospital to Medical Superintendent Tokanui Mental Hospital, 15 September 1920; patient case notes, 7 July 1921.
[61] YCBG 5904/8/278, Dr J. MacPherson, Medical Superintendent, Tokanui Mental Hospital to [patient's aunt], 7 June 1921.
[62] *Statutes*, 1928, No. 23, sec. 7.

Jessie was committed in October 1930, by a Child Welfare Officer who had assumed responsibility for her family after her mother's death in 1919, and her father's committal to a mental hospital in 1921.[63] The Child Welfare Officer stated in the application for a reception order that Jessie's mother was the cause of mental deficiency and mental illness in the family, as the 'supposed mental taint [was] in her family'.[64] Of Jessie's nine siblings, two of her sisters had also endured short stays in mental hospitals. When the Child Welfare Officer responsible for Jessie applied to have her committed she stated:

> This girl … has for years had anti-social tendencies – It has been with the greatest difficulty that we have prevented disaster – for she sees in every man – a possible husband. She is not a ward of the state, the local Public Trustee 10 yrs ago asked me to supervise the girls of this family.[65]

From the evidence of the Child Welfare Officer it appears that Jessie's family was considered a 'problem family', as both parents and two siblings had some form of mental illness. In Jessie's medical certificate the certifying doctors stated: 'We give as our opinion that she is of subnormal mentality and suffers from sexual prococity. [sic]… [The Child Welfare Officer] has informed us of the difficulty she has experienced in keeping the girl out of trouble and that she is undoubtedly oversexed'.[66] Jessie's file contains no other evidence that would suggest that she was promiscuous, and it is difficult to know exactly what was meant by the word 'oversexed'. Jessie's anti-social tendencies appear to have been the main reason for her committal. So, possibly Jessie's actions would be more in line with a classification of social defective than 'mentally infirm', which was the category given on her medical certificate.[67] However, it is difficult to ascertain more about Jessie other than the information that was provided on her committal documents. There were no doctor's notes included in her file from her time at Tokanui. Jessie was discharged and readmitted under section 26 of the *Mental Defectives Act* (1911) after she turned 21, eight months

[63] YCBG 5904/35/985, application for the reception and detention of a minor, 8 September 1930. Emphasis in original.
[64] YCBG 5904/35/985, application for the reception and detention of a minor, 8 September 1930. Emphasis in original.
[65] YCBG 5904/35/985, application for the reception and detention of a minor, 8 September 1930. Emphasis in original.
[66] YCBG 5904/35/985, joint medical certificate for the reception of a minor.
[67] YCBG 5904/35/985, joint medical certificate for the reception of a minor.

after her initial admission to Tokanui. A second file created for her re-admission is missing, so it is impossible to know how Jessie was further categorised in Tokanui.

Another social defective was admitted soon after Jessie. Elizabeth T., 15 years old, was committed to Tokanui by her father after the idea was raised by a local minister. Elizabeth had held several jobs since she finished school after passing Standard 6, although none lasted long: 'Her employers (15 during the past 2 ½ years) have all dismissed her in account of her impossible demeanour and her habits'.[68] During her time at Tokanui Elizabeth was generally a good patient, although sometimes 'troublesome' and needed 'firm supervision'.[69] However, Elizabeth's time in Tokanui was relatively short, eleven months, after her parents took her home on probation, under the condition that she be supervised.[70] With her good behaviour in Tokanui and parental supervision assured, Elizabeth did not require the long term segregation like some female defectives. Norman B. was the only male patient in the sample who was specifically categorised as a social defective; his case will be discussed further in Chapter Four.

Conclusion

Mentally defective patients at Tokanui were committed to provide either care or control. Children were most often classified as care patients due to the constant attention that they required. Most high grade female patients were considered control patients. Low grade female patients however, required both care and control, as they were unable to guard themselves against physical danger or support themselves and their potential to produce defective children. The methods of, and reasons for, control differed between female and male patients at Tokanui. The freedom of both groups was thought to be potentially harmful to New Zealand society; physically, through crime and violence; sexually, by reproduction or sexual offending; or financially, as increasing numbers of defectives were institutionalised and increased their burden on the State. Nearly

[68] YCBG 5904/36/1005, joint medical certificate for the reception of minor, 17 December 1930.
[69] YCBG 5904/36/1005, patient case notes, 2 March 1931; 5 May 1931.
[70] YCBG 5904/36/1005, patient case notes, 24 November 1931.

all female defectives at Tokanui, according to institutional practice as well as legislation and policy, required control. Females were more likely to be institutionalised for longer periods than males, particularly during their child bearing years. Hilda B.'s case is a typical example of this. In contrast to the female population at Tokanui, not all male patients could be classified as control patients. Low grade male defectives were usually simply described in their case notes as care patients, because their mental and physical condition meant that they posed little threat to wider society. Male defectives could be classified as control patients because of crimes they had, or could possibly commit. The following chapter explores this theme in more depth.

Chapter Four

Male mental defectives and criminality: 'a source of constant trouble'

Len T., a labourer, was transferred to Tokanui in March 1917 after a year-long stay at Porirua Hospital following his arrest in Wellington. The arresting police officer lodged an application for a reception order on the grounds that Len was '[f]ound wandering in female attire. Says she went to Honolulu in a tramway car'.[1] It is not clear from his file if Len had actually committed a crime. It seems, from the information available, that the constable had decided that Len posed a danger in some way and needed to be removed from society. He was further examined by two doctors, one of whom described Len as 'very simple and effeminate, lacks self control. ... He tells me he preferred to be dressed as a girl than as a boy, because he had been used to that garb from childhood, in fact he has all the characteristics of a female and behaves as such'.[2] In both Porirua and Tokanui hospitals Len was described as a good worker but 'cunning and deceitful. Has a mania for thieving and is very untruthful'.[3] In August 1917 Len escaped from Tokanui and was not recaptured. Eventually, in 1921, he was formally discharged under section 79(3) of the *Mental Defectives Act* (1911).

Len's case is not unusual among the cases in this study. There were some successful escapes, others not, and a number of the male defectives had been admitted after arrest. Often in these cases, anxiety over the possible impact defectives, usually males, could have on society was the reason for their committal to the institution, rather than any actual crime. The experiences of males in asylums have often been less emphasised by historians, particularly in relation to the concerns throughout the 1920s and 1930s over the connections between criminality and mental and social defectives. This chapter argues that Tokanui reinforced this connection, through its treatment of 'criminal'

[1] YCBG 5904/5/188, application for a reception order, 25 January 1916.
[2] YCBG 5904/5/188, medical certificate, 1 February 1916.
[3] YCBG 5904/5/188, memo from Superintendent, Mental Hospital, Porirua to the Medical Superintendent, Tokanui Mental Hospital, 19 March 1917.

defectives committed there, and also due to its relationship with neighbouring Waikeria Prison.

Of the 69 mentally defective male patients admitted to Tokanui, 30, or 27 per cent of all defectives, were either committed after arrest, transferred from a prison, industrial school or training farm, or were transferred after their stay in Tokanui to a prison. A few were arrested after their discharge from Tokanui and imprisoned. Males transferred from the Prisons Department, or placed directly under the control of the Mental Hospitals Department, were typically categorised as imbeciles or feeble-minded. The reasons for their committal were not always clear cut, but usually they had posed some sort of threat to their family or community.

The term 'criminal' is used to broadly describe this group; although not all were in fact criminals. It was the potential these males appeared to possess to become criminals that was of concern to contemporary authorities. 'Criminals' were thus a significant group among Tokanui defectives, and the reasons for their committal, arrest or admission to another site of control warrants exploration. This group was also the largest of the 'control' patients discussed in Chapter Three. Anxieties about criminality, hereditarism and the danger or threat that they did, or could pose to society, was considered reason enough to segregate these men. Also of particular concern was the possibility that male defectives would commit sexual offences. A small number of men were committed to Tokanui between 1912 and 1935 because they had already, or might possibly in the future, commit a sexual offence. As noted in Chapter One, the 1924 Committee made it clear that there was no established link between defectives and sexual offenders.[4] However, it was true, they observed, that, 'a certain proportion of mental defectives show their lack of self-control in regard to sex instincts. … Some of this class find their way into prison on account of sexual offences, but it is far from correct to assume that all feeble-minded persons are sexual offenders'.[5]

Within the criminal group of 30 males, 16, or over half, were between the ages of 15 and 30. Most of the patients in the sample were classified as feeble-minded. This is unsurprising given the connections made between

[4] *AJHR*, 1925, H-31A, p. 5.
[5] *AJHR*, 1925, H-31A, p. 5.

criminality and feeble-mindedness, beginning in the late-nineteenth century. Crime and feeble-mindedness continued to be linked together during the twentieth century, as this chapter will show. Most criminal males, 14, or 46 per cent, had a stay of less than five years in Tokanui. This was because they were discharged, transferred, or escaped.

There were 11 patients admitted between 1921 and 1930, and another 11 admitted between 1931 and 1935. These numbers are a small increase on the 7 patients committed between 1912 and 1920. There are two possible reasons for this. First, the increased awareness of this category of mental defectives as a result of the legislation introduced in the period 1911 to 1935 and subsequent committals. Second, the re-classification of patients already in other mental hospitals, and in the case of Tokanui, the reception of patients transferred from other mental hospitals as they became over crowded. It is likely that the debate during the 1920s over mental deficiency and morally corrupt behaviour also heightened public awareness and led to an increase in committals as some defectives and their actions became less acceptable in society.

Table 4.1 Criminal defectives: Number of admissions to Tokanui, 1912-1935 (number and percentage of total sample)

	Number	***%***
1912 – 1915	2	2
1916 – 1920	5	5
1921 – 1925	8	7
1926 – 1930	3	3
1931 – 1935	11	10

(Source: YCBG 5904, patient files, 1912-1935)

This criminal group can be divided into three types of patient: the long stay and usually low grade defectives; more troublesome defectives, who were violent or sexually dangerous; and young high grade, ‘reformable’ defectives who had a shorter stay. The long stay males were aged 35 or older, were committed after arrest for a minor crime, such as theft, being a nuisance, or minor acts of violence and later transferred to Tokanui from another mental hospital.

There were a small number of defectives who could be considered sexually dangerous, either because an actual crime had been committed, or could possibly occur. Generally these men were regarded as the more dangerous patients, but this was not always the case. Finally, there were the patients that were discharged back to the Prisons Department after a few years at Tokanui, to complete their sentences. Some patients completed their sentences while they were in Tokanui, and upon their discharge they returned to their families. The number of escapes and attempted escapes was higher among this group of patients.

Young, high grade men committed to Tokanui were more likely to be discharged to their families or the supervision of an employer. They had sometimes previously been inmates from Burnham Industrial School near Christchurch, or Weraroa Boys' Training Farm, near Levin. Typically, these young men were described in their committal documentation as too dangerous to remain in these insecure facilities that did not have the resources to control them. They were usually classified as feeble-minded; perhaps reflecting the fact there was little wrong with them mentally, but that the category was broad enough to be applied to them. Authorities also considered that they more likely to be reformed or rehabilitated.

