

Mental Health at Tokanui in the Early Years

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

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



FIG 3.1 Dorothy 'Dot' Whittle

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

PHOTO COURTESY OF GRAEME DAYSH, GRANDSON OF GEORGE REYNOLDS

Space: A Mixed Blessing

According to the department's annual report for 1907, space was the primary consideration when selecting a location for its proposed new hospital. Not only did the site have to be 'sufficiently large for a mental hospital made up of detached buildings', and be 'capable of very considerable extension', it also required sufficient space, 'apart from [the] mental hospital ... for other institutions or "colonies" which may be placed hereafter under the control of this department'.² To this end, just under 5,000 acres of land was acquired at Te Mawhai, and although in 1926 this would be reduced to 1,200 acres³, the sense of spaciousness which the estate engendered remained a feature of the hospital for the duration of its operation. In later years, when civilisation began to encroach and a greater connection was forged with the outside world, Tokanui's space would be remembered positively, by staff and patients alike, for the respite that it provided those who, as Lloyd Anderson put it, needed to 'get away from other people'.⁴

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

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

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

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

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

Sir Frederic Truby King (1858-1938)

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

Notes

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

² Caldwell, p.42.

³ Caldwell, p. 44.

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

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

Neat beautiful grounds, the result of staff and patient labour, brought an outward appearance of civility and normality to something perceived to be

the direct opposite. In this way they helped to dispel public prejudice and dampen any outcry over asylum care.

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

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

The land at Tokanui was described in a 1919 article by estate manager, J Drysdale, as being comprised primarily of low hills, 'the greater proportion ploughable and suitable for cultivation', 'extensive' wide valleys and 'easily drained and decidedly fertile' swamps.²²

The natural vegetation was recorded as including 'bracken-fern, manuka, and tutu (taupaki), with a proportion of flax (phormium), toetoe, and koromiko', and the introduced shrubs as 'gorse and broom'.²³ The soil was described as being 'semi-volcanic' in nature, 'light and open', 'easily worked' and of 'medium fertility, ... particularly responsive to the application of fertilizers'.²⁴ No wonder, then, that on several occasions official reports extolled the virtues of the estate and the wisdom of its acquisition,²⁵ especially 'in view of increasing numbers to provide for and the upward tendency in the price of meat, butter and other produce'.²⁶ However the sheer size of the estate seems to have been a mixed blessing. While on the one hand the copious amount of land helped to compensate for any deficiencies in

Camps

During the 1920s two semi-permanent, under-canvas work camps were established on remote parts of Tokanui's vast estate. Located at too great a distance to be worked from the central institution the camps, simply named No.1 and No.2, were respectively situated on Korokanui and Waikeria Roads. The twenty or so patients and handful of staff who took up residence at the camps were primarily employed in scrub-cutting, general land clearing and fencing. In 1921 a block-making shed was completed at No.1 Camp with the intention that it would supply the hospital with much needed building material. Work, however, was suspended the following year due to a shortage of cement.² At some point during the 1920s it appears that both camps were closed. However, on instruction from acting Inspector-General Sir F Truby King No.2 camp was reopened in 1924.³ Although reports of its enterprise were highly favourable, the camp was "evacuated" in 1927 and as part of a total transfer of 3,500 acres, was handed over to the Prisons Department for use by the neighbouring Waikeria reformatory. Efforts were instead concentrated on No.1 camp which was reoccupied that same year.⁴ Two years later in 1928 a new dormitory capable of housing 14 worker-patients and additional accommodation for staff were added and the existing dormitory transformed into a living room.⁵ Operating for a further 20 years, No.1 camp was ultimately closed as a result of staff shortages in 1947, and in 1948 the land was transferred to the Lands and Survey Department before being used as farm settlements for ex-servicemen.

Notes

¹ *AJHR*, 1922, H-7, p. 8.

² *AJHR*, 1923, H-7, p. 8.

³ *AJHR*, 1925, H-7, p. 10.

⁴ *AJHR*, 1928, H-7, p. 6.

⁵ *AJHR*, 1929, H-7, p. 6.

fertility, on the other, as time passed, it became apparent that Tokanui simply lacked the resources to bring into cultivation and maintain the thousands of acres at its disposal. From 1917 onwards Tokanui's progress was limited by insufficient²⁷ and, in some cases, a lack of skilled labour.²⁸

In 1925 Dr MacPherson reported that while all but 300 acres of the estate had been brought under cultivation (a significant milestone and one that had taken over a decade), a shortage of labour was hampering efforts to maintain the land and keeping down the new growth of scrub and fern was proving difficult, concluding that 'some parts of the property were in danger of reverting [back] to its