In Tokanui, male defectives were also more likely than females to have no contact with their family, or have no fixed residence. Thomson argues that 'the only reason more adult women were reported was because men were more easily lost sight of.'[6] The evidence available from Tokanui from 1912 to 1935 appears to support Thomson's claim. Ted H., for example, had some contact with his family after his committal to Tokanui, but one Tokanui doctor noted that 'his ties with home & family are not very strong. He has not seen his mother for years, & is unconcerned about making a trip over to meet her'.[7] Only two criminal defectives were committed by their families. Male defectives were often thought to pose a threat because of their mobility and their minimal contact with their families, who would usually be responsible for their control and committal. Without control by families, they were far more likely to be admitted by the police or another institution. Under section 38 of the *Mental*

[6] Thomson, p. 28.
[7] YCBG 5904/28/825, patient case notes, 26 May 1931.

Defectives Act (1911) the Mental Hospitals Department took control of prisoners held by the Prisons Department if there were reasonable grounds to believe that the prisoner was a mental defective.[8]

Tokanui and Waikeria

Institutions provided sites for control, and while Tokanui was primarily concerned with mental defectives or the mentally ill, its geographical proximity to Waikeria Prison added another dimension to the care and control the hospital could provide. Official and public understandings of mental deficiency, and its relationship to crime, were likely reinforced by the nearly simultaneous establishment of these neighbouring institutions. Waikeria Prison was established in 1912 alongside Tokanui on land that had originally been set aside in 1896. The function of Waikeria changed over time.[9] Waikeria's inmates for much of the first half of the twentieth century were usually young men, in their late teens or early twenties, who had received short sentences for minor crimes, and who authorities thought might be rehabilitated or 'reformable'. Land that was originally part of the hospital estate was transferred to the Waikeria in 1916, 4000 acres in total, when it became clear that Tokanui could not utilise such a large tract of land effectively, due to the size of the farm and the shortage of able workers from the hospital. In the early years of both institutions, patients and prisoners worked on the farm together. Prisoners were responsible for creating a road connecting Waikeria to the main road.[10] The proximity of these two institutions created an 'institutional landscape' in the Waikato.

In 1920 the links between Waikeria and Tokanui were strengthened when, 'The Comptroller-General of Prisons, wishing to place the Waikeria Reformatory on a scientific footing, asked for, and obtained the loan of Dr Gribben, the Medical Superintendent of Sunnyside Mental Hospital.'[11] The 1921 Annual Report to the Prisons Department noted the increasing number of feeble-minded or 'otherwise irresponsible' prisoners, and raised the possibility

[8] *Statutes,* 1911, No. 6, sec. 38.
[9] Waikeria was established as a prison in 1912, and then became a reformatory for young men between the ages of 16 and 25 in 1918. In 1926 Waikeria became a borstal institution.
[10] *AJHR,* 1916, H-7, p. 4; 1919, H-7, p. 10; 1920, H-7, p. 7.
[11] *AJHR,* 1920, H-7, p. 5.

of establishing a separate institution for the feeble-minded, the criminally insane, and 'the offender imprisoned for acts of sexual perversion due to physical disease or disability.'[12] The Report then suggested that Waikeria and Tokanui could eventually become the location of an institution for the criminally insane:

> The three classes of criminals named [feeble-minded, criminally insane, sexual offenders] could readily be confined in one special institution under a system of classification that would provide treatment and useful work in the case of classes 1 and 3, and for safe custody and occupation in the case of the criminal insane. The place for such an institution is undoubtedly in the large estate in the neighbourhood of Te Awamutu and on which the Tokanui Mental Hospital and the Waikeria Reformatory Prison have been established. … The necessary professional staff would be available at Tokanui, while the prison side of the work could be supervised and managed from the Waikeria Reformatory.[13]

This institution was not created, but from 1925 onward there were an increased number of criminal patients admitted to Tokanui, a circumstance which suggests changing attitudes towards mental deficiency and criminality. These attitudes were reflected in the official discourse of the 1920s and 1930s. The 1931 Annual Report commented again on dangerous patients, but observed that most patients admitted to mental hospitals as criminals were 'not violent or dangerous if provided with proper occupation, environment, and treatment, and, instead of causing any trouble or anxiety in our institutions, they are not infrequently amongst the most amenable and industrious of our patients'.[14] In some respects, then, mental defectives were regarded as not so dangerous as other criminals. However, only two years later, the Auckland superintendent, Dr Buchanan, commented on the difficulties presented by the increasing number of criminal lunatics:

> Many of a feeble-minded type, on completion of their prison sentence, are put under Mental Hospital control for the safety of the public. These patients, in general, are a conceited, self-opinionated lot, who suffer under what to them is a very real sense of victimisation. They consider that, having served their sentences, they have completely expiated their wrongdoings. Treatment in most of these cases is of no avail – custodial care is the sole

[12] *AJHR*, 1921, H-20, p. 6.
[13] *AJHR*, 1921, H-20, p. 6.
[14] *AJHR*, 1931, H-7, p. 3.

> requirement. It is hard to get them to occupy themselves usefully, and, consequently, more attendants are required in the airing courts. This curtails the outing of other patients. If these men do work they demand such privileges as are granted to many of our ordinary workers – i.e., parole, leave to go to entertainments, &c. … they are a source of constant trouble.[15]

As these two extracts show, there was a range of opinions on the worth and abilities of defective criminals among doctors and institutions.

At Tokanui, treatment for criminal defectives was work-based, with the aim of making defectives into productive citizens, even though these men were considered patients who required 'control'. Their behaviour and potential to harm society were often given as reasons for their committal. In contrast to female patients, also admitted to control their behaviour, the males were more likely to be placed on probation and eventually be discharged. Table 4.2 shows that of the 17 male defectives discharged from Tokanui, referred to in Table 2.4, 11 were criminal patients. This highlights the differences between authorities' perceptions of 'dangerousness' of male and female mental defectives. While there was an actual physical threat in the cases of a number of criminal defectives, the threat that defective women posed through the possibility of reproducing and bearing a defective child, who would be a further burden upon New Zealand society, was considered far more dangerous, and could have a longer lasting effect.

Table 4.2 Criminal defectives: Outcomes, 1912-1935 (number and percentage of total sample)

	Number	***%***
Died	12	11
Discharged	11	10
Transferred	2	2
Escaped	4	4

(Source: YCBG 5904 patient files, 1912-1935)

[15] *AJHR*, 1933, H-7, p. 6.

Female control patients who were given probation found employment after discharge from Tokanui, but their number was much smaller than males who were discharged.

The following sections discuss and analyse the patient cases that fell into the category 'criminal'. There were different 'types' of criminals admitted to Tokanui for distinct reasons, (as well as control). Some low grade defectives, for example, required a therapeutic environment to provide the attention unavailable in a prison. Analysis of individual cases illustrates how mental hospitals, police, prisons, and other institutions, perceived a relationship between criminality and mental defect.

Imbecile 'criminals'

William C. was committed to Mount View in 1894, and transferred to Tokanui in 1912, where he remained until his death in 1945 at age 81.[16] He had been arrested and then committed to Mount View, and although an offence was not noted in William's file: 'Constable Collerton reports that he had been called to see him on account of his wandering about the hills around Castlepoint with fern fronds and ti-trees tied around his legs, a piece of red blanket dangling outside his coat and he had been out three or four nights'.[17] An imbecile, William had worked in the flower garden and orchard at Mount View and subsequently with the carpenters for much of his time at Tokanui.[18] John S., also an imbecile, was sentenced to three months hard labour in Auckland prison for being idle and disorderly. He had previously been imprisoned four times for vagrancy, and after John apparently threatened the prison warders, he was finally committed to Avondale in 1894.[19] His medical certificate noted he had likely been an imbecile since birth, which prison authorities must have known given his previous imprisonment. It seems that when it became clear that John would continue to offend, although in a minor way, a more permanent way of segregating him from society was needed, resulting in his committal to a mental hospital. He was transferred to Tokanui in 1925, and died in 1939. His total stay

[16] YCBG 5904/1/11, patient file.
[17] YCBG 5939/11, Case Book, Tokanui Mental Hospital.
[18] YCBG 5904/1/11, patient case notes.
[19] YCBG 5904/15/469, medical certificate, 10 April 1894.

in both mental hospitals was 45 years. Other imbecile 'criminals' included James L. who spent seven years in Auckland, then another 36 years in Tokanui; Thomas M., a mental hospital patient for 39 years, first at Porirua, then at Tokanui; and John W. who endured a stay of 33 years.[20] Authorities considered the long term segregation of these men prudent, as they typically had no family to assume responsibility for their care.

Dangerous defectives

Some male patients were considered sexual threats to women, men, or children. In certain cases, this seems to have been alarmist rather than justified or based on the patient's behaviour prior to committal or in an institution. Mental hospitals were well aware of the difficulties posed by patients whose 'abnormal proclivities' (one of the phrases used to describe sexual activities and interests) meant they were a danger to other patients, staff and the public if they were to be released.[21] The pressure on mental hospitals caused by providing custodial care for these patients was to the detriment of other patients, and dangerous patients would be better provided for in a separate institution according to some mental hospital doctors.[22] As Len's case discussed at the beginning of the chapter showed, 'uncontrollable' sexuality was one reason for committal to Tokanui. Anxieties over male cross-dressing and homosexuality were clear in several cases discussed below.

A small number of these dangerous young men were patients at Tokanui. Feeble-minded Arnold D., was nineteen-years old when he was transferred from Porirua in 1925, was considered by staff at both hospitals to be one of the more dangerous patients they had seen. His behaviour at Weraroa, where he lived for three years before committal to Porirua, meant that he was 'a positive danger through his sexual tendencies'.[23] The manager of Weraroa stated that during Arnold's time there, he 'had to be kept under strict surveillance on account of his sexual proclivities. … He cannot control himself and truly admits it. If

[20] YCBG 5904/6/225, patient file; YCBG 5904/1/26, patient file; YCBG 5904/14/437, patient file.
[21] *AJHR*, 1931, H-7, p. 3.
[22] *AJHR*, 1931, H-7, p. 3.
[23] YCBG 5904/14/445, application for a reception order, 9 June 1924.

allowed about without supervision he would be a great menace to the public'.[24] Arnold's medical certificates expand on this, recording that, '[h]e admits interfering with animals and also was a willing participant in the act of sodomy'.[25] Moreover, '[b]esides being a sexual degenerate … he periodically gives way to violent fits of temper and has on occasions injured boys [at Weraroa]'.[26] Although categorised as feeble-minded, he was more fittingly described as a 'moral imbecile' by Dr MacPherson, then Superintendent of Tokanui, and staff at Porirua.[27] He was even more dangerous because of his escape attempts: 'He has escaped twice since his admission to Tokanui, and also from Porirua Mental Hospital on two occasions, and, as there is no refractory yard, nor indeed a refractory ward, in this institution, we cannot safely hold him here'.[28] After the first escape attempt, Dr MacPherson wrote to the Inspector-General requesting Arnold's transfer to a more secure institution:

> He informed the police that he would again escape, and says so still. Of course I will not let him again be sent out to work, but I am convinced that, sooner or later, he will escape from the building. He is strong, cunning, and determined and our building is not sufficiently secure to hold him. He has already been trying to tamper with the shutter in his room, and has been found in possession of wire, nails, &c. … What I dread is that, if he again escaped, and had his liberty for a day or two, he would if opportunity offered, assault, sexually, women or children. Is it possible to have him removed to a more strongly built institution? If that is not practicable, all I can do is put a special attendant to keep him under surveillance continually.[29]

Arnold was transferred to Avondale Mental Hospital a few weeks later. Concerns about Arnold coincided with the report of the 1924 Committee. The heightened fears during this time over mental defectives and sexual offenders are evident in the language MacPherson used to describe Arnold. He had proved to be 'sexually dangerous' to other young men, and, although there was no evidence of assaults or approaches to women and children, he was considered a

[24] YCBG 5904/14/445, application for a reception order, 9 June 1924.
[25] YCBG 5904/14/445, medical certificate, 9 June 1924.
[26] YCBG 5904/14/445, medical certificate, 9 June 1924; medical certificate [no date].
[27] YCBG 5904/14/445, medical certificate, 9 June 1924; J. MacPherson, Tokanui Mental Hospital, to Inspector-General, Mental Hospitals, Wellington, 21 August 1925; memo, Porirua Mental Hospital, to Tokanui Mental Hospital, [no date].
[28] YCBG 5904/14/445, J. MacPherson, Tokanui Mental Hospital, to medical superintendent, Auckland Mental Hospital, 9 September 1925.
[29] YCBG 5904/14/445, Dr J. MacPherson, Tokanui Mental Hospital, to Inspector-General, Mental Hospital, Wellington, 31 August 1925.

danger to them as well. Arnold's committal to a mental hospital was not because of mental illness or impairment, but because of his 'uncontrollable' sexual behaviour. As he proved increasingly difficult to control, he was moved on to what were though to be more secure institutions.

There were similar fears about Frederick B., who was transferred to Tokanui from Waikeria in 1935. Frederick had been sentenced to seven years' reformative detention for the indecent assault of a ten-year old girl.[30] He had been a patient at Porirua in 1927 after he had been in 'similar trouble with another girl of 10 years'.[31] While at Porirua a doctor spoke with his parents, who were 'anxious to have him out. Showed them recent letter on file [in the letter Frederick denied his crime, and suggested that others were responsible] Were not so keen after that'.[32] Doctors regarded him as particularly dangerous, as Frederick did not 'realise the full significance' of what he considered to be an 'innocent incident'.[33]

Francis C., seventeen-years old and apparently feeble-minded, was transferred to Tokanui from Porirua in September 1921. He had been committed to Porirua from Weraroa Training Farm three months earlier. While an inmate at Weraroa for the previous four years '[t]his lad has been addicted to self abuse … has been guilty of sodomy and attempted sodomy.'[34] Despite the Farm manager's attempts to 'cure' him, he committed Francis because he 'is a menace to the welfare of the institution and is not fit to be placed out anywhere'.[35] At Tokanui, Francis was polite, well behaved, and 'seems willing to make himself useful'.[36] After he 'persisted in speaking to children on the public road', Francis was moved from gardening work to ward work, where he stole a war medal from an attendant's room.[37] Francis was discharged 'recovered' from Tokanui in November 1926, as he 'was not a suitable case for detention in a Mental Hospital. He was at no time insane unless moral degeneracy should be looked

[30] YCBG 5904/56/1378 , [writer unknown], Tokanui Mental Hospital, to probation officer, Magistrates Court, New Plymouth, 25 May 1959.
[31] YCBG 5904/56/1378, [writer unknown], Tokanui Mental Hospital, to probation officer, Magistrates Court, New Plymouth, 25 May 1959.
[32] YCBG 5904/56/1378, patient case notes, 5 May 1928.
[33] YCBG 5904/56/1378 , [writer unknown], Tokanui Mental Hospital, to probation officer, Magistrates Court, New Plymouth, 25 May 1959.
[34] YCBG 5904/9/306, application for a reception order, 21 June 1921.
[35] YCBG 5904/9/306, application for a reception order, 21 June 1921.
[36] YCBG 5904/9/306, patient case notes, 1 October 1921.
[37] YCBG 5904/9/306, patient case notes, 21 January 1923; 21 July 1923.

on as insanity.'[38] In August 1927, Francis was found guilty on 'two charges of grave offences against boys and one of indecent assault'.[39] As Francis was not mentally defective or ill, the only sentence that could be passed was two years hard labour, after which he would be 'detained for reformative purposes for a period not exceeding three years'.[40] In this case, the patient's offending was known when he was committed to Porirua, and the hospital staff was aware that Francis was likely to re-offend upon his release from Tokanui. Indeed, the only reason Francis was committed originally was because he posed a threat to the other inmates at Weraroa, and was 'unsafe to be at large'.[41] In circumstances similar to Arnold's case, Francis was transferred to Tokanui in the hope of curbing his behaviour, but there was little the hospital could do.

Malcolm B. was transferred to Tokanui from Waikeria Borstal in September 1935. He had been detained at Waikeria since March that year after receiving a two year sentence for committing incest. However, it was clear that Malcolm, an imbecile, was not suited to the borstal environment and was transferred to Tokanui. Mr D. Dunlop, Superintendent of Waikeria, said in one medical certificate that Malcolm was 'simple in manner & behaviour', while his second medical certificate stated that, '[h]e has appearance of mental degenerate his cerebrations are very slow – is unable to read & can write very little'. [42] Malcolm had obviously experienced difficulties adjusting to the borstal environment, for Dr Corban later commented, '[h]e has settled down into the routine & now says he would sooner be here than at Waikeria, because is getting used to it, though he would sooner be at home'.[43] Malcolm proved to be a capable worker at Tokanui in the boiler room, and as fireman in the Nurses Home.[44] Overall Malcolm was described as 'a useful and fairly trustworthy worker, but who is emotionally unstable, easily depressed, and quite unable to

[38] YCBG 5904/9/306, Dr J. MacPherson, Tokanui Mental Hospital to the Inspector-General, Mental Hospital, Wellington, 23 August 1927.
[39] YCBG 5904/9/306, *New Zealand Herald, (NZH),* 9 August 1927, [clipping in patient's file].
[40] YCBG 5904/9/306, *NZH,* 9 August 1927, [clipping].
[41] YCBG 5904/9/306, application for a reception order, 21 June 1921.
[42] YCBG 5904/57/1409, medical certificate, 17 September 1935; medical certificate, 14 September 1935.
[43] YCBG 5904/57/1409, patient case notes, 16 October 1935.
[44] YCBG 5904/57/1409, patient case notes, 9 October 1935; 28 December 1935; 25 March 1938; 25 September 1938.

assume any responsibility'.[45] Despite Malcolm's crime, his status as an imbecile, and an able worker, seemed to prove to Tokanui that he not so dangerous. Indeed, other than the reason for his sentence at Waikeria, Malcolm was not classified as a sexual danger.

'Reformable' young defectives

The criminal patients that were most likely to receive probation and discharge were those with the greatest prospect of reform, young high grade defectives. Typically, these males were committed due an isolated event, rather than a series of incidents. Leopold H.'s case was, in some respects, similar to that of Malcolm. In May 1927 Leopold H. was committed to Tokanui at the age of 18. An imbecile since birth, according to evidence from his father, Leopold had made little progress at school. He could not 'add simple numbers beyond 1 and 1 are 2. Can spell "cat", but not "at" or "ox". Doesn't know his age'.[46] Leopold was committed due to concerns about his behaviour, and because he 'could not be kept under control. His father also says the patient does not appear to understand right from wrong, and that he is afraid his son might tamper with little girls'.[47] These concerns seemed to stem from Leopold's habit of wandering around the countryside during the day, and 'peering in at neighbours windows', which 'Frightens the neighbours & [he] is only got back home with difficulty'.[48] However, once at Tokanui, Leopold 'settled down in his new environment, is cheerful, ready with speech, & expresses a desire to go out working on the farm'.[49] Indeed, throughout his six month stay Leopold was 'well behaved', and employed usefully on the hospital farm, although doctors noted that little mental improvement could be expected.[50] Leopold's father, according to case notes written in August, was willing to have his son remain at Tokanui for some time: 'Father states that the boy was quite useful at home and careful about his work, but had arrived at an age where he might commit a moral offence, hence the

[45] YCBG 5904/57/1409, patient case notes, 25 September 1937.
[46] YCBG 5904/19/596, preliminary statement as to mental and bodily condition, 31 May 1927.
[47] YCBG 5904/19/596, preliminary statement as to mental and bodily condition, 31 May 1927.
[48] YCBG 5904/19/596, medical certificate, 31 May 1927; medical certificate, 31 May 1927.
[49] YCBG 5904/19/596, patient case notes, 7 June 1927.
[50] YCBG 5904/19/596, patient case notes, 14 June 1927; 10 August 1927.

steps taken'.[51] But just a short time later, in early November 1927, Leopold was released on probation 'at the request of his father'.[52] At the end of the initial six month probation period, Leopold's father wrote to Dr Childs, Tokanui's Medical Superintendent, requesting that Leopold's probation be extended a further twelve months as 'my son has not been as bad since he came home & so far has not given us any trouble'.[53] Permission was given for extended probation and Leopold was formally discharged from Tokanui in May 1929.

Leopold's father's anxieties about his son's possible sexual offending seemed to be prompted by neighbours' fears, but Leopold had committed no crime, and no proof was presented that he had expressed any interest in young girls. Tokanui doctors did not consider Leopold as a potential threat either. When it became clear after Leopold returned to his family that he posed little danger, and his father realised his fears were unfounded, Leopold was discharged from Tokanui. It is also likely that Leopold's contribution to the family farm was missed while at Tokanui, since both his father and Tokanui staff considered him to be an able, productive worker.

In 1935 the Annual Report of the Mental Hospitals Department commented that the social defectives were among the 'dangerous and difficult cases … which is being increasingly recognized in all countries, largely through the extended facilities now provided for the psychiatric examination of criminals and juvenile delinquents.'[54] Social defective Norman B., 16-years old, had been an inmate of the Auckland Probation Home, Weraroa Farm, and Otekaieke School since he had been boarded out from his neglectful family at age nine.[55] The reasons for his committal, given in his medical certificate, were not strong.[56] He was committed to Porirua in January 1934, then escaped, and made his way to Cambridge, where he was employed on a farm for two months. His employer thought Norman a capable worker, and although he was an escapee, firmly believed that 'He will make good if given a chance', and 'I'll pay him a

[51] YCBG 5904/19/596, patient case note, 10 August 1927.
[52] YCBG 5904/19/596, patient case notes, 9 November 1927.
[53] YCBG 5904/19/596, [patient's father], Matamata, to Dr T.W.G. Childs, Acting Medical Superintendent, Tokanui Mental Hospital, 30 April 1928.
[54] *AJHR*, 1935, H-7, p. 2.
[55] YCBG 5904/55/1338, preliminary statement as to mental and bodily condition, 26 January 1926.
[56] YCBG 5904/55/1338, medical certificate, 24 January 1934.

good wage and also watch his movements closely'.[57] Porirua's Medical Superintendent was willing to arrange for Norman's probation, but this did not happen.[58] Instead, Norman was returned to Tokanui in October, and escaped twice more within the space of a few months, the second time managing to find work.[59] The staff at Tokanui was aware of his intention to attempt to run away again, and in September 1936 Norman successfully escaped. When he was not found three months later, Norman was discharged under section 79 (3) as an unrecovered escapee. He was arrested again some years later, but his crime is unknown.[60] Norman was committed because of his criminal tendencies and 'asocial' behaviour. The Weraroa manager considered him a danger to society, and although Norman stole while he was an escapee, he also found employment and proved to be a good worker. Unlike the criteria for other mental defectives, the social defective's anti-social behaviour was the main reason for their committal.