Water Shortages

Issues with the water supply began soon after operations at Tokanui commenced. Low water pressure prompted talk, in 1913, of a reservoir to be placed on a nearby hill, but it would be 1915 before one capable of storing 75,000 gallons was constructed.² Then in 1920 Dr Gribben, Tokanui's Medical Superintendent, began reporting serious water shortages.³ Increased consumption and an inadequate pump were causing the well to run dry, forcing the hospital to ration water use with severe restrictions. Female patients were reduced to weekly baths while males were bathed in the Puniu River.⁴ In particular, Gribben expressed his anxiety over the impossibility of maintaining an adequate reserve of water for fire fighting purposes.⁵ Despite plans to dam two streams half a mile distant⁶ and the installation of a new water pump, shortages continued into 1924.⁷ By this time bathing had been entirely eliminated and the laundry closed; washing instead being sent to Auckland at the considerable expense of £40 per week.⁸ In desperation Gribben appealed directly to the Inspector-General via telegram informing him that, despite all possible restrictions, the water supply was failing and describing the hospital's position as "grave".⁹ Finally in 1925, four years after the idea was first broached, Tokanui was connected to the Te Awamutu water supply, effectively ending the shortages which had plagued the hospital for half a decade.

Notes

¹ *AJHR*, 1913, H-7, p. 8.

² *AJHR*, 1916, H-7, p. 4.

³ *AJHR*, 1921, H-7, p. 6.

⁴ *A History of Te Awamutu Hospital*, p. 5.

⁵ *AJHR*, 1921, H-7, p. 6.

⁶ *AJHR*, 1922, H-7, p. 8.

⁷ *A History of Te Awamutu Hospital*, p. 5.

⁸ *A History of Te Awamutu Hospital*, p. 5.

⁹ *A History of Te Awamutu Hospital*, p. 5.

original state'.²⁹ The following year he reported that 'the task of keeping down the growth of fern and noxious weeds' had reduced cultivation to bare necessity.³⁰ Even with the assistance of inmates from the neighbouring Waikeria Reformatory, an arrangement that hospital officials appear never to have been entirely comfortable with³¹, the size of the property and the amount of work it required dwarfed the labour available to complete it. The alternative of external paid labour was understandably less appealing than the unpaid efforts of the male patients. While the department made no secret of the fact that patient labour was essential to keep running costs down and that the work patients engaged in helped to cover the cost of their treatment, or at least maintenance, ostensibly patients were not paid for their work because it *was* their treatment. In addition to providing occupation, the farm supplied a variety of fresh produce which, in the wake of Sir Frederic Truby King's initiatives, came to be viewed as an essential aspect of treatment. In assisting to grow their own food, patients not only occupied their mind but helped to feed, and hence heal it. The therapeutic value of the farm, including the orchards and kitchen gardens, was such that Inspector-General Hay, in his 1920 report, was moved to state that they were necessary 'even if we had to work them at a loss', and that their success had led to their primary objective – 'that of diffusing a sentiment of privacy and freedom while providing normal healthy occupation in the open air' – being overlooked.³²

Things began to improve, however, following the transfer of the greater portion of the estate to Prisons Department for use by the Waikeria Reformatory in 1926. Dr Childs reported in 1929 that 'the work on the farm has proceeded steadily, and since a large part of the estate has been transferred to the Prison's department, a great improvement has been noted'.³³ The crops grown on the estate included red clover, turnips, swedes, marigolds, lucerne, wheat, oats, potatoes, vegetables and

fruit, either for consumption by patients or by the livestock, which included pigs, Clydesdale horses, poultry and dairy cattle. Dot Whittle remembers that:

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

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

In addition to emphasising the use of nursing staff and patient labour, Dot's memories draw attention to the fact that the majority of the produce grown on the estate was consumed there by staff and patients. Although the excess produce and livestock was sold to the wider public, the revenue it generated appears never to have exceeded the value of that consumed.³⁵ As well as selling surplus fruit, vegetables and other crops, the hospital sold excess stock. However, 'before any livestock could be sold to the public' notes Wendy Hunter Williams, 'the hospital had first to make enquiries as to whether any of the department's other hospitals required stock and an inter-departmental transfer could be arranged. The price was set by mutual agreement'.³⁶ A 'typical year', she explains, 'would be 1938 when 100 ewes and two Romney rams were sent to Tokanui which, in turn, supplied Porirua with twenty-five dairy heifers to replace old dairy cows'.³⁷ These exchanges, however, were not solely limited to livestock and 'could include anything from fence posts to sheep-dogs, from farm machinery to seedlings'.³⁸ Although receipts from the sale of produce and the savings made on the value of that consumed helped to defray the cost of expenses, until the 1930s the cost per patient of the farming operations at Tokanui remained the most expensive of the existing mental hospitals, at times by more than £10.³⁹ Unsurprisingly, the largest expense, not just at Tokanui, but generally across all the hospitals, was salaries and wages. Feed; stock; implements, harnesses and repairs; and seeds and manure rounded out the top five expenses. Ownership of sufficient land for cultivation removed the need to pay rent or rates, but the isolation which was the trade off made railage a necessary expense.