Frank W., a feeble-minded young man, was admitted to Tokanui in 1931 after being discharged on probation from Porirua. Frank, a fourteen-year old boarder at New Plymouth Boys' High School, had stolen a revolver and a high-power air rifle and ammunition, locked himself in a shed on the school grounds, fired a few shots, and refused to come out.[61] The police were called and Frank was arrested, and committed to Porirua in December 1928. His medical certificates include testimony of Frank's mental deficiency provided by his doctor, a teacher, and his uncle. His doctor wrote that he had seen Frank several times during the year and that he had 'always regarded him as of low mentality and very taciturn'. Frank's teacher regarded him as 'deficient mentally', and Frank's uncle stated that 'the boy has never been normal since his birth and has always been fascinated by guns and other weapons'.[62] Frank's stay at Porirua was only six months before he was given probation. However, in October 1931 he was taken to Tokanui by his mother after he had stolen a revolver with the

[57] YCBG 5904/55/1338, J.C. Hanna, Cambridge, to Medical Superintendent, Tokanui Mental Hospital, 1 October 1934. Emphasis in original.
[58] YCBG 5904/55/1338, Dr J. Williams, Medical Superintendent, Porirua Mental Hospital, to Medical Superintendent, Tokanui Mental Hospital, 3 October 1934.
[59] YCBG 5904/55/1338, patient case notes, 13 February 1935.
[60] YCBG 5904/55/1338, Dr H.M. Buchanan, c/o Regional Probation Officer, Auckland to Medical Superintendent, Tokanui Mental Hospital, 19 January 1953.
[61] YCBG 5904/39/1070, application for a reception order, 2 December 1928.
[62] YCBG 5904/39/1070, medical certificate, 2 December 1928.

intention of selling it: 'He denies any suggestion of dangerous intentions, but seems to realise he is guilty of something fairly serious'.[63] Frank's attraction for firearms was the reason for his committal, clearly a cause for serious concern to all those around him. However his case notes describe him as well behaved, and a good worker, with 'a wide knowledge of engines etc – reads with avidity copies of "Popular Mechanics"'.[64] Since Frank had also passed the sixth standard at school, he could not have lacked mental ability, despite the evidence which was provided in support of his committal. It seems he wanted to put the school incident behind him. When asked about guns by Corban, 'he was disinclined to discuss it – said he wants to get those things out of his mind – "that's what I'm here for"'.[65] It seems that Frank's interest in guns, which might be called typical behaviour for teenage boys, combined with his withdrawn personality, made him a dangerous figure in the eyes of police. Locking himself in the school shed seemed to be an isolated incident. Once institutionalised he gradually appreciated the consequences and wanted to move on from the experience. Frank was given probation under control of his mother in 1932, and was discharged in 1933.

Staff aimed to treat most of the criminal patients in Tokanui to the point where they could be returned to society. Probation to the care of their families, or an employer, was granted if the hospital could be assured that the defective would be kept under proper control. For example, Ted H. was committed to Tokanui in November 1929, aged 25. This feeble-minded young man was considered by Tokanui staff to be 'cunning and apparently a bit of a schemer', and as a result he received 'surveillance' while in Tokanui. [66] Ted's history was unclear, as he 'does not seem able to give a clear account of his past' and his 'statements are apt to be contradictory'.[67] Ted's file gives two different last names because he 'cannot state definitely' which was correct.[68] However, staff made inquiries to Porirua as '[h]e is believed to have been in Porirua under

[63] YCBG 5904/39/1070, patient case notes, 25 October 1931.
[64] YCBG 5904/39/1070, patient case notes, 25 May 1932.
[65] YCBG 5904/39/1070, patient case notes, 25 November 1931.
[66] YCBG 5904/39/1070, patient case notes, 3 December 1929.
[67] YCBG 5904/28/825, patient case notes, 26 January 1930; preliminary statement as to mental and bodily condition, 26 November 1929.
[68] YCBG 5904/28/825, preliminary statement as to mental and bodily condition, 26 November 1929.

[another name]'.[69] Porirua staff remembered him as John R. When he was asked why he had 'forgotten' his name, he replied, '"I don't know – I generally lose my head sometimes"'.[70] As a result, Ted's classification and prognosis changed. Although originally thought to be a potential moral imbecile, by May 1931 it was noted that '[h]is mental processes are now more normal & he can give a fairly good account of his past history … He may be regarded as a high grade feeble-minded person'.[71] It became clearer to doctors that there would be no further improvement in Ted's mental condition, and Tokanui staff encouraged Ted to leave the hospital over the next several months. Initially unwilling, one morning it was discovered that Ted had left Tokanui during the night. No attempt was made to find Ted as staff considered he was suitable for discharge.

Regardless of the progress they made while at Tokanui, some patients were not discharged, either because of doctor's opinions, or those of government departments. Emas D. was transferred to the control of Tokanui from Waikeria in January 1925. A 33-year old imbecile, Emas was admitted after he became angry and threw his lunch bag at another prisoner. 'When asked why … [he] replied that some of the men had been teasing him'.[72] This seemed a minor incident, but to prison staff it proved his mental deficiency. Initially highly emotional and prone to outbursts of temper, Emas settled into Tokanui easily, gave no trouble, and was well behaved. He was employed in the kitchen, then the fowl yard, and received full parole.[73] In September 1925 Dr MacPherson, Medical Superintendent, wrote to the Inspector-General recommending that Emas be released on probation to the care of his brother-in-law, and outlined his 'exemplary' conduct while at Tokanui. MacPherson argued strongly for Emas' release, saying:

> I think it should be borne in mind that he made his living till he was 33 years of age without giving any offence, and that the offence for which he was sentenced (indecent exposure) was committed on his own premises and not in a public place. He states that he was merely urinating and had no intention of exposing himself. … I think it would be unduly cruel to send him back to prison. He is a simple, emotional creature, and responds quickly to

[69] YCBG 5904/28/825, patient case notes, 26 January 1930.
[70] YCBG 5904/28/825, patient case notes, 26 August 1930.
[71] YCBG 5904/28/825, patient case notes, 26 May 1931.
[72] YCBG 5904/13/407, medical certificate, 16 December 1924.
[73] YCBG 5904/13/407, patient case notes, 27 July 1925.

> kindly treatment, and the restraint of prison routine would, in time, I am sure cause a complete mental breakdown.[74]

Emas was certified as no longer requiring care in an institution, but the Mental Hospitals Department could not give him his discharge 'as he is a sentenced prisoner and as such can only be released by the Prisons Board', and his sentence would not be complete until May 1928. [75] After his release from Tokanui, therefore, he was transferred to Auckland Prison. There is no further information on what happened to Emas after his transfer. Emas was a high grade mental defective, who had attended school, and could read only a little, but he had been able to earn his own living.[76] It is possible, given the contemporary debates and anxieties surrounding mental deficiency, that Emas' arrest, conviction, and imprisonment was a result of overreaction to a minor incident. Despite his apparent mental deficiency, it seems unlikely he would have been committed to a mental hospital if it were not for his arrest and imprisonment.

Of the 30 criminal patients in the sample taken for this research, 13 or just under half died while in Tokanui. These men tended to be older, long stay patients. Eleven males, or 36 per cent, were discharged, usually after stays of less than ten years. These patients were typically young men and most were discharged to the care of their family. Two patients were transferred to another mental hospital, Richard B., after he complained a number of times to the staff at Tokanui, and wrote letters to the Mental Hospitals Department about his dislike of Tokanui.[77] Arnold D., whose case was discussed earlier, was transferred to a more secure institution. Escapes, successful and unsuccessful, were not uncommon for this group of patients. Eight male patients tried to escape, but were recaptured, usually fairly quickly, and four defectives escaped successfully.

Escape required some forethought and planning; those who were successful typically were under surveillance, yet were able to elude capture, despite efforts by Tokanui and police to recapture them. For three of the

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[74] YCBG 5904/13/407, Dr J. MacPherson, Medical Superintendent, Tokanui Mental Hospital, to the Inspector-General, Mental Hospitals Department, Wellington, 26 September 1925.
[75] YCBG 5904/13/407, Inspector-General's Office, Mental Hospitals Department, Wellington, to the Medical Superintendent, Tokanui Mental Hospital, 9 November 1925.
[76] YCBG 5904/13/407, admission notes, 15 January 1925.
[77] YCBG 5904/4/164, patient file.

successful escapees, this suggests there was no need for their institutionalisation. As they were not returned to Tokanui, or another institution, this demonstrated that despite the diagnosis of the authorities, they were capable of making their own way in the world. Continued escape attempts indicated how unhappy patients were to be institutionalised. Often they felt they were able to support themselves independently of the institution, and in some cases this was true.

Conclusion

The association between mental deficiency and criminality had been established internationally about forty years before Tokanui and Waikeria were built in the Waikato. The proximity of these New Zealand institutions strengthened the correlation between crime and defectives made by authorities during the early-twentieth century. The patient cases analysed in this chapter show that for some of the Tokanui patients designated as criminals, there seemed to be justification for their continued segregation. Usually, these patients were violent or sexual offenders. However, there were men whose committal to Tokanui seemed unnecessary and, perhaps, were based more on assumptions about mental defectives, rather than the careful assessment of individual circumstances. In this respect, these men are similar to the female patients discussed in Chapter Four. However, unlike those female patients, these men did not have the same level of care or control available to them outside Tokanui. Despite the danger that all mental defectives were thought to pose to New Zealand society, male defectives were not subject to the same concerns as female defectives. Therefore, gender and the role of families in providing care, control, or supervision was significant for defectives, and whether or not they were committed to an institution such as Tokanui.

Conclusion

Tokanui Mental Hospital housed a small mental defective population during the period 1912 to 1935. In this period, legislation and policy created in New Zealand increased State control of defectives through segregation in mental hospitals. This thesis has explored an under examined topic, mental deficiency, using gender and social control as theoretical approaches. It has argued that gender was a major factor in the committal of mental defectives, and also determined the length of their stay. Specific categorisation was just as important; so-called lower grades, idiots and imbeciles, were classified within Tokanui as care patients who benefited from the protective environment of the mental hospital. However, high grades, the feeble-minded and social defectives, were segregated simply to ensure their behaviour could be controlled and that New Zealand society would remain protected.

Discourses surrounding mental deficiency during the early-twentieth century have been explored through official sources. Policies of the Mental Hospitals Department in particular have been examined. These have shown that New Zealand, although among the first countries to recognise and legislate for mental deficiency, followed the example of other countries, mainly Britain, in the classification system introduced and expanding segregation.

As Chapter One showed, a number of policies were considered in New Zealand between 1911 and 1935. Although some proponents argued for more radical steps, segregation of mental defectives in mental hospitals, like Tokanui, remained the policy for New Zealand throughout the twentieth century, until the process of deinstitutionalisation began in the 1980s. Legislation and policy introduced in New Zealand during the early twentieth century had a significant impact on those categorised as mental defectives and the operation of mental hospitals. Tokanui's response to legislation was influenced by the gender, age, category, year of admission, and circumstances surrounding committal of the patients.

Chapter Two argued that Tokanui's status as a new mental hospital limited its implementation of some aspects of the new legislative categories. However, between 1925 and 1935, Tokanui had firmly established unique institutional practices. This chapter showed that gender and categorisation were also important elements in determining what patients' lives were like inside Tokanui. Families had a central role in the committal, especially of female defectives, in contrast to male defectives who had often lost contact with family. Committal was not always an easy decision for families to make. Cases discussed throughout the thesis have revealed parents' wishes to place their child into a more therapeutic environment, where they could receive appropriate attention, or an increasingly difficult relationship between the defective and their family members. The evidence provided by families during the certification process was also significant, when the diagnostic criteria and medical knowledge of mental deficiency in New Zealand was still uncertain.

Chapters Three and Four have argued through detailed readings of cases that mentally defective patients at Tokanui were committed to provide either care or control. The methods of, and reasons for, control differed between females and males. According to contemporary theories of heredity, female defectives were thought to be responsible for the transmission of mental deficiency, and were therefore more likely to be institutionalised for longer periods than males. Despite the danger posed by these young men, they were more likely to be discharged. This group also generally had little contact with their families, who would normally be responsible for them, which sometimes increased the perception of 'dangerousness', and concern that no one was responsible for providing care or control. These men had been committed by someone who was concerned about their behaviour, or their potential behaviour, and felt that they needed to be under control. The neighbouring institutions of Tokanui and Waikeria strengthened the association between crime and defectives made by New Zealand authorities during the early-twentieth century. The threats that mental defectives posed to New Zealand society, either through reproduction, violence, or crime, warranted their segregation.

Legislation changed from the mid-twentieth century. The *Mental Health Amendment Act* (1954) replaced mental defective with 'intellectually handicapped person'.[1] In 1969, the legal category was again changed to 'mentally subnormal', which specified mental development as the major criteria of intellectual disability rather than the vague definitions given to idiot, imbecile, feeble-minded and social defective.[2] Tokanui was finally closed in 1998 after the process of deinstitutionalisation, which began in 1989.[3] The services available to the intellectually disabled, and their families, increased in the latter half of the twentieth century. For example, the Levin Training Farm and Colony opened in 1945 after years of lobbying by parents of intellectually disabled children, for an institution specifically for children to be established in the North Island. The Intellectually Handicapped Children's Parent's Association, later the IHC, was set up in 1949 by Wellington parents of defective children, and it later became a national organisation.[4] Families continued to be important in provision of care, control, supervision and treatment of the intellectually disabled in New Zealand beyond 1935. This thesis has shown how important families, together with fears over gender and sexuality, were in the experiences of intellectually disabled patients at Tokanui during the early-twentieth century. In addition, the development of doctors' knowledge contributed changing attitudes towards intellectual disability throughout the twentieth century.

There is potential for other histories of Tokanui. This thesis has focused on mentally deficient patients during the early years of Tokanui's operation, when the majority of patients were psychiatric patients. Currently there has been no study, or analysis, of the psychiatric patients admitted to Tokanui during the first half of the twentieth century. Race has not been discussed here, although there is scope for this to be included in other studies. The number of Māori psychiatric and intellectually disabled patients at Tokanui increased from the mid-twentieth century. There have been few histories of intellectual disability in New Zealand, other than the works by

[1] *Statutes,* 1954, No. 66, Mental Health Amendment Act, sec. 3.
[2] *Statutes,* 1969, No. 16, Mental Health Act, sec. 2.
[3] Midland Health, pp. 2-3.
[4] Millen, pp. 13-16.

Robertson, Bardsley, and the institutional histories discussed in this thesis. The connection between Tokanui and Waikeria could also be explored in much greater depth. This thesis contributes to the emerging field of disability history in New Zealand, as well as histories of the asylum and its patients in New Zealand.

Bibliography

1. Primary sources:

Unpublished:

Archives New Zealand/Te Rua Mahara o te Kawanatanga, Auckland Regional Office

YCBG series	Tokanui Mental Hospital Files
5904/1 – 1430	Tokanui Patient Files, 1912-1935
5908	Tokanui Registers of Voluntary Boarders/Voluntary Inpatients, 1920-1969
5922	Tokanui Registers of Mechanical Restraint and Seclusion, 1926-1969
5929	Tokanui Administration Files
5930	Tokanui Registers of Admissions, Male and Female, 1912-1969
5932	Photographs of Tokanui, 1912-1960
5933	Tokanui Registers of Discharge and Transfers, 1920-1969
5934	Tokanui Registers of Patients on Leave, 1930-1969
5939	Tokanui Case Book, 1912-1920

Tokanui Official Visitors Report Book, 1912-1935, Te Awamutu Museum

Published:

A: Official publications:

Appendices to the Journals of the House of Representatives, 1910-1936
New Zealand Parliamentary Debates, 1911-1935
New Zealand Official Yearbook, 1925
New Zealand Statutes, 1846, 1868, 1873, 1882, 1907, 1908, 1911, 1928

B: Newspapers:

The Waipa Post, 1917-1935

C: Periodicals:

New Zealand Medical Journal, 1921-1936

D: Contemporary books and pamphlets:

Chapple, W.A., *The Fertility of the Unfit* (Christchurch: Whitcombe & Tombs, 1903)

Corban, Corban Assid, 'Reflections on Occupational Therapy in Mental Treatment, parts I and II', *New Zealand Medical Journal,* 31, 1932, pp. 191-198; 31, 163, 1932, pp. 334-340

Drydale J., 'The Tokanui Mental Hospital Estate: King Country Development' *New Zealand Journal of Agriculture,* 18, 1, 1919, pp. 34-37

Kayll, J.L.A., *A Plea for The Criminal: Being a reply to Dr. Chapple's work: "The Fertility of the Unfit" and an attempt to explain the leading principles of criminological & reformatory science* (Invercargill: W. Smith, 1905)

MacPherson, James, 'A Plea for the Early Recognition and Treatment of Mental Disorders, with Some Reflections on Their Heredity', *New Zealand Medical Journal,* 20, 98, 1921, pp. 239-245

Mander, A.E., *To alarm New Zealand* (Wellington: L.T. Watkins, 1936)

Terman, Lewis, M., *The measurement of intelligence: An explanation of and a complete guide for the use of the Stanford Revision and extension of the Binet-Simon intelligence scale* (London: George G. Harrap & Co., 1919)

Secondary sources:

Books:

Andrews, Jonathan and Anne Digby, eds, *Sex and Seclusion, Class and Custody: Perspectives on Gender and Class in the History of British and Irish Psychiatry* (Amsterdam & New York: Rodopi, 2004)

Aspden, P.G., *75 years service: a review of Campbell Park School, 1908-1983* (Oamaru: P.G. Aspden, 1983)

Baird, Bob, ed, *Lake Alice 40 years* (Wanganui: Community Health Services, Manawatu-Wanganui Area Health Board, 1990)

Ballard, Keith, ed, *Disability, Family, Whanau and Society* (Palmerston North: The Dunmore Press Ltd, 1994)

Bartlett, Peter and David Wright, eds, *Outside the Walls of the Asylum: The History of Care in the Community 1750-2000* (London: The Athlone Press, 1999)

Brookes, Barbara, Charlotte MacDonald and Margaret Tennant, eds, *Women in History 2* (Wellington: Bridget Williams, 1992)

Brookes, Barbara and Jane Thomson, eds, *'Unfortunate Folk': Essays on Mental Health Treatment, 1863-1992* (Dunedin: University of Otago Press, 2001)

Brunton, Warwick, *Sitivation 125: A History of Seaview Hospital, Hokitika and West Coast Mental Health Services, 1872-1997* (Hokitika: Seaview Hospital 125th Jubilee Committee, 1997)

Bryder, Linda and Derek A. Dow, eds, *New Countries and Old Medicine: Proceedings of An International Conference on the History of Medicine and Health* (Auckland: The Auckland Medical Historical Society, 1995)

Bynum, W.F., Roy Porter and Michael Shepherd, eds, *The Anatomy of Madness: Essays in the History of Psychiatry, Vol. III* (London: Routledge, 1988)

Catran. Ken and Penny Hansen, *Pioneering a vision: a history of the Royal New Zealand Foundation for the Blind, 1890-1990* (Auckland: RNZFB, 1992)

Clark, Michael and Catherine Crawford, eds, *Legal Medicine in History* (Cambridge: Cambridge University Press, 1994)

Coleborne, Catharine and Dolly MacKinnon, eds, *'Madness' in Australia: Histories, heritage and the asylum* (St Lucia: University of Queensland Press, 2003)

Dale, Pamela and Joseph Melling, eds, *Mental Illness and Learning Disability Since 1850: Finding a place for mental disorder in the United Kingdom* (London: Routledge, 2006)

Dalley, Bronwyn, *Family Matters: Child Welfare in Twentieth Century New Zealand* (Auckland: Auckland University Press, 1998)

Dalley, Bronwyn and Margaret Tennant, eds, *Past Judgement: Social Policy in New Zealand* (Dunedin: University of Otago Press, 2004)

Dugdale, Pat, *Talking hands, listening eyes: the history of the Deaf Association of New Zealand* (Auckland: Deaf Association of New Zealand, 2001)

Finnane, Mark, *Punishment in Australian Society* (Melbourne: Oxford University Press, 1997)

Garton, Stephen, *Medicine and Madness: A Social History of Insanity in New South Wales, 1880-1940* (Kensington: New South Wales Press, 1988)

Godfrey, Barry and Graeme Dunstall, eds, *Crime and Empire 1840-1940: Criminal justice in local and global context* (Devon: William Publishing, 2005)

Health, History and Culture Group, *Body Language: Framing Subjects of Medical Knowledge* (Hamilton: History Department, University of Waikato, 2004)

Hetherington, Penelope and Philippa Maddern, eds, *Sexuality and Gender in History: Selected Essays* (Nedlands, W.A.: P. Hetherington and P. Maddern, 1993)

Hubert, Jane, ed, *Madness, Disability and Social Exclusion: The archaeology and anthropology of 'difference'* (London: Routledge, 2000)