With the transfer of land, Tokanui reached a turning point. Its initial pioneering phase drew gradually to a close and the hospital settled into a steady routine as a largely custodial institution and a self-sufficient community. Although the farm remained an important aspect of the life of the hospital, it had become apparent that a proportion of the patients were not going to be able to contribute to outdoor work. Many were elderly, disabled, chronically mentally unwell or otherwise infirm. Rather than contributing as workers, these patients would need care and supervision from the nurses and attendants. In official reports, details of Tokanui's farming operations featured less, being replaced instead by accounts of the various recreational activities and amusements that were possible now that much of the basic infrastructure was in place. Despite only significant changes featuring in the superintendents' reports, such as the establishment of a new orchard and vegetable garden⁴⁰, or the installation of a new milking-machine and separator,⁴¹ farming operations continued well into the 1950s. However, with the revolution in treatment brought about by new drug and shock therapies, the farms gradually became less important and in 1967 the Minister of Health, Mr McKay announced that farming activities at all mental hospitals would be discontinued in order that the institutions could concentrate on their primary function of treating patients.⁴² On the 1st of July 1967 [t]he control and operation of the farm [at Tokanui] was ... handed over to the Department of Agriculture'.⁴³

A Unique Community

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

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

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

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

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

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

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

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

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

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

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

Tokanui employed very small numbers of tradesmen and farm workers, because attendants were expected to be generalists. There was no strict boundary between 'attendance' and other occupations. A newspaper advertisement from 1921 calling for single attendants emphasises this: 'Wanted: Single attendant with farm experience for Mental Hospital, Kihikihi, Waikato'.⁵³ From time-to-time, men therefore

1918 Influenza Pandemic

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

Notes

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

chose to leave their roles as attendants for other positions in the institution, sometimes achieving a higher salary.⁵⁴ Hedley McKerrow, who was one of the first junior attendants at Tokanui, had an interesting career in this regard. He was appointed on 6 October 1913 and four years later was promoted to Deputy Charge Attendant'. In 1919, McKerrow exchanged his role of attendant for a position as engine driver and in 1924 he was appointed Assistant Farm Manager. A year later, he was promoted to Estate Manager and attained a salary that was second-only to the Head Attendant. Across the department non-treatment related staff accounted for about one fifth of all employment.⁵⁵ During the first two decades of operation the number of farming and building maintenance workers reached their peaks, accounting for nearly 5.5 per cent and 9.5 per cent of the labour force respectively.⁵⁶ Their roles gained greater currency as the number of worker patients dwindled and, consequently, a greater portion of attendants' working hours were taken up with the duty of care.

Just two years after Tokanui opened, New Zealand entered World War One. Not only did the war delay progress of the building programme for all mental hospitals, it also had a huge impact on staffing. By 1915, 11.7 per cent of the Department of Mental Hospital's male staff was at the front or in military training. Over the next three years, a large number of experienced doctors and attendants went away to war. The Department did what it could to manage the situation: men were employed on a temporary basis to fill the gaps and the hospitals relaxed the rule that they must remain

single for the first two years of employment.⁵⁷ As the experience level of the workforce plummeted, vacancies 'had to be filled with what offered' and hospitals relied heavily on their senior staff to provide some stability.⁵⁸

Initially, only one Tokanui man volunteered. David Onion, a junior attendant, enlisted in the first few months of war. Unfortunately, Onion was reported missing, believed dead, in 1916.⁵⁹ By March 1917, the situation at Tokanui had changed dramatically. Nine men, five of whom were senior attendants, had left to serve their country. This was almost one-third of the attendant workforce. A year later, three very experienced men, George Fowlie, Robert Gray and Gilbert Unwin also went to the front, their absence leaving a substantial gap in the upper levels of the attendant hierarchy.⁶⁰ Tokanui managed the shortages by employing more probationers, many of whom were married. This caused problems because of the lack of 'married accommodation' in the district. The hospital was forced to build another four cottages on the estate and to adapt the original, temporary kitchen and staff rooms to create 'married quarters'.⁶¹

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



FIG 3.3 Photo of wards F, G & H

PHOTO COURTESY OF WAIKATO DISTRICT HEALTH BOARD

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

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

expected of attendants, usually expressed as prohibitions'.⁶⁶ For example, the 1910 edition 'forbade disobedience to any order, drunkenness, immoral conduct, foul language, falsehood, dishonesty, insubordination, disrespectful conduct towards superior officers, breaches of regulations, ill-treatment of patients, absence without or beyond leave, neglect of duty, loss of stock or general inefficiency'.⁶⁷ From a disciplinary position, female nurses were favoured because of their perceived tractability. Not only were they more likely to comply with the outlined rules, they were, according to Brunton, more 'likely to follow the instructions of male doctors, prefer collegiality, be generally unambitious, and submit to bureaucratic control'.⁶⁸

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

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

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

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

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

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

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

1930s Economic Depression

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

Notes

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

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

A narrative of Tokanui in the early years would, of course, not be complete without an account of those individuals for whom the hospital was built. While the journeys of individual patients will be explored at greater length in Chapter Seven, there is scope within this narrative of the first twenty-three years to provide a brief overview of the patient population. As Chapter One noted, the records indicate that Tokanui's first four patients arrived in mid-July 1912.⁹⁵ Accompanied by James Cran and Andrew Brown (Tokanui's first attendants), their arrival set a precedent that would last until 1915 when the transferral of 50 female patients brought to an end the brief period of male exclusivity. The numerical dominance of male patients, although most marked in the first 10 years, continued throughout the first decades. One explanation for this imbalance is that the work required to develop the estate was of a physically demanding nature. Often conducted outdoors, it typically belonged to a masculine sphere of work. The viability of all other institutions at this time, but especially Tokanui as it built accommodation and brought land into cultivation, relied on the labour of patients to be self-sustaining. In the pioneering environment of those early years at Tokanui, the practicalities of institutional life were most suited to accommodating male patients, and it was their labour that was most valuable.

In keeping with its intended purpose as a site for the reception of the yearly increment of sufferers, those first four men, and all patients made resident until 1919, would be transferred to Tokanui from existing institutions.⁹⁶ Even once patients began to be received directly, transfers remained the bulk of new and existing patients. As such, the information pertaining to them in the statistical appendixes of the Departmental reports is limited, having been originally collected on first admission at a previous hospital. Falling under the category of transfers or readmissions, it is often not until discharge or death that information, beyond the basics of age and gender, is recorded for a patient. One interesting exception is the data collected on native countries. Figures indicate that at the beginning of the period, patients at Tokanui were most likely to have been born in New Zealand, followed by England and Wales, and Ireland. Just over a third of all transfers had their native country listed as New Zealand.⁹⁷ By 1934 this had nearly doubled, and although England and Wales, and Ireland, remained the next closest categories, their numbers were significantly less than they had been in 1912.⁹⁸ The fact that the New Zealand born sufferers were predominant, not just at Tokanui but across the institutional network, illustrates that by the twentieth century, insanity had well and truly become a New Zealand problem, not just a burden transferred from 'home'.

In terms of age, the first patients, and the majority of the residents for the first 10 years, were aged between 20 and 40 years. No patients exceeded 80 years, and there were no children or young adults under the age of 20. In the decade that followed, this gradually changed as the existing population aged and Tokanui moved out of its initial construction phase to become an established institution. By 1930 over half the patients accommodated at Tokanui were aged between 40 and 60 years of age, and the range of ages had considerably broadened to encompass sufferers as young as five and as old as 90.⁹⁹ The listed causes of illness would also alter over the first 23 years with some categories 'officially' disappearing altogether. Although data pertaining to Tokanui's residents in those early years of transfers is absent, a broader institutional perspective offers some insight. In 1912, when causes of mental defect included religious excitement, masturbation, sexual excess, constipation and lead poisoning, the most common cause of insanity for males was alcohol, followed by senility and heredity. Comparably for females, heredity, previous attacks, and senility were the top three reasons given for suffering. Although senility remained within the top three listed causes of mental abnormality, by 1934, mental stress and

Death at Tokanui

In October 1913, a male, aged somewhere between 20 and 30 years, had the dubious honour of becoming the first patient to die at Tokanui. Like many of the patients who died during the first decades of operation, little else is known about him, other than that he had been a resident in the system for 5-7 years and that his death was the result of septicaemia.² With recovery, for the most part, contingent on time and good fortune, death was the inevitable outcome for many patients at Tokanui. Warwick Brunton notes, more generally, that 'deaths accounted for 44 per cent of all deregistrations among committed patients; slightly more than the proportion discharged'.³ Between 1912 and 1935, 282 patients, 162 of them male and 120 female, died at Tokanui.⁴ The majority were over 50 years of age and if they had not died within the first three months of arrival were most likely to have been resident for more than 10 years.⁵ Although certain 'Diseases of the Nervous System', including general paralysis of the insane, and exhaustion from confusional insanity, mania and melancholia, became more common from the late 1920s, the majority of deaths which occurred during this period were attributed to physical causes that had no direct relation to the sufferer's mental illness. Senile decay, heart disease and various respiratory illness, including pneumonia, tuberculosis and bronchitis, were the most frequently attributed causes of death. After 1928, all bodies would have been moved to the hospital mortuary for examination. Records indicate that not one, but two mortuaries were constructed on site, one in 1928⁶ and another some 10 years later, presumably as a replacement for the first.⁷ Post mortems were conducted on site until 1971, when the last was conducted by local GP and police pathologist, Dr Laurie Neil.⁸ According to the department's 1914 annual report, a coroner's inquest was 'held into every case of death in an institution, irrespective of the cause'.⁹

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

Notes

¹ *AJHR*, 1914, H-7, pp. 14, 16.