Hunt, Anne, *The Lost Years: From Levin Mental Deficiency Colony to Kimberley Centre* (Christchurch: Anne Hunt, 2003)

Jackson, Mark, *The borderland of imbecility: Medicine, society and the fabrication of the feeble mind in late Victorian and Edwardian England* (Manchester: Manchester University Press, 2000)

Kingseat Hospital, 50 years, 1932-1982 (Papakura: Kingseat Jubilee Editorial Committee, 1981)

Long, Jane, Jan Gothard and Helen Brash, eds, *Forging Identities: Bodies, gender and feminist history* (Nedlands, W.A.: University of Western Australia Press, 1997)

Mangere Hospital and Training School, 25 years, 1963-1988 (Auckland: The School, 1989)

McLaren, Roger, ed, *A History of Tokanui Hospital Te Awamutu, 1912-1997* (Te Awamutu: Tokanui Hospital, 1997)

Midland Health, *From institution to independence: The movement of people with an intellectual disability from Tokanui Hospital into the community* (Hamilton: Midland Health, 1996)

Millen, Julia, *Breaking Barriers: IHC's first 50 years* (Wellington: IHC New Zealand Inc., 1999)

Mitchell, David and Nirbhay Singh, eds, *Exceptional Children in New Zealand* (Palmerston North: The Dunmore Press, 1987)

Morris, Norval and David J. Rothman, eds, *The Oxford History of the Prison: the practice of punishment in western society* (Oxford: Oxford University Press, 1995)

Newbold, Greg, *Quest for equity: a history of blindness advocacy in New Zealand* (Palmerston North: Dunmore Press, 1995)

Noll, Steven and James W. Trent, eds, *Mental Retardation in America: A Historical Reader* (New York: New York University Press, 2004)

Olssen, Mark, ed, *Mental Testing in New Zealand: Critical and Oppositional Perspectives* (Dunedin: University of Otago Press, 1988)

Pratt, John, *Punishment in a Perfect Society: The New Zealand penal system, 1840-1939* (Wellington: University of Victoria Press, 1992)

Rapley, Mark, *The Social Construction of Intellectual Disability* (Cambridge: Cambridge University Press, 2004)

Reilly, Philip R., *The Surgical Solution: A History of Involuntary Sterilization in the United States* (Baltimore: The John Hopkins University Press, 1991)

Rice, Geoffrey W., ed, *The Oxford History of New Zealand* (Auckland: Oxford University Press, 1992)

Rowbotham, Judith and Kim Stevenson, eds, *Criminal Conversations: Victorian Crimes, Social Panic and Moral Outrage* (Columbus: The Ohio State University Press, 2005)

Shephard, Brian, ed, *Fifty Years of Templeton Hospital and Training School, 1929-1979* (Christchurch: Templeton Hospital, 1979)

Stearns, Peter N., ed, *Encyclopedia of Social History,* (New York: Garland Publishing, 1994)

Taylor, Alan G., ed, *Waikeria: Memories of our school 1964-1998, and the first Waikeria School: 1921-1938 and our Community village: 1918-1998* (Eltham: Alan G. Taylor, 1998)

Thomson, Mathew, *The Problem of Mental Deficiency: Eugenics, Democracy and Social Policy in Britain, c. 1870-1959* (Oxford: Oxford University Press, 1998)

Tokanui 50th Jubilee, 1912-1960 (Tokanui: 1962)

Trent, James W., *Inventing the Feeble Mind: A History of Mental Retardation in the United States* (Berkley and Los Angeles: University of California Press, 1994)

Waikato District Health Board, *Deinstitutionalisation: Issues and Challenges for people with an Intellectual Disability discharged from Tokanui Hospital between 1996-1998* (Hamilton: Waikato District Health Board in association with the Ministry of Health, Disability Support Link and Life Unlimited, 1998)

Williams, Wendy Hunter, *Out of Sight, Out of Mind: The story of Porirua Hospital (*Porirua: Porirua Hospital, 1987)

Winterbourne, Ralph, *Educating Backward Children in New Zealand* (Wellington: New Zealand Council for Educational Research, 1944)

Wright, David and Anne Digby, eds, *From Idiocy to Mental Deficiency: Historical perspectives on people with learning disabilities* (London: Routledge, 1996)

Wright, David, *Mental Disability in Victorian England: The Earlswood Asylum, 1847-1901* (Oxford: Oxford University Press, 2001)

Wright-St Clair, Rex, ed, *Proceedings of the first New Zealand Conference on the History of New Zealand and Australian Medicine* (Hamilton: The Waikato Postgraduate Medical Society Inc., 1987)

Wright-St Clair, Rex, *Medical practitioners in New Zealand, 1840 to 1930* (Hamilton: R.E. Wright-St Clair, 2003)

Young, Dorothy, *Andy-Pandy: A mother's story of an intellectually handicapped child* (Dunedin: McIndoe, 1973)

Articles and chapters:

Atkinson, D., and J. Walmsley, 'Using autobiographical approaches with people with learning difficulties', *Disability and Society*, 14, 2, 1999, pp. 203-216

Bardsley, Sandy, 'The Otekaieke Special School for Boys, 1908-1950', in *'Unfortunate Folk'*, edited by Barbara Brookes and Jane Thomson (Dunedin: University of Otago Press, 2001), pp. 123-137

Barker, David, 'How to Curb the Fertility of the Unfit: the feeble-minded in Edwardian Britain', *Oxford Review of Education*, 9, 3, 1983, pp. 197-211

Berreen, Rosemary, 'Illegitimacy and "feeble-mindedness" in early twentieth-century New South Wales', in *Forging Identities*, edited by Jane Long, Jan Gothard and Helen Brash (Nedlands, W.A.: University of Western Australia Press, 1997), pp. 202-227

Bredberg, Elizabeth, 'Writing disability history: problems, perspectives and sources', *Disability and Society*, 14, 2, 1999, pp. 189-201

Brookes, Barbara, 'The Early Days of the Seacliff Asylum: The admission and treatment of patients', in *Proceedings of the first New Zealand Conference on the History of New Zealand and Australian Medicine*, edited by Rex Wright -St Clair (Hamilton: The Waikato Postgraduate Medical Society Inc., 1987), pp. 172-176

Brookes, Barbara, 'Women and Madness: A Case Study of the Seacliff Asylum, 1890-1920', in *Women in History 2*, edited by Barbara Brookes, Charlotte MacDonald and Margaret Tennant (Wellington: Bridget Williams, 1992), pp. 129-148

Brunton, Warwick, 'The New Zealand Lunatic Asylum: Conception and misconception', *Proceedings of the first New Zealand Conference on the History of New Zealand and Australian Medicine,* edited by Rex Wright-St Clair (Hamilton: The Waikato Postgraduate Medical Society Inc., 1987), pp. 155-171

Brunton, Warwick, 'Out of the Shadows: Some Historical Underpinnings of Mental Health Policy', in *Past Judgement,* edited by Bronwyn Dalley and Margaret Tennant (Dunedin: University of Otago Press, 2004), pp. 75-90

Carpenter, Peter K., 'Missionaries with the hopeless? Inebriety, mental deficiency and the Burdens', *British Journal of Learning Disabilities*, 28, 2000, pp. 60-64

Coleborne, Cathy, 'Legislating lunacy and the female body in nineteenth century Victoria', in *Sex, power and justice: historical perspectives on law in Australia*, edited by Diane Kirkby (Melbourne: Oxford University Press, 1995), pp. 86-98

Coleborne, Catharine, 'Preserving the Institutional Past and Histories of Psychiatry: Writing about Tokanui Hospital, New Zealand, 1950s-1990s', *Health and History*, 5, 2, 2003, pp. 104-122

Coleborne, Catharine, '"Like a family where you fight and you roar": Inside the "personal and social" worlds of Tokanui Hospital, New Zealand, through an oral history project', *Oral History in New Zealand,* 16, 2004, pp. 17-27

Cox, Pamela, 'Girls, deficiency and delinquency', in *From Idiocy to Mental Deficiency,* edited by David Wright and Anne Digby (London: Routledge, 1996), pp. 184-206

Dale, Pamela, 'Implementing the 1913 Mental Deficiency Act: Competing Priorities and Resource Constraint Evident in the South West of England before 1948', *Social History of Medicine,* 16, 3, 2003, pp. 403-418

Dale, Pamela, 'Training for Work: domestic service as a route out of long-stay institutions before 1959', *Women's History Review,* 13, 3, 2004, pp. 387-405

De la cour, Lykke and Geoffery Reaume, 'Patient Perspectives in Psychiatric Case Files', in *On the case: Explorations in Social History,* edited by Franca Iacovetta and Wendy Mitchinson (Toronto: University of Toronto Press, 1998), pp. 242-265

Dwyer, Ellen, 'The State and the Multiply Disadvantaged: The Case of Epilepsy', in *Mental Retardation in America,* edited Steven Noll and James W. Trent (New York: New York University Press, 2005), pp. 258-280

Egan, Matt, 'The "manufacture" of mental defectives: Why the number of mental defectives increased in Scotland, 1857-1939', in *Mental Illness and Learning Disability since 1850,* edited by Pamela Dale and Joseph Melling (London: Routledge, 2006), pp. 131-153

Eghigian, Greg, 'Care and Control in a Communist State: The Place of Politics in East German Psychiatry', in *Psychiatric Cultures Compared: Psychiatry and Mental Health Care in the Twentieth Century: Comparisons and Approaches,* edited by Marijke Gijswijt-Hofstra, Harry Oosterhuis, Josst Vijselaar and Hugh Freeman (Amsterdam: Amsterdam University Press, 2005), pp. 183-199

Ford, Ruth, 'Sexuality and "madness": regulating women's gender "deviance" through the asylum, the Orange Asylum in the 1930s', in *Madness in Australia,* edited by Catharine Coleborne and Dolly MacKinnon (St Lucia: University of Queensland, 2003), pp. 109-119

Fox, Charles, '"Forehead low, aspect idiotic": Intellectual disability in Victorian asylums, 1870-1887', in *'Madness' in Australia,* edited by Catharine Coleborne and Dolly MacKinnon (St Lucia: University of Queensland Press, 2003), pp. 145-156

Garton, Stephen, 'Sound Minds and Healthy Bodies: Re-Considering Eugenics in Australia, 1914-1940', *Australian Historical Studies,* 26, 103, 1994, pp. 163-181

Gladstone, David, 'The changing dynamic of institutional care: The Western Counties Idiot Asylum, 1864-1914', in *From Idiocy to Mental Deficiency,* edited by David Wright and Anne Digby (London: Routledge, 1996), pp. 134-160

Harman, Bronwyn, 'Women and Insanity: The Fremantle Asylum in Western Australia, 1858-1908', in *Sexuality and Gender in History,* edited by Penelope Hetherington and Philippa Maddern (Nedlands, W.A.: P. Hetherington and P. Maddern, 1993), pp. 167-182

Hubert, Jane, 'The social, individual and moral consequences of physical exclusion in long-stay institutions', in *Madness, Disability and Social Exclusion,* edited by Jane Hubert (London: Routledge, 2000), pp. 196-207