² *AJHR*, 1914, H-7, pp. 19-2

³ Brunton, 'A Choice of Difficulties', p. 246

⁴ Calculated from *AJHR*'s, H-7, 1913-1936.

⁵ See *AJHR*'s, H-7, 1913-1936.

⁶ *AJHR*, 1928, H-7, p. 3.

⁷ *AJHR*, 1938, H-7, p. 2.

⁸ John Graham, 'Tokuani Hospital Photo Show', created 18 December 2008, held by John Graham, Slide 51

⁹ *AJHR*, 1914, H-7, p. 4.

¹⁰ 'A History of Tokanui Hospital', p. 14.

¹¹ 'A History of Tokanui Hospital', p. 14.

¹² 'A History of Tokanui Hospital', p. 13.

¹³ 'A History of Tokanui Hospital', p. 14.

¹⁴ 'A History of Tokanui Hospital', p. 14.

¹⁵ 'A History of Tokanui Hospital', p. 14.

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

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

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

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

Accommodating Insanity

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

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

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

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

Mental stimulation also included recreational activities, which were an important aspect of the activation programme and integral to fostering a sense of community. For the first eight years of Tokanui's operation, the provision of recreational activities and other amusements took a back seat to the development of basic infrastructure, then were frustrated by the fiscal constraints and staff shortages brought about by World War One. However, by the 1920s the hospital had become more settled and the medical superintendents began to report the various activities that were on offer to alleviate 'the monotony' of institutional life.¹⁰⁹ Initially, this consisted of fortnightly dances during the winter months and concerts put on by the musical people of the district, both of which were to continue throughout the 1920s and into the 1930s.¹¹⁰ Visits to the picture theatre in Te Awamutu were also conducted on a fortnightly basis throughout the first half of the 1920s, however by 1924, following connection to the hydro-electric system, Dr Gribben called for the hospital to be provided with a cinematograph that all patients could enjoy.¹¹¹ In 1927 this was finally installed and patients were weekly shown a silent film courtesy of Australian Films Ltd., who provided the pictures free of charge.¹¹² However the silent films were to prove relatively short-lived. Just four years later, Dr Prins reported that screenings had ceased because of a lack of availability, and although it was noted that a further supply had been secured¹¹³, a year later in 1932 the pictures had again ceased.¹¹⁴ Fortunately, in the following year, the old cinema machine was converted to a "talkie" allowing weekly screenings to resume.¹¹⁵

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

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

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

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

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

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

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

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

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

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

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

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

Alpha-Numeric Divisions

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

Thus, in 1928 a contract was let for the construction of three female villas¹³² and in 1930 these were completed, providing accommodation for 150 patients.¹³³ Wards F, G and H were virtually identical two-storied brick buildings used for refractory and long-term stay accommodation.

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

Conclusion

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

A Family Tradition of Psychiatric Nursing

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

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

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

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

My mother made Tokanui her life. She was a very respected, proud, straight lady (tough). She was much loved and respected by the patients and for years I was often afforded the goodwill and mana that was hers, from patients who asked "how's Sister Whittle?"

My mother was often called from all over the hospital to bath Alice in D Ward – a patient who barricaded herself in her room ... until "Whittle" had been ordered by matron to attend her. I was later thankful when Alice accepted me as my mother's daughter and allowed me the privilege of opening the bathroom door for her.

My mother then became a Sister-in-Charge of the Nurses' Home for many years, until my sister tried her luck at nursing. Because trainee nurses had to live in, Mum transferred back to ward work at that point to avoid any conflict of interest. When she eventually retired, I don't think she ever recovered from missing the work and society of Tokanui.



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

PHOTO COURTESY OF JUDY BESLEY

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

Notes

- 1 'A family story by Dot Whittle née Cran', Reproduced by John Graham, July 2001, held in John Graham Archival Collection, p. 2.
- 2 Report on Mental Hospitals of the Dominion for 1907, *Appendix to the Journals of the House of Representatives (AJHR)*, 1908, H-7, p. 5.
- 3 Report on Mental Hospitals of the Dominion for 1926, *AJHR*, 1927, H-7, p. 7.
- 4 Transcript of interview with Lloyd Anderson, [n.d], Interviewer's name not given. Held Te Awamutu Museum, Side A, p. 6
- 5 Warwick Brunton, 'A Choice of Difficulties': National Mental Health Policy in New Zealand, 1840-1947' (unpublished doctoral thesis, University of Otago, 2001), p. 256.
- 6 Report on Mental Hospitals of the Dominion for 1877, *AJHR*, 1878, H-10, p. 3; Report on Mental Hospitals of the Dominion for 1876, *AJHR* 1977, H-8, p. 13 and Report on Mental Hospitals of the Dominion for 1880, *AJHR* 1881, H-13, p. 9.
- 7 *AJHR*, 1878, H-10, p. 3.
- 8 Brunton, 'A Choice of Difficulties', p. 240.
- 9 *AJHR*, 1927, H-7, p. 10.
- 10 Report on Mental Hospitals of the Dominion for 1927, *AJHR*, 1928, H-7, p. 6.
- 11 Report on Mental Hospitals of the Dominion for 1928, *AJHR*, 1929, H-7, p. 6.
- 12 Report on Mental Hospitals of the Dominion for 1931, *AJHR*, 1932, H-7, p. 5.
- 13 Report on Mental Hospitals of the Dominion for 1932, *AJHR*, 1933, H-7, p. 7.
- 14 Report on Mental Hospitals of the Dominion for 1934, *AJHR*, 1935, H-7, p. 6.
- 15 Supporting this assumption is a description of Kingseat's gardens. At Kingseat it was reported that staff returning from days off or holidays contributed to the beautification of the hospital by bringing with them "boots full" of native trees, shrubs and plants that they had acquired for planting. Kingseat also benefited from the gift of surplus plants from the Ellerslie Racecourse including 'hundreds of boxes of pansy plants grown from imported French seeds. Built after Tokanui, also to a villa design, both hospitals would have been governed by the same policies, and while there is no record of staff or other facilities gifting plants, the use of natives and bright, colourful flowers such as pansies seems certain. See *Kingseat Hospital, 50 Years 1932 – 1982* (Papakura, N.Z.: Kingseat Jubilee Editorial Committee, 1981), pp. 7-8.
- 16 Wendy Hunter Williams, *Out of Mind, Out of Sight: The Story of Porirua Hospital* (Porirua, N.Z.: Porirua Hospital, 1987), p. 115.
- 17 Cheryl Caldwell, 'Truby King and Seacliff Asylum, 1889-1907, chapter in *"Unfortunate Folk": Essays on Mental Health Treatment, 1863-1992*, ed. by Barbara Brookes and Jane Thomson (Dunedin, N.Z.: University of Otago Press, 2001), pp. 40-41.
- 18 James Beattie, 'Colonial Geographies of Settlement: Vegetation, Towns, Disease and Well-Being in Aotearoa/New Zealand, 1830's-1930's', *Environment and History*, 14 (2008), p. 584.
- 19 Beattie, p. 593.
- 20 Warwick Brunton, 'Colonies for the Mind: The Historical Context of Services for Forensic Psychiatry in New Zealand' in, *Psychiatry and the Law: Clinical and Legal Issues*, edited by Warren Brookbanks (Wellington, N.Z.: Brookers, 1996), p. 30.
- 21 'A History of Tokanui Hospital: Te Awamutu, 1912-1997', ed. by Roger McLaren ([n.p.]: [n.pub.], 1997). Located as photocopy at the National Archives Auckland Branch, YCBG., p. 3.
- 22 J. Drysdale, 'The Tokanui Mental Hospital Estate: King-Country Development', *New Zealand Journal of Agriculture* (January 20, 1919), p. 34.
- 23 Drysdale, p. 34.
- 24 Drysdale, pp. 34; 36.
- 25 Report on Mental Hospitals of the Dominion for 1911, *AJHR*, 1912, H-7, p. 8; Report on Mental Hospitals of the Dominion for 1912, *AJHR*, 1913, H-7, p. 10.
- 26 *AJHR*, 1913, H-7, p. 10.
- 27 Report on Mental Hospitals of the Dominion for 1916, *AJHR*, 1917, H-7, p. 6.
- 28 Report on Mental Hospitals of the Dominion for 1917, *AJHR*, 1918, H-7, p. 6.