Hunter, R. M., 'Historical Notes on Tokanui, Kingseat and Raventhorpe Psychiatric Hospitals', *The New Zealand Nursing Journal,* 50, 6, 1957, p. 57

Jackson, Mark, 'Institutional provision for feeble-minded in Edwardian England: Sandlebridge and the scientific morality of permanent care', in *From Idiocy to Mental Deficiency,* edited by David Wright and Anne Digby (London: Routledge, 1996), pp. 161-183

Jackson, Mark, '"A Menace to the Good of Society": Class, Fertility, and the Feeble-Minded in Edwardian England', in *Sex and Seclusion, Class and*

Custody, edited by Jonathan Andrews and Anne Digby (Amsterdam & New York: Rodopi, 2004), pp. 271-294

Jimenez, Mary Ann, 'Social Control', in *Encyclopedia of Social History,* edited by Peter N. Stearns (New York: Garland Publishing, 1994), pp. 680-683

Labrum, Bronwyn, 'Looking beyond the Asylum: Gender and the Process of Committal in Auckland, 1870-1910', *New Zealand Journal of History*, 26, 1992, pp. 125-144

Luckin, Bill, 'Towards a social history of institutionalization', *Social History*, 8, 1, 1983, pp. 87-94

Matthews, Kay Morris, 'The Deviant Child and Larrikin Youth in Colonial Towns: State intervention and social control through education in New Zealand', *Educational Review*, 54, 2, 2002, pp. 115-123

McConville, Sean, 'The Victorian Prison: England, 1865-1965', in *The Oxford History of the Prison*, edited by Norval Morris and David J. Rothman (Oxford: Oxford University Press, 1995), pp. 131-167

McGovern, Constance M., 'Asylums', in *Encyclopedia of Social History*, edited by Peter N. Stearns (New York: Garland Publishing, 1994), pp. 70-71

McKenzie, Anna, '"Saving our unfortunate sisters"? Establishing the first separate prison for women in New Zealand', in *Crime and Empire 1840-1940*, edited by Barry Godfrey and Graeme Dunstall (Devon: William Publishing, 2005), pp. 154-173

McKenzie, David, 'Little and Lightly: The New Zealand Department of Education and mental testing, 1920-1930', in *Mental Testing in New Zealand*, edited by Mark Olssen (Dunedin: University of Otago Press, 1988), pp. 76-89

Mitchell, David, 'Special Education in New Zealand: An History Perspective', in *Exceptional Children in New Zealand*, edited by David Mitchell and Nirbhay Singh (Palmerston North: The Dunmore Press, 1987), pp. 26-38

Noll, Steven, 'Southern Strategies for Handling the Black Feeble-minded: From Social Control to Profound Indifference', *Journal of Policy History*, 3, 2, 1991, pp. 130-151

Noll, Steven, 'The Public Face of Southern Institutions for the "Feeble-Minded"', *The Public Historian*, 27, 2, 2005, pp. 25-41

Olssen, Erik, 'Towards a New Society', in *The Oxford History of New Zealand*, edited by Geoffrey W. Rice (Auckland: Oxford University Press, 1992), pp. 254-284

Park, Deborah C. and John P. Radford, 'From the Case Files: reconstructing a history of involuntary sterilization', *Disability and Society*, 13, 13, 1998, pp. 317-342

Park, Deborah C. and John P. Radford, 'Rhetoric and Place in the "Mental Deficiency" Asylum', in *Mind and Body Spaces: Geographies of illness, impairment and disability*, edited by Ruth Butter and Hester Parr (London: Routledge, 1999), pp. 70-97

Potts, Patricia, 'Medicine, Morals and Mental Deficiency: the contribution of doctors to the development of special education in England', *Oxford Review of Education*, 9, 3, 1983, pp. 181-196

Radford, John P., 'Sterilization versus Segregation: Control of the "feeble-minded", 1900-1938', *Social Science and Medicine*, 33, 4, 1991, pp. 449-458

Rafter, Nicole, 'The Criminalization of Mental Retardation', in *Mental Retardation in America*, edited by Steven Noll and James W. Trent (New York: New York University Press, 2004), pp. 232-257

Robertson, Stephen, '"Production not Reproduction": The problem of mental defect in New Zealand, 1920-1935', in *'Unfortunate Folk'*, edited by Barbara Brookes and Jane Thomson (Dunedin: University of Otago Press, 2001), pp. 200-214

Ryan, Patrick J., 'Unnatural selection: Intelligence testing, eugenics and American political cultures', *Journal of Social History*, 30, 3, 1997, pp. 669-685

Saunders, Janet, 'Quarantining the weak-minded: psychiatric definitions of degeneracy and the late-Victorian asylum', in *The Anatomy of Madness, Vol. III*, edited by W.F. Bynum, Roy Porter and Michael Shepherd (London: Routledge, 1988), pp. 273-296

Simmons, Harvey G., 'Explaining Social Policy: The English Mental Deficiency Act of 1913', *Journal of Social History*, 11, 1978, pp. 387-403

Stace, Hilary, 'The invisibility of disability history in New Zealand', *Phanzine: Newsletter of the Professional Historians' Association of New Zealand/Aotearoa*, 12, 1, April 2006, pp. 4-6

Taylor, David, 'Beyond the Bounds of Respectable Society: The "Dangerous Classes" in Victorian and Edwardian England', in *Criminal Conversations*, edited by Judith Rowbotham and Kim Stevenson (Columbus: The Ohio State University Press, 2005), pp. 3-22

Taylor, Tony, 'Thomas Hunter and the Campaign Against Eugenics', *New Zealand Journal of History*, 39, 2, 2005, pp. 195-214

Tennant, Margaret, 'Disability in New Zealand: An Historical Survey', *New Zealand Journal of Disability Studies*, 2, 1996, pp. 3-34

Thomson, Mathew, 'Family, community and the state: The micro-politics of mental deficiency', in *From Idiocy to Mental Deficiency*, edited by David Wright and Anne Digby (London: Routledge, 1996), pp. 207-230

Trent, James W., 'To Cut and Control: Institutional Preservation and the Sterilization of Mentally Retarded People in the United States, 1892-1947', *Journal of Historical Sociology*, 6, 1, 1993, pp. 56-73

Tyor, Peter, L., '"Denied the Power to Choose the Good": Sexuality and Mental Defect in American Medical Practice, 1850-1920', *Journal of Social History*, 10, 1977, pp. 472-489

Walmsley, Jan, Dorothy Atkinson and Sheena Rolph, 'Community care and mental deficiency 1913-1945', in *Outside the Walls of the Asylum*, edited by Peter Bartlett and David Wright (London: The Athlone Press, 1999), pp. 181-203

Walmsley, Jan, 'Women and the Mental Deficiency Act of 1913: citizenship, sexuality and regulation', *British Journal of Learning Disabilities*, 28, 2000, pp. 65-70

Watson, Stephen, 'Malingerers, the "weakminded" criminal and the "moral imbecile": how the English prison medical officer became an expert in mental deficiency, 1880-1930', in *Legal Medicine in History*, edited by Michael Clark and Catherine Crawford (Cambridge: Cambridge University Press, 1994), pp. 223-245

Wright, David, '"Childlike in his innocence": Lay attitudes to "idiots" and "imbeciles" in Victorian England', in *From Idiocy to Mental Deficiency*, edited by David Wright and Anne Digby (London: Routledge, 1996), pp. 118-133

Theses:

Bardsley, Sandy, 'The functions of an institution: the Otekaieke Special School for Boys, 1908-1950', BA (Hons) long essay, University of Otago, 1991

Brunton, Warwick, '"A Choice of Difficulties": National Mental Health Policy in New Zealand, 1840-1947', PhD thesis, University of Otago, 2001

Fleming, P.J., 'Eugenics in New Zealand, 1900-1940', MA thesis, Massey University, 1981

Gregory, Penelope, 'Saving the children in New Zealand: A study of attitudes towards larrikinism in the later nineteenth century', BA (Hons) research essay, Massey University, 1975

Haver, Bjorg, 'New Zealand attitudes and practices towards mental retardation and its aetiology', MA Education thesis, Victoria University, 1967

Hill, Marguerite, ‘Madness in Early Twentieth-Century New Zealand: the patient case records of Porirua Hospital, 1909-1915’, Honours dissertation, Victoria University, 2005

Ireton, Douglas, ‘Time to heal: The appeal of Smith Wigglesworth in New Zealand, 1922-24’, BA (Hons) essay, Massey University, 1984

Metcalfe, R.W., ‘The debate about eugenics: Eugenics and social legislation in New Zealand 1900-1930’, MPhil thesis, Massey University, 2000

Robertson, Stephen, ‘“Production not reproduction”: the problem of mental defect in New Zealand, 1900-1939’, BA (Hons) long essay, University of Otago, 1989

Appendix

This Appendix contains reproductions of documents that were included in Tokanui's patient files, and is set out to resemble these files. The sequence of materials below reflects the order in which they were created. Certification documents preceded hospital assessments and notes. Additional information received while patients resided at Tokanui was also included in their files. This Appendix also contains a suggested plan for an admission block, which is part of Tokanui's administration files.

The patients' first and last names have been blanked out in accordance with WDHB and Archives New Zealand requirements.

Contents

[Form No. 2.

Medical Certificate under the Mental Defectives Act, 1911.

I, Samuel James Thompson
(Name in full.)

being a medical practitioner duly registered in New Zealand, and residing at Kent Street, Levin
(Address in full.)
, do hereby certify that on the 24th day of January, 193 4 at Boys Training Farm, Weraroa
(Place of examination.)
, I personally examined _____, a Farm Labourer
(Full name.) (Occupation.)
of Boys Training Farm, Weraroa
(Address.)
, and am of opinion that he is a mentally defective person within the meaning of the above-mentioned Act, and requires detention as such. *[*Where application is being made for detention in private house, add:* I hereby further certify that it would be safe and convenient that the said person should be received and detained as a single patient under the said Act, instead of in an institution].

* Delete and initial matter in brackets if inapplicable.

1. The following are the facts observed by me on the occasion of the examination aforesaid, on which my opinion is based:—

He is definitely subnormal mentally. He admits stealing but can give no reason for it and does not seem to understand that it is wrong. He admits masturbation.
He has anti-social tendencies and acts on impulse. He should be under restraint in the interest of others.

2. In pursuance of section 11 of the said Act, I make this further statement with respect to the said person:—

(*a.*) The following facts, indicating mental defect on the part of the said person, have been observed by me on occasions other than the date of examination aforesaid [*Set out date of observation and facts observed*]:

Not examined before.

(*b.*) The following facts concerning the said person, indicating mental defect, have been communicated to me by [*Set out facts communicated by other persons, together with the names and addresses of such persons*]:

Manager, B.T.F. Weraroa.