- 29 Report on Mental Hospitals of the Dominion for 1924, *AJHR*, 1925, H-7, p. 10.
- 30 Report on Mental Hospitals of the Dominion for 1925, *AJHR*, 1926, H-7, p. 9
- 31 In the 1925 department report it was hopefully commented that accommodation in the vicinity of No.1 camp would enable the whole property to be worked to advantage allowing labour from the Waikeria Borstal Institution to be dispensed with entirely. See *AJHR*, 1925, H-7, p. 9
- 32 Report on Mental Hospitals of the Dominion for 1919, *AJHR*, 1920, H-7, p. 4.
- 33 *AJHR*, 1929, H-7, p. 6
- 34 Dot Whittle, p. 2.
- 35 In 1913 the value of produce consumed versus that sold for cash was £408 8s 9d compared with £66 18s 5d. By 1920 the respective figures were £2,577 15s 7d versus £1,811 12s 3d. See Report on Mental Hospitals of the Dominion for 1913, *AJHR*, 1914, H-7, p. 8; *AJHR*, 1920, H-7, p. 4.
- 36 Hunter Williams, p. 132.
- 37 Hunter Williams, p. 132.
- 38 Hunter Williams, p. 132.
- 39 *AJHR*, 1920, H-7, p. 22.
- 40 *AJHR*, 1932, H-7, p. 2.
- 41 *AJHR*, 1935, H-7, p. 6.
- 42 Hunter Williams, p. 137.
- 43 Letter to Mr. Chapman from A.D. Croasdale, Medical Superintendent, regarding the provision of services to assist the Agriculture Department with running of the farm, p. 1 of Tokanui File: Land, Building & Accommodation; Land: General, Grazing, File No.8/9, p. 1.
- 44 Brunton, 'A Choice of Difficulties', p. 451.
- 45 Hunter Williams, p. 125.
- 46 Brunton, 'A Choice of Difficulties', p. 452.
- 47 *AJHR*, 1912, H-7, p. 7.
- 48 *AJHR*, 1928, H-7, p. 3.
- 49 Prior to transferring from Porirua, James Cran had just recovered from typhoid which he contracted during an epidemic at the hospital. While recovering at Wellington Public Hospital, Cran met his wife, Adeline Agnes McArthur who he married before they transferred to Tokanui.
- 50 Janet Frame, *An Autobiography* (Auckland, N.Z.: Century Hutchinson, 1989), p. 221.
- 51 Brunton, 'A Choice of Difficulties', p. 325.
- 52 'A History of Tokanui Hospital', p. 6.
- 53 Newspaper advertisement, 7 October 1921, Archives New Zealand (ANZ), Wellington, H-MHD, 1, 8/116/0.
- 54 'Notice of Appointments, promotions and transfers', Supplement to the *New Zealand Gazette* (NZG), 1914, vol. 2, p. 4202.
- 55 Brunton 'A Choice of Difficulties', p. 305.
- 56 Brunton 'A Choice of Difficulties', table 13 p. 307.
- 57 Report on Mental Hospitals of the Dominion for 1914, *AJHR*, 1915, H-7, p. 6.
- 58 Report on Mental Hospitals of the Dominion for 1915, *AJHR*, 1916, H-7, p. 4
- 59 'List of Persons Employed in the Public Service on the 31st Day of March', Supplement to the *New Zealand Gazette* (NZG), 1915, vol. 1, p. 1582 & 'Notice of Retirement', Supplement to the *New Zealand Gazette* (NZG), 1916, vol. 1, p. 872.
- 60 'List of Persons Employed in the Public Service on the 31st Day of March', Supplement to the *New Zealand Gazette* (NZG), 1918, vol. 1, pp. 1578-9.
- 61 *AJHR*, 1917, H-7, p. 6.
- 62 'Tokanui 50th Jubilee', [No Further Publishing Details Available]. Located as photocopy at the National Archives Auckland Branch, 5931/1a, p. 6.
- 63 Brunton 'A Choice of Difficulties', p. 333.
- 64 'A History of Tokanui Hospital', p. 3.

- 65 Brunton 'A Choice of Difficulties', p. 327.
- 66 Brunton 'A Choice of Difficulties', p. 327.
- 67 Brunton 'A Choice of Difficulties', p. 327.
- 68 Brunton 'A Choice of Difficulties', p. 333.
- 69 Report on Mental Hospitals of the Dominion for 1918, *AJHR*, 1919, H-7, p. 10.
- 70 Brunton 'A Choice of Difficulties', p. 340.
- 71 Brunton 'A Choice of Difficulties', p. 340.
- 72 Caldwell, p. 43.
- 73 Brunton 'A Choice of Difficulties', p. 304 -05.
- 74 Brunton 'A Choice of Difficulties', p. 304.
- 75 Brunton notes, regarding keys, that 'attendants and other staff who needed access to the wards were given a standard key for all doors in either the male or female division. Senior staff had a "master key" that enabled those doors to be check-locked or double-locked. Principal officers possessed a 'grand master key' to lock and check-lock all doors in either division'. See Brunton 'A Choice of Difficulties', Footnote no. 5, p. 304. Regarding uniforms, Brunton notes that in 1885, Gribben, then superintendent of Hokitika, 'wanted attendants to wear striped trousers and caps with a distinguishing badge of rank: an oak leaf band for attendants, and silver lace band and crown for the Head Attendant'. See Brunton 'A Choice of Difficulties', Footnote no. 178, p. 336. By 1934 Brunton notes that 'probationers wore pink and white striped frocks, and nurses a blue uniform. Charge nurses wore cream but later white uniforms'. Brunton 'A Choice of Difficulties', Footnote no. 201, p. 340.
- 76 See Brunton 'A Choice of Difficulties', p. 337.
- 77 Brunton 'A Choice of Difficulties', caption for image which appears after p. 328.
- 78 Brunton 'A Choice of Difficulties', Footnote no. 201, p. 337.
- 79 'A History of Tokanui Hospital', p. 7.
- 80 'Tokanui 50th Jubilee', p. 8.
- 81 Brunton 'A Choice of Difficulties', p. 338.
- 82 *AJHR*, 1926, H-7, p. 6.
- 83 Brunton 'A Choice of Difficulties', p. 338.
- 84 Brunton 'A Choice of Difficulties', p. 346.
- 85 Brunton notes that '[t]he proximity of staff rooms to the wards meant that "one does not get the freshest, and therefore the best, work from officials who have had had little leisure, and who cannot in their hours of rest be disassociated from their office"'. See Brunton 'A Choice of Difficulties', p. 338 – 39.
- 86 Brunton 'A Choice of Difficulties', p. 339.
- 87 *AJHR*, 1927, H-7, p. 10.
- 88 *AJHR*, 1932, H-7, p. 5.
- 89 Transcript of Joint Interview with Laurie (Monty) Mills and Laura Condon, 13 June 1996, Interviewed by John Graham and Bub Lubline, John Graham Archival Collection, p. 1.
- 90 Caldwell, p. 44.
- 91 'Tokanui 50th Jubilee', p. 8.
- 92 'A History of Tokanui Hospital', p. 5.
- 93 'Tokanui 50th Jubilee', p. 8.
- 94 Brunton 'A Choice of Difficulties', p. 338.
- 95 'A History of Tokanui Hospital', p. 3; 'Tokanui 50th Jubilee', p. 1; *AJHR*, 1913, H-7, p. 17 – See note at bottom of page pertaining to average number of patients resident during the year for Tokanui.
- 96 Report on Mental Hospitals of the Dominion for 1909, *AJHR*, 1910, H-7, p. 7.
- 97 *AJHR*, 1913, H-7, p. 21.
- 98 *AJHR*, 1935, H-7, p. 13.
- 99 Report on Mental Hospitals of the Dominion for 1929, *AJHR*, 1930, H-7, p. 16.
- 100 *AJHR*, 1910, H-7, p. 7.
- 101 *AJHR*, 1910, H-7, p. 7.

- 102 *AJHR*, 1913, H-7, p. 7.
- 103 *AJHR*, 1920, H-7, p. 2.
- 104 J. Conolly, 'The Treatment of the Insane without Mechanical Restraints', London, 1856, Cited in Hunter Williams, p. 5.
- 105 Hunter Williams, p. 66.
- 106 Brunton, 'A Choice of Difficulties', Footnote 88, p. 373.
- 107 Brunton, 'A choice of Difficulties', p. 381.
- 108 Brunton, 'A Choice of Difficulties', p. 382.
- 109 Report on Mental Hospitals of the Dominion for 1923, *AJHR*, 1924, H-7, p. 7.
- 110 *AJHR*, 1924, H-7, p. 7.
- 111 *AJHR*, 1925, H-7, p. 10.
- 112 *AJHR*, 1928, H-7, p. 6.
- 113 *AJHR*, 1932, H-7, p. 5.
- 114 *AJHR*, 1933, H-7, p. 7.
- 115 Report on Mental Hospitals of the Dominion for 1933, *AJHR*, 1934, H-7, p. 4.
- 116 *AJHR*, 1928, H-7, p. 6.
- 117 Mention is first made of the annual picnic in the 1928 report, however the way it is written makes it appear that it was already an established event. See *AJHR*, 1928, H-7, p. 6. The fancy dress ball is first mentioned a year later in the 1929 report. See *AJHR*, 1929, H-7, p. 6.
- 118 'Tokanui 50th Jubilee', p. 7.
- 119 *AJHR*, 1924, H-7, p. 7.
- 120 *AJHR*, 1934, H-7, p. 4.
- 121 Brunton, 'A Choice of Difficulties', p. 259.
- 122 Brunton, 'A Choice of Difficulties', p. 259.
- 123 Brunton, 'A Choice of Difficulties', p. 259.
- 124 Brunton, 'A Choice of Difficulties', p. 259 - 60.
- 125 Brunton, 'A Choice of Difficulties', p. 265.
- 126 Brunton, 'A Choice of Difficulties', p. 264.
- 127 Brunton, 'A Choice of Difficulties', p. 264.
- 128 Brunton, 'A Choice of Difficulties', p. 255.
- 129 Brunton notes that although Mercier believed that recent cases, new admissions and epileptics should be accommodated in separate wards, he 'urged that "suicides, general paralytics, &c." could share some facilities but that general paralytics should be kept apart from epileptics, because of their proneness to injury and aggression-provoking habits. At night, the restless and dirty habits of patients with general paralysis of the insane meant they could share wards with feeble and quieter patients.' See Brunton 'A Choice of Difficulties', p. 264.
- 130 *AJHR*, 1919, D-1, pp. 40-41.
- 131 'Tokanui 50th Jubilee', p. 6.
- 132 *AJHR*, 1928, D-1, p. xxiv.
- 133 *AJHR*, 1930, D-1, p. xxvi.