This boy has been under control of the Child Welfare Branch since 1926 ~~and an inmate of the Training Farm since 1931.~~ During the whole of this time he has been very unsatisfactory At school he ~~has not progressed beyond the 4th Standard.~~ His behaviour is erratic and irresponsible He has definite criminal tendencies, and ~~does the most unexpected things.~~ Recently he was tried at service, the employer reported that he was unable to concentrate on his work and required constant supervision. He returned to the Farm on the Saturday with a view to placing him in another situation on the Monday, but in the meantime he broke into a house stealing two watches and amount 2/- in cash, after which he took a bicycle. He does not seem to realise the seriousness of his actions. His history suggests mental instability.

(*c.*) In my opinion the said person may be properly classified as being of ~~unsound mind [or mentally infirm or an idiot or imbecile or feeble-minded or epileptic or~~ socially defective].

(*d.*) In my opinion the factors which have caused the mental defect of the said person are the following:—

--

(*e.*) In my opinion the said person ~~[or]~~ is not] suicidal.

(*f.*) In my opinion the said person ~~[or]~~ is not] dangerous.

(*g.*) The following treatment has been employed for the said person in respect of his mental condition (*Describe treatment, if any*):—

(*h.*) The said person's present bodily health and condition are as follows (*Describe bodily condition, &c., with special reference to the presence or absence of communicable disease or recent injury*):—

No sign of communicable disease. He complains of an injury to the back three weeks ago. No sign see of this on examination.

* See section 12, subsections (1) and (2).

I hereby declare that I am not prohibited by the *Mental Defectives Act, 1911, from signing this certificate.

† "Every such medical certificate shall bear date of the day on which the certifying medical practitioner last examined the person alleged to be mentally defective before the signing of the certificate." (Section 5 (5).)

† Dated at Levin, this 24th day of January, 193

Signature of Medical Practitioner: S.J. Thompson.

[M.H.—9.

PRELIMINARY STATEMENT AS TO MENTAL AND BODILY CONDITION

of _____ (Name of person.) admitted to F.1. (Villa or Ward.)

on 2.1.31. (Date.)

UNDER SECTION 66 (2) OF THE MENTAL DEFECTIVES ACT, 1911.

I HAVE this day examined the above-named person, and certify with respect to his/her mental and bodily condition as follows:—

Relate the symptoms present on admission so as to give a clinical picture of the case.

She states that she passed Std. 6 at 13½ years and then worked at various places until her father kept her at home because he reckoned she could not keep a job long enough. She first worked a week in the alteration room of a large drapery establishment but could not thread needles fast enough. Then she was employed as a domestic at a few places, but admits that she disliked housework. The Welfare Officer who brought her here states that the Patient has been making a nuisance of herself, calling at various houses and throwing stones. She used to call on a local minister of religion until she openly expressed to him her idea that they should become wedded. She then used to pass the minister's house at night and throw stones on the roof, and she also wrote him anonymous letters. Before the girl's entry to Hospital this minister had written confirming the statements about her being a source of trouble, and had described her as being "Hopelessly oversexed."

She slept well last night and has been quiet and well behaved since admission.

Physically she is a well developed, well nourished overgrown girl of 15 years 11 months who has the appearance of a grown woman. Height 5ft. 6". Weight 9st. 10lbs. Breasts fully developed. She states that monstruation commenced at 13 years.

NERVOUS SYSTEM. Pupils equal, circular, and react to light and accommodation slight nystagmus. Uses spectacles for myopia. Knee jerks and ankle jerks normal. Plantar response flexor. No tremors, incoordination, or impairment of sensation.

ALIMENTARY SYSTEM. Tongue dry and coated. Upper jaw edentulous. Lower teeth fair, a few molars absent. Appetite good, bowels acting, abdomen nil to note.

CIRCULATORY SYSTEM. Pulse 84, regular. Artery soft. Systolic B.P. 150 m.m. Apex beat normal. Heart sounds closed.

RESPIRATORY SYSTEM. Chest resonant. Breath sounds vesicular. No accompaniments.

URINALYSIS. Acid, sp.gr. 1034, slight mucous deposit. No albumin. Trace of sugar.

SKIN BONES & JOINTS. No rash or evidence of recent injury.

Certificate under Section 39 (3). * Delete if not applicable.

I further certify in my opinion _____ (Name of person.) is a proper person to be admitted as a Voluntary Boarder.

Dated at Mental Hospital, KIHIKIHI., this 3rd day of January, 19 31.

Medical Officer. C.A.C. M.O.

NOTE.—This form should be completed and sent to Head Office in respect of every person admitted to the Institution including Voluntary Boarders and cases on remand.

7,000/8/29—8064

Med. Supt. Tokanui Mental Hospital
Copy of Dr. Todd's report for your file
J. Russell. S.S.O.
1.6.33

The Psychological Clinic,
Post Office Buildings,
Wellesley Street,
AUCKLAND, C.1.

24th March, 1933.

The Chairman,
Eugenics Board,
WELLINGTON.

re:-

Address: C/o Mrs. A. Glazer
40, Galloway Street,
Hamilton East.

Date Birth: 11:12:24.

Recommended for examination by Child Welfare Department, Hamilton.

Family History:

Mr. died in a Mental Hospital in 1929, condition being syphilitic. Mrs. contracted syphilis from her husband and was under treatment at the Waikato Hospital in 1930. In 1931 was admitted to Tokamui Mental Hospital. There are 4 children:-

born 8:2:20. Passed Proficiency in 1932 and has been recommended for secondary education.
8 years. Primer 1 Hamilton East.
born 8:12:26.
Three miscarriages in the family.
½: illegitimate: her father being the brother of Mr.

The mother's people appear to be in a good position but take no interest in the children for fear of infection. The children are boarded out by the Public Trust Office, the 3 eldest with the above foster mother, under the supervision of the Child Welfare Officer, but are not committed as this would forfeit their pension.

Personal History:

Little known of early history. It was difficult to find a suitable home for the boy owing to his troublesome behaviour and his bad habits - he is faulty, he masturbates, is determined and stubborn and subject to fits of screaming. Mrs. Glazer states that every 4-6 weeks he has "turns" with musdular rigidity and tremors of the legs: he is dazed but not unconscious and kicks and fights if anyone comes near him during the "turn". At these times he is destructive and cruel to the other children. He cannot dress or undress himself and during his attacks cannot feed himself. A few weeks ago he did not return from school at the proper time and late in the evening was found 3 miles away in a paddock at the Ruakura State Farm. He attends School at Hamilton East where he is in Primer 1: is reported hopeless at learning and kicks and screams when told to do any work.

On Examination:

... is a restless, irritable child who displays obviously the stigmata of the congenital syphilitic: bossing of the cranial bones, a square shaped head and Hutchinsons teeth. There is deformation of the ears and a distended abdomen. He can give his name, **can** count up to 3, he recognises 1d and 3d but does not appreciate their value; he cannot discriminate colours, copy a square, name familiar objects or add 2 plus 1, 3 plus 2 etc. He displays echolalia, is impulsive, stubborn and resistive during the examination and is not amenable to discipline.

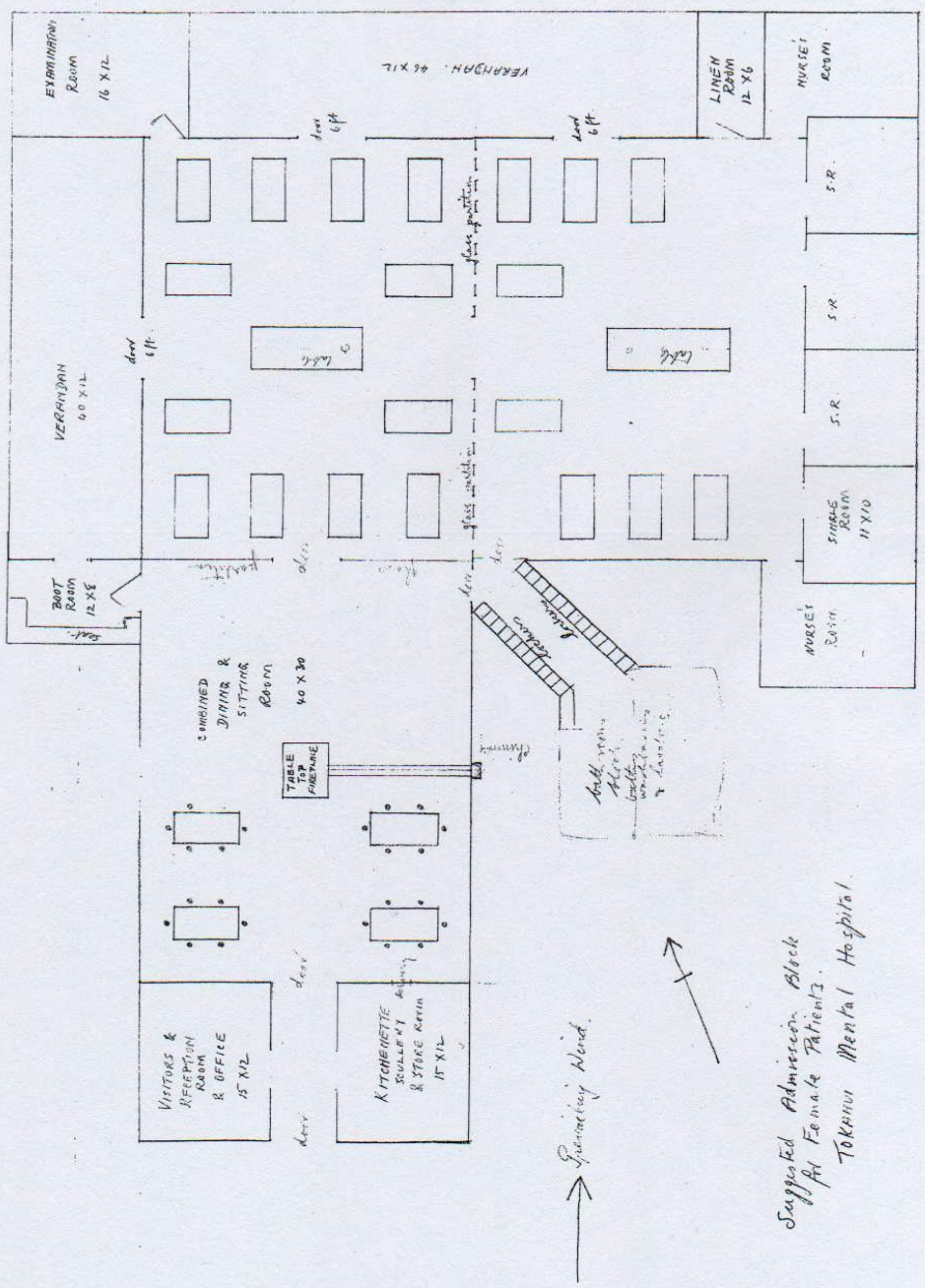
Report:

This child is an unstable imbecile, his condition being due to congenital syphilis. He should be committed to the Nelson Villa, the Child Welfare Department having agreed to escort him in the near future. It was advised that his brother and sisters should be examined by a medical practitioner and their blood Wassermanns done to exclude the possibility of syphilis in their cases.

Date examined: March 15th, 1933.

*61.

Kath Todd.



